MSIS State Anomalies/Issues: All States

State	File Type	Record Type	Issue
_ALL	All	All	Some states submit claims and enrollment records that don't carry the same MSIS ID for the same person. This can occur when the state changes their MSIS ID numbering scheme, or records processed outside the state MMIS system are reported with different MSIS ID's. This most often impacts capitation claims and encounter claims. The details are reported in the anomalies report under the specific states involved.
	Claims		Comments are all related to FFS claims unless specified otherwise.
			In states with heavy managed care penetration, the distribution of FFS claims by type of service and other measures is often difficult to assess as generally there are FFS claims only for a few people, often with special characteristics.
			Some states submitted claims for people enrolled in S-CHIP only. Since these claims are from a state only program with no Medicaid involvement, they should have not bee included. In order to identify and remove most of them, the S-CHIP only enrollees need to be identified from the EL file and then claims for those enrollees removed. The details are mentioned for the specific states involved in the anomalies report.
			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.
		LT	Some states submit separate LT claims for services provided by the facility that are not included in the bundled services. These claims are not supposed to include covered days.

State	File Type	Record Type	Issue
_ALL	Claims	LT	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, or the state did not void the original and included both the original and resubmittal claim in the LT file, or the claim includes days that were paid for by the patient (spend down), or it is a crossover claim with days.
		OT	In some states there are claims with invalid combinations of Service Code Indicator and Service Code format.
		RX	1. 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 to choose to report either the most expensive rebatable drug or all the line items. The line items do not include the Medicaid Amount Paid. NCPDP D.0 version is going to be released probably in February 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. 2. 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 2009 Q1 forward, we are investigating the best method of reporting compounds into MSIS.
AK		All	Alaska is not submitting any service tracking claims.
		Capitation	There aren't any capitation claims as Alaska doesn't have a managed care program.
		Encounter	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.
		IP	The average Medicaid amount paid per hospital claim is high, but the state confirms it is correct. 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.

State	File Type	Record Type	Issue
AK	Claims	LT	There is a lower than expected percent of claims with Patient Liability.
			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.
			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, that provides services to many people who might be served by Medicaid NF institutions.
			There aren't any claims with a Type of Service of 05 [Intermediate Care Facilities for the Mentally Retarded (ICF/MR)] or 02 (Mental Hospital/Aged) as these are not covered.
			The average Medicaid Amount Paid per day is about two times higher than expected, but is consistent across years.
			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). This situation was significantly improved starting with Quarter 2 (Q2) 2003.
		OT	Claims with state defined service codes are incorrectly reported with a Service Code Indicator = 6 (HCPCS)
		RX	A small percent of NDC fields are 0-filled.
			There aren't any claims with a Program Type of 2 [Family Planning (FP)].
			There are only a few claims with Other Third Party Payment, also known as Third Party Liability (TPL).
			Date Prescribed is always missing.
			The Point of Service (POS) system results in few adjustments.
			A small percentage claims have a HCPCS Service Code instead of an NDC code in the NDC field.
			Alaska started reporting IHS as a Program Type in Q2 2003.

State	File Type	Record Type	Issue
AK	Eligibility	1115 Waivers	In FY05, Q1-Q4 AK did not report any children to its 1115 'KidCare' waiver. The enrollees in this waiver were a subgroup of state group '000009', and could not be identified in MSIS until AK revamped its state specific coding in Q1 FY06. This issue can not be fixed in CY05 MAX. Effective 2004, CMS approved an 1115 waiver amending the Denali KidCare M-CHIP program. This waiver covers M-CHIP child applicants with family income of 150-175 percent FPL. Unlike other M-CHIP children, they are subject to a 1 year "waiting period" without insurance. This group was not reported to MASBOE 54 until Q1 FY06.
		County Codes	Alaska's county codes do not follow the usual pattern of three-digit odd numbers. However, they are correct.
		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. About 80-85 percent of persons age 65 and older are dual eligibles. This is a lower proportion than expected. For example, in Q1 FY06, only 77 percent of aged were dual eligibles, but this increased to 88 percent by Q1 FY07. Initially, we agreed that Alaska could assign dual code 99 to enrollees whose Medicare status is unknown. In Q1 FY 2003, no enrollees received dual code 99.
		Managed Care	No one in Alaska's Medicaid population is enrolled in a managed care plan.
		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.

State	File Type	Record Type	Issue
AK	Eligibility	MASBOE	2006: Between July and September 2006, child enrollment declined by 8 percent. This decline happened for several reasons: 1) New citizenship verification requirements have slowed down the processing of new applications and recertifications of existing cases; 2) In FY04 AK ammended its M-CHIP program to reduce the income level from 200 to 175 percent FPL 3) AK's seasonal workforce results in some enrollees exceeding income limits while they have summer work. The citizenship requirements in particular caused delays in application processing that did not begin to clear until Spring of 2007. A higher volume of correction/retro records may reduce some of the enrollment decline for 2006.
			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.
			Alaska has a six months continuous eligibility guarantee for children.
			July is a peak employment time in Alaska, contributing to a decrease in Medicaid enrollment for children and adults each July.
		Private Health Insurance	In Q2 FY06, AK implemented a "Pharmacy Cost Avoidance" program. Part of this program included improving identification of enrollees with third party drug coverage. As a result of this effort, the number of enrollees reported with third party insurance fluctuated through Q2-Q4 FY06.
			More than 40 percent of Alaska's Medicaid population is enrolled in a private health insurance plan. This is much higher than we see in other states. It happens because a high percentage are Native Americans and eligible for coverage under the IHS.
		Restricted Benefits Flag	Beginning in February 2006, AK began reporting QI (Dual Code 06) individuals for aged and disabled duals under state specific codes '01SL78' and '03SL78,' respectively. The state refers to these individuals as "SLMB-Plus," even though they acknowledge that CMS considers them to be "QI." These individuals were erroneously given RBF=1 instead of RBF=3 beginning in February 2006 and through the end of FY08. The state has been asked to submit retro records to correct this beginning Q1 FY07 thorugh Q4 FY08; meanwhile, MAX will need to correct all FY06 data beginning in month 2 of Q2 FY06.

State	File Type	Record Type	Issue
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.
		Retroactive/Correction Records	AK uses retroactive and correction records.
			From FY99 through FY05, AK did not submit retro records for any Q4 file, due to programming that only allows retro records to apply within the current reported fiscal year. AK reports about 2,000 retro records (2% of the original file size) for Q1-Q3. No retros or correction records were submitted in FY06. Then, in Q1 FY07, the state began to report both retro and correction records. The volume increased substatially in Q2 FY07, primarily related to an application processing backlog caused by new citizenship verification requirements.
		CHIP Code	In addition to children reported to MASBOE 34, roughly 400 to 1,000 M-CHIP eligibles are mapped to MAS/BOE 35 each month through Q1 FY07. This could be an age sort issue.
			In Q1 FY08, AK's the 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 eligiblity, being reported 30 days after the end of the next quarter. Meanwhile, MSIS reporting methodology has the CHIP 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.
			Beginning in FY 2001, there is a higher than expected discrepancy between MSIS and SEDS CHIP counts. It appears that the SEDS data are more reliable. The data become comparable in Q3 FY 2003. After that point, MSIS M-CHIP counts appear to be more reliable than SEDS data.

State	File Type	Record Type	Issue
AK	Eligibility	CHIP Code	AK reports its M-CHIP eligibles in MSIS. The state does not have an S-CHIP program. In 1998, AK's original M-CHIP program covered infants from 185-200 percent FPL, children 1-6 years from 133-200 percent FPL, and older children 100-200 percent FPL. The upper income threshold was reduced to 175 percent FPL effective 10/03. Then, in 2004, AK's M-CHIP applicants with income 151% - 175% FPL were transferred to the Denali KidCare 1115 waiver. These children are deemed eligible under AK's 1115 waiver guidelines - unlike children <150% FPL, they are subject to a 1yr "waiting period" without insurance. However, by mistake, MSIS reporting to MASBOE 54-55 did not begin for this group until Q1 FY06.
		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.
		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 (the contract for which is currently under protest) is in place (not until 2010), the state will be able to report TANF data reliably.
		Waivers	In FY05 Q1-Q4, AK reported erroneous waiver ID codes for enrollees in its 1915c waivers. Enrollees who were assigned waiver ID '30', '31', or '34' should have been reported to waiver ID 'AD'. Enrollees in waiver codes '40', '41' or '44' should have been reported to waiver ID 'OA'. Enrollees in waiver codes '70', '71' or '74' should have been reported to waiver ID 'MR'. Finally, enrollees in waiver codes '80' and '81' should have received waiver code 'CM'. This issue was resolved in Q1 FY06.
		xReview Note	Look for RBF=A (PRTF Grant) in future submissions. We expect to see it in FY2009.

State	File Type	Record Type	Issue
AL	Claims	IP	Alabama included global payment claims for people enrolled in prenatal/delivery managed care until 2008 Q2. They generally represented about 75 percent of the IP claims. They can be identified by a "58" in the first two positions of the Provider ID field. These claims are not billed on the UB-92 and so are missing data elements such as UB-92 Revenue Codes, patient status, and procedures. There is a big drop in the number of IP claims starting in 2008 Q2 when they were redefined as PHP capitation claims and reported in the OT file.
			There is a high proportion of crossover claims because most non-crossovers are enrolled in managed care.
			There are no IP claims with a program type of family planning.
			The average Medicare coinsurance/deductibles were much higher than expected - - over $2000 -- in the 2006 files.
			Patient status is frequently missing.
		IP/LT/OT	Between Q2 2000 and Q4 2002 Alabama coded most credit claims as crossovers (by 0-filling the coinsurance/deductible fields).
			On some claims in Q1 1999, the diagnosis codes are padded with an extra zero.
		LT	Only about one third of the claims have Nursing Facility Days in 1999. They are reported starting in 2000.
			Very few LT claims have Other Third Party Payment (or Third Party Liability/TPL).
			No claims have Leave Days in 1999. Starting in 2000 they are reported, but the percentage of claims with leave days varies widely by quarter, from 3 percent to more than 25 percent. Alabama reports this is correct.
			There aren't any claims with a Type of Service of 04 (Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under).
			Some facilities bill for more than a month, resulting in some claims having more than 31 covered days.
		Managed Care	The average amount paid on HMO capitation claims is lower than usual because their HMO plan is dual Medicaid/Medicare managed care and the risk part for Medicaid is just for coinisurance and deductibles. In 2008 those payments are around $15.

State	File Type	Record Type	Issue
AL	Claims	MSIS ID	In 1999 to 2000, some of the adjustment claims had an extra character in the 20th position of the MSIS ID. This extra character needs to be removed in order to link the eligibility with the claims files. This situation was fixed starting with Q1 2001.
		OT	AL has under reported individual capitaion payments since Q1 1999. In 1999 HMO and PCCM capitations were reported as Service Tracking claims and there were no PHP payments although there was PHP enrollment. In 2000 individual PCCM capitation claims were submitted and the HMO and PHP capitation payments were submitted as service tracking claims. Also there were some PCCM Service Tracking payments as well. In Q1-3 2001 they only submitted some individual PHP and PCCM capitation claims and also Service Tracking claims for HMO, PHP and PCCM. Starting in Q4 2001 the file had a few individual HMO claims. During 2002-2003 there were individual PHP and PCCM payments and Service Tracking claims for HMO, PHP and PCCM.
			Even though AL discontinued their PCCM program in Q2 2004, there are still some PCCM capitation claims in the MSIS files through Q1 2006.
			The state did not start submitting individual PHP capitation claims until 2001. However, those PHP capitation claims contain the managed care plan beneficiary ID and not the MSIS ID. The state will have to resubmit these files correcting this problem.
			The credit adjustment claims do not include the Service Code, making it very difficult to properly adjust the claims.
		RX	NDC's are not reported on credit claims.
			Very few RX claims have Other Third Party Payment (or Third Party Liability/TPL) in 1999.
			RX claims with a Type of Service of 19 (Other Services) are for Clozapine Support System; this is a kit used to monitor the blood of individuals using Clozaril (a drug with significant potential negative side-effects). The NDC code on these claims is "CLOZSS."

State	File Type	Record Type	Issue
AL	Eligibility	1115 Waivers	AL experienced a substantial decline in enrollment within MASBOE 55 betweeen Q4 FY06 (when enrollment was 92,864 in July 2006) and Q3 FY07 (when enrollment was 58,029 in June 2007). AL reported that this was attributable to a decline in the enrollment of family planning recipients, which in turn was due to CMS's requirement of citizenship/identity documentation and requirement of states to perform an annual review that is not an automated passive review. AL indicated that many enrollees did not follow up on these requirements because, with limited services, "most applicants and clients don't believe the value is worth the effort." Family planning enrollment also declined after January 2006 because AL conducted an annual review of their family planning population, removing individuals who failed to complete their annual renewal. This clean-up resulted in a 25 percent decline (32,000) in family planning enrollment. Alabama had an 1115 Waiver program (the Mobile County BAY Health Plan) that was active in FY99. The program was terminated, however, on 9/30/99. Beginning in FY2000 Q4, Alabama implemented a new 1115 Waiver. This 1115 welfare waiver provides family planning services for Plan First families (State codes 5-FP and 5XFP). Prior to Q1 FY06, these enrollees correctly received RBF code '4' (pregnancy). In Q1 FY06, these enrollees should have received restricted benefit code '6' (family planning only) but continued to receive rbf '4'. The state largely to corrected this in Q2 FY06. AL had a Hurricane Katrina Waiver approved on 9/22/05. The waiver was in effect from August 24, 2005 to June, 30 2006. These enrollees were reported to MASBOE 51-55. Between Q4 FY05 and Q1 FY06, AL made some programming changes in the aftermath of Hurricane Katrina that resulted in roughly 13,000 family planning enrollees shifting from MASBOE 54 to MASBOE 55. From Q1 FY06 forward, all family planning enrollees are reported to MASBOE 55. Between November and December 2005, Family planning enrollment fell by 12,000 (9%). This happened when the state performed a one-time cleanup of its data, removing people no longer eligible. These individuals still have eligibile children, and were erroneously reported to MASBOE 35 in December 2005 and January 2006. See MASBOE note concerning state group 5_PN.

State	File Type	Record Type	Issue
AL	Eligibility	County Codes	Alabama assigns county code 100 to its Foster Care recipients.
		Dual Eligibility Codes	Beginning in Q1 FY05, when AL implemented the monthly dual code, the state had a small number (<200) of enrollees reported to MASBOE 31-32 with a full dual code. AL responded that there is sometimes a small lag in dual coding when someone moves from full to partial dual status.
			Compared to MMA data in FY06, MSIS data for Q1-Q4 FY06 identified about 4,000 more full duals reported to dual code 08. This is because AL retroactively applied to MSIS data information it received from MMA prospective (pro) records on unidentified Medicaid enrollees with Medicare entitlement.
			More than 16,000 eligibles in Q1 FY 1999 incorrectly received the dual code 08. They should have been coded as 09s. This change was made in subsequent quarters.
			There appears to be a switch for duals with code 01 and 02 (QMB onlies and QMB pluses) between FY1999 Q1 and Q2. Roughly 5,000 duals who are reported with dual flag 01 in Q1 are reported with dual flag 02 in Q2 and beyond.
			There are no dual eligibles with dual flag 04 (SLMB plus full Medicaid) in FY1999 Q1. Beginning in FY1999 Q2, about 5,500 individuals with dual code 04 are reported each quarter.
			From Q2 FY02 through Q1 FY05, AL reported a very small number of duals to dual code 07 (QI-2). The QI-2 program was discontinued by CMS in December 2002. The state has been asked not to use dual code 07 in future files.
			Through September 2002, Alabama assigned dual flag 00 ("not Medicare eligible") to many persons (approximately 5,000 persons in Q4 FY02) in MAS/BOE 31 - 32. These persons should have received dual flag 07 ("QI-2"). Not until Q103 were a substantial number of duals assigned code 07. The QI-2 program was discontinued in December 2002, although this is not reflected in MSIS files until February 2003.
			In Q1-Q4 FY06, roughly 250 enrollees were reported to dual code '06' (QI1) and restricted benefits code '1' (full benefits). These enrollees are "district office certified recipients" with full benefit eligibility, and should be reported to dual code 08 (other full dual). The state will fix this in Q1 FY07.

State	File Type	Record Type	Issue
AL	Eligibility	Dual Eligibility Codes	In FY06, AL reported roughly 8,000 enrollees in MASBOE 11-12 to dual code 08, instead of dual code 02. The state reported that these individuals did not appear to have QMB status, but were found on an EDB file provided by CMS, prompting AL to assign them dual code 08. The FY06 counts of dual code 02 are very consistent with AL's MMA files. Prior to Q1 FY06, only about 3,000 enrollees in MASBOE 11-12 were assigned dual code 08.
			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 a recipient has 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.
			Through FY02, Alabama assigned dual flag 02 ("QMB & full Medicaid coverage") and 04 ("SLMB & full Medicaid coverage") to about 18,000 persons in MAS/BOE 32. These persons should have been assigned dual codes 01 ("QMB-only") and 03 ("SLMB-only"). The state fixed this problem beginning in FY 2003.
			AL discovered a problem where they were assigning dual code 08 to individuals with 0-filled Medicare start dates. This may have resulted in a slight overcount (roughly 500 people) of duals in dual code 08 until the issue was corrected in Q1 FY05. It appears that this problem began when AL stopped using dual code 09 in Q1 FY03.
			Between Q4 FY04 and Q1 FY05, the number of duals reported to dual code 08 increased by 3,000 (26 percent). The state is unsure of why this increase occurred.
		Managed Care	From FY05 forward (when AL implemented monthly dual coding) roughly 8,000 full duals are reported to Plan Type 08 (other), AL's partnership hospital program. The PHP network provides inpatient services to eligibiles without Medicare Part A. AL has confirmed that these duals do not have Part A.
			In Q3 FY06, AL reported 16% fewer PCCM enrollees than CMS administrative data. AL could not explain this discrepancy, but believes MSIS data are reliable.
			In Q2 FY07, a one-time system processing problem in January 2007 caused an erroneous decline in plan type 08 enrollment. AL indicated that enrollment counts for December 2006 and February 2007 are correct, though.

State	File Type	Record Type	Issue
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. By June 2005, enrollment is expected to reach 400,000. Although disparities existed between CMS and MSIS Medicaid PCCM counts through FY03 (between 8 and 20% discrepancy in PCCM counts), Alabama assures us that the MSIS counts are more accurate. In Q1 FY 2000, about 40,000 eligibles were no longer enrolled in a comprehensive managed care plan. According to the state, these persons were children in Mobile County who were enrolled in the Bay Health Plan. The plan was discontinued and the children moved into Primary Care Case Management (PCCM) plans. More than 300,000 eligibles received Plan Type 08 each month. These persons were enrolled in what Alabama refers to as its "PHP (Partnership Hospital Program) Network." This is not a comprehensive managed care plan. Rather, the PHP Network provides only inpatient care for persons who do not have Medicare Part A coverage. In Q4 FY04, AL began reporting Mobile County individuals to the PHP Network, resulting in an increase in plan type 08 enrollment of about 50,000 enrollees from August - September 2004. 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" includes four AL Medicare Advantage plans: Medicare Complete, VIV Medicare Plus, Health Spring Senior First, and BC/BS Advantage. See notebook insert on Medicare Complete. This plan is not reported in CMS managed care data.
		MASBOE	In the first month of Q1 FY 2001, enrollment in MAS/BOE 35 increased by about 5,000 before returning to its previous level in the following month. The jump in enrollment represented the added enrollment of about 5,000 women into a family planning program. Most of the women elected not to remain enrolled beyond the first month.

State	File Type	Record Type	Issue
AL	Eligibility	MASBOE	There were nearly 800 persons in state-specific eligibility group "L" who were incorrectly mapped to MAS/BOE 11 and 12 in Q1 FY 1999. They should have been mapped to MAS/BOE 31 and 32. This problem was corrected in subsequent quarters.
			AL reports enrollees who were initially certified into Medicaid as disabled in BOE 2 after they turn 65.
			Enrollment in MASBOE 14 declined by 8% from June to July 2004. AL has confirmed that this drop was due to changes in Medicaid redetermination responsibilities for TANF recipients. The drop occurred when many TANF recipients did not recertify their children.
			AL reports almost no one to MASBOE 44-45 due to state coding limitations. Presumably TMA enrollees are included in the MASBOE 14-15 counts, as well as other 1913 enrollees. The State intends to review its TMA coding after Q1 FY04 is approved.
			2006: Between September 2005 and October 2005 (month 1, Q1 FY06) it appears that rougly 12,000 individuals shifted from MASBOE 54 to MASBOE 55. Most of these individuals appeared to be 19-20 years old, and it seems likely that an age shift occurred. The state said that their family planning programming would not move people in such a way, but did say that in the wake of Katrina, many people were terminated for not completeing annual reviews. Many of these people reapplied using a modified application process, and the state made many quick programming changes to prevent people from being removed from the rolls, and this "shift" appears to be the result.
			2006: In December 2005, AL terminated roughly 13,000 Family Planning-Only enrollees, but mistakenly reported them to MASBOE 35 because they still had eligible children. These individuals were reported to state group 5_PN. These individuals should have been reported to MASBOE 00 in the months of December 2005 and January 2006. These error was not corrected until February 2006, when enrollment in MASBOE 35 returned to normal levels. Prior to December 2005, very few enrollees (200/month) were reported to state group 5_PN. These were enrollees terminated in the current month.
		Restricted Benefits Flag	Through Q1-Q4 FY06, several thousand Family Planning enrollees were assigned restricted benefits code '4' (pregnancy related) instead of code '6' (family planning only). All enrollees in state groups 5_FP and 5XFP should receive rbf '6'. AL will fix this in Q1 FY07.

State	File Type	Record Type	Issue
AL	Eligibility	Restricted Benefits Flag	In January 2006, roughly 12,000 individuals in MASBOE 35 were assigned restricted benefits code '6' (family planning only). These are the individuals in state group 5_PN who should have been reported to MASBOE 00 (see MASBOE anomaly).
			Effective Q4 FY 2000, most persons in MAS/BOE 54-55 only qualify for family planning benefits. These persons were correctly assigned restricted benefits code 4 through Q4 FY05. In Q1 FY06, these enrollees should have been reported to restricted benefits code '6' (family planning only); however, this change was not made. In Q1 FY06, all enrollees in MASBOE 54-55 with restricted benefits code 4 should be assigned restricted benefits code '6'.
		Retroactive/Correction Records	Through FY02 Q4, the state sent in correction records with erroneous changes. Invalid correction records caused monthly enrollment to be overstated in 99 MAX. Correction records should be ignored for 2000-2002 MAX. Effective FY03, CMS asked that AL stop submitting retro/correction records.
		CHIP Code	Alabama reported its M-CHIP children, but did not report any of its S-CHIP children (a much larger program) in MSIS. In FY 2001, M-CHIP enrollment declined and enrollment phased out by Q1 FY 2003. Alabama did not ever report its S-CHIP program in SEDS.
		SSN	AL reports over 99 percent of its records with SSNs. AL requires applicants to obtain SSNs for newborns and young children. AL believes its SSN data is very reliable. MPR has used the SSA high-group test to check the validity of AL's SSNs. Looking at Q1 FY06, MPR found that 1.46% (12,467) SSNs did not pass the high group test. AL maintains that its SSN data is reliable, and that only SSNs are entered into the SSN field.
			In Q4 FY 2001, about 850 Social Security Numbers (SSNs) were assigned to more than one person. This occurred because both correct and incorrect MSIS ID numbers were submitted with the same SSN. This problem cannot be fixed without resubmission of the entire file.
		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.

State	File Type	Record Type	Issue
AL	Eligibility	TANF/1931	In FY05, AL's TANF reporting in MSIS continued to be unreliable. MPR recommended that the state 9-fill its TANF flag from Q1 FY05 forward.
			Alabama experienced major problems with its TANF flag in FY 2000 and FY 2001. As a result, the monthly TANF information was not reliable. The state fixed the flag in FY 2002. However, in FY03 and FY04, problems with the TANF flag occurred again, making it unreliable.
		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 eligiblity in such a program is preempted by aid categories that are internally changed to reflect enrollees' pending applications for other eligiblity programs. The same programming logic is responsible for a discrepancy of about a 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.
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.
		IP	There aren't any claims with a Program Type of 2 (Family Planning).
			Each claim can only have a maximum of two diagnosis codes.
		LT	Patient Liability is not shown on any LT claims.
			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.
		OT	In 1999 to 2002, Arkansas submitted one Primary Care Case Management (PCCM) capitation payment claim per month for everyone enrolled in Medicaid, not just for the PCCM enrollees. This will be corrected starting with the Q1 2003 file.
			There is a big increase in the number of transporation claims starting in Q3 2004 with a decrease in the average amount paid. These are probably actually transportation capitation claims that were reported as FFS.
		RX	In 2003 Q3 only 23% of drug claims reported quantity and in 2004 Q1 77% had quantity. Other quarters reported the quantity on virtually all claims
			A larger than expected percent of claims have days supply greater than 30.

State	File Type	Record Type	Issue
AR	Claims	RX	The few FFS debit claims appear to be all, or mostly, service tracking claims while credit adjustments are all individual claims.
			Both the Fill Date and Prescribed Date fields contain the Fill Date through 2003 Q4. The state will '9' fill the Prescribed Date in future submission as it is not available.
	Eligibility	1115 Waivers	AR implemented a Katrina 1115 waiver on 9/28/05. However, when reporting to MSIS in Q1 FY06 , AR included these enrollees under their regular aid categories rather than reporting them with Waiver ID 'B4' (AR's waiver ID for the 1115 Katrina waiver) or Waiver Type 'A' (disaster related) or a waiver ID.
			In October 2006 (Q1 FY07), AR implemented a HIFA waiver that expanded eligibility to parents and spouses of Medicaid/CHIP 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. These enrollees should be reported to MASBOE 55. The waiver will also transition AR's ConnectCare 1915(b) waiver population (approx. 311,000 individuals) into the demonstration. Benefits and service delivery (through AR's PCCM program) of this group will not be impacted. The connect care group is not an eligibility expansion (so these enrollees are not reported to MAS 5).
			Arkansas has an 1115 Waiver program called ARKIDS B (called ARKIDS First when implemented in 10/97) and is reporting many of its poverty-related children into MAS/BOE 54. The adults in MAS/BOE 55 only qualify for family planning benefits under an 1115 waiver approved in 1996.
			AR implemented a cash and counseling 1115 waiver called "Independent Choices" in 1998. This waiver did not have any eligibility expansion. This waiver scheduled to expire 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. They should have been reported to MASBOE 52, which began in Q1 FY07.
		County Codes	Before Q1 FY03, the AR county code data are not valid.

State	File Type	Record Type	Issue
AR	Eligibility	Dual Eligibility Codes	Through FY05, AR assigns dual code 02 (QMB plus) to all full duals. As of FY05, AR was working on large system changes that would enable use of dual code 04 and 08. AR hopes to have these changes in place by Q1 FY06.
			Through Q1 FY03, AR dual eligible data were not fully reliable. AR did not report about 9,000 enrollees who had a Medicare match as duals. The state also reported approximately 7,500 false duals who did not have a Medicare match. The state does not have the original data required to improve its data for this earlier period.
			In Q2-Q4 FY06, there were substantial differences between MSIS and MMA dual reporting. From Q2-Q4 FY06, AR reported roughly 19 percent fewer duals than the MMA files for the corresponding months. Large differences existed between full and partial dual counts. There were also substantial differences by dual code. AR has been asked to explain why these differences existed.
			AR assigns dual code 02 to all full duals. As of FY06, AR was working on large system changes that will enable use of dual code 04 and 08. Hopefully these improvements will be in place for FY07 MSIS files.
			In Q2 FY04, AR further improved its dual reporting, resulting in an increase of roughly 8,000 full and partial duals from Q1 FY04. Part of the increase was improved reporting of QI1 duals. The number of QI1 duals increased by 3,000 in Q2 FY04.
		Managed Care	In FY05 and FY06, 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. The state has not provided an explanation for these differences.
			Until Q1 FY03, Arkansas reported PCCM enrollment in MSIS; however, it only reported PCCM enrollment for children in its ARKids program (MAS/BOE 54). This is a significant under-count (about 20 percent of total PCCM enrollment). This was not corrected until Q1 FY03.

State	File Type	Record Type	Issue
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, 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. In Q1 FY06, AR transportation managed care enrollment appears reliable. Plan Type 08 represents AR's Transportation 1915(b) Waiver program (ID="NET").
			In Q1 FY06, enrollment declined across all dual codes (perhaps in anticipation of Part D implementation). In addition, about 5,000 persons previously reported as partial duals (especially QI-1) were no longer identified as duals. However, they continued to be reported to MASBOE 31-32 and they were shifted to RBF 1. This erroneous pattern continued through Q4 FY06. AR should only report partial duals with RBF 3 to MASBOE 31-32.
		MASBOE	2004: In Q2 FY04, the number of enrollees reported to MASBOE 22 fell 17 percent from Q1 FY04, cause unknown. Most of this decrease occurred in state group 470. Similarly, the number of enrollees in MASBOE 25 fell 8 percent (state group 272).
			Beginning with Q2 FY04 data, AR reports SSI disabled enrollees age 65 and older to MASBOE 11.
			2000: After Q3 FY 2000, Arkansas' enrollment data are always highest in month 1 of each quarter and then declines in months 2 to 3. Recent discussion with the state has indicated that they are not submitting retroactive records, as expected.
			2004: In Q2 FY04, AR began reporting BCCP enrollees to MASBOE 3A.
			2002: In Q2 FY02, enrollment declined in MASBOE 24-25, with a corresponding increase in MASBOE 14-15 (cause unknown).
			2003-2004: In Q4 FY03 and Q1 FY04, AR reported a small number of enrollees to MASBOE 19. These individuals are in a new TB-Related State group (080) and should be reported to MASBOE 41, 44, or 45, dependent on age. AR fixed this problem in Q2 FY04.
			2003: In Q1 FY03, AR data show a large increase in enrollment (7% from September 2002). This occurred in part because the file was resubmitted late in 2004. SSI disabled enrollment in particular showed a big increase

State	File Type	Record Type	Issue
AR	Eligibility	MASBOE	2004: In Q1 FY04, AR reported about 14 percent more SSI recipients to MASBOE 11-12, than were reported in SSI administrative data (cause unknown). In Q2 FY04, AR's SSI reporting improved somewhat, reporting about 7 percent more SSI recipients to MASBOE 11-12 than were reported in December, 2005 SSI administrative data.
			Roughly 10 percent of eligibles in BOE 5 are 18 or younger. Nearly all of these enrollees are between age 15-18, and are reported to MASBOE 35 and 55. These enrollees are most likely pregnant women or receiving family planning-only benefits.
			2004: Prior to Q2 FY04, roughly three percent of the eligibles in BOE 2 were older than age 65. This proportion was greater than expected. In Q2 FY04, AR improved its age sorting, which resulted in large shifts from MASBOE 12 and 32 to 11 and 31.
		Private Health Insurance	AR's insurance data are not reliable in FY04 and FY05. Due to AR's late file submission, some private insurance information was lost, as the state can only use current information to report TPL. As a result, TPL data was under reported in FY04. This problem will improve as AR becomes more current in its MSIS file submissions.
			AR's insurance data are not reliable except for FY03. Until Q1 FY 2002, less than 50 eligibles are reported to have private health insurance each month. The level increased to over 1000 enrollees per month in Q1 to Q2 FY 2002, before dropping to about 200 per month in Q3. In Q1 FY01, it increased dramatically to 20,000/month, 3.8% of current enrollees.
		Restricted Benefits Flag	AR MMIS does not have access to information that would identify aliens receiving emergency services. As a result, AR does not use restricted benefits code '2'.
			AR MMIS does not have access to information that would identify aliens receiving emergency services. As a result, AR does not use restricted benefits code '2'.
			Beginning in 2002, AR expanded Medicaid eligibility to extend full Medicaid benefits to all aged persons with income <80% FPL. These persons are reported to state code 18, along with QMB only seniors. As a result, they cannot be directly identified in MSIS data. By mistake, AR continued to assign these seniors who qualified for full Medicaid benefits to RBF 3 until October 2005 (Q1 FY06).

State	File Type	Record Type	Issue
AR	Eligibility	Restricted Benefits Flag	Beginning in 2008, AR is expected to begin implementation of 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. MPF enrollees will be assigned RBF code 8 in MSIS.
			Most adults in MAS/BOE 55 should have been assigned restricted benefits code 5 (other) since they only qualify for family planning benefits. This was fixed in Q1 FY03.
			Look for RBF 8 ("Mone Follows the Person") in future submissions. We expect to see it in Q2 or Q3 of FY08.
		CHIP Code	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 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. Some TEFRA waiver children (state group 49) are reported to MAS 5 as well.
		TANF/1931	The TANF flag is 9-filled for all eligibles.
		Waivers	From Q1 FY05-Q4 FY06, AR incorrectly reported "NOT ENROLLED" beneficiaries (MAS/BOE 00) as having Waiver Type 8 and Waiver ID 88. These enrollees should have received Waiver Type 0 and Waiver ID 00.
			In Q1-Q4 FY05, AR incorrectly reported two 1915(c) waivers in waiver types 2 and 3, rather than giving them precedence in waiver type 1 and leaving other waiver enrollment for waiver type 2 or 3. This issue was fixed in Q1 FY06.

State	File Type	Record Type	Issue
AR	Eligibility	xWaivers	AR does not report enrollment for its 1115 HIFA waiver (waiver ID never assigned), which began [TBD]. AR reported that it's HIFA waiver population is not included in the state's MSIS reporting because the waiver is not available in its MMIS, which is the source of all eligibility data. AR's Division of Medical Services (DMS) subsidizes this waiver's enrollees' employment-based insurance through a capped monthly payment to the HIFA contractor, who maintains data on those insured, manages utilization, and reports to DMS.
AZ	Claims	All	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 indentification of enrollees over time.
			Since most people are enrolled in capitated managed care plans, FFS distributions are not always as expected.
			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.
		Crossovers	There are very few crossover FFS claims. This is because most dual eligibles are enrolled in managed care.
		IP	About 25% of the IP services are reported on Indian Health Service forms that do not include the reporting of ancillary services.
			About one quarter of the claims are missing UB-92 revenue codes as they are Indian Health Service claims.
			There aren't any claims with a Program Type of family planning due to special population in FFS.
		LT	Beginning in 2001 all LT claims were mostly only paid in month 3. The state has no explanation, but believes all claims paid in each of those quarters are included in the files.
			The percent of claims with Patient Liability is lower than expected.
			Arizona started reported the Program Type of Indian Health Service in Q2 2004.

State	File Type	Record Type	Issue
AZ	Claims	LT	Beginning Q2 2002, 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.
			There are no claims with a Type of Service of Aged Mental Health.
			There aren't any claims with Other Third Party Payment (or Third Party Liability/TPL) due to the small FFS population.
			In the 2004 Q1-4 files only, the state does not report covered days on LT claims. The files were approved as AZ said it would be very difficult to fix due to system changes. Also the FFS claims are only slightly more than 10% of the file as it is a mostly managed care state. They are reported again beginning with Q1 2005.
		OT	The percent of outpatient hospital claims with UB-92 Revenue Codes codes went from almost 100 percent in 2000 to 36 percent in 2001.
			Service codes are missing on some claims.
			Arizona sometimes makes multiple capitation payments per person/month/plan to cover different plan services.
			There aren't any Federally Qualified Health Center (FQHC) claims because Arizona doesn't have a FQHC program.
			There was a big increase in the average amount paid between 2000 and 2001 for Physician and outpatient hospital services. The state hasn't any explanation except volatility probably due to most people being enrolled in managed care.
			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 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.
			There was a big increase in the percent of claims with Type of Service of 11 (Outpatient Hospital) from 2000 to 2001. Arizona investigated and has no explanation.
			The Program Type of 5 (I.H.S.) was under reported prior to Q2 2004. In Q2 2004 38% of OT claims were for I.H.S and after that the percentage increased to about 50%.

State	File Type	Record Type	Issue
AZ	Claims	OT	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.
			The error tolerance is set at 100 percent for Diagnosis 1 but 95 percent or more of the claims actually have a diagnosis.
			All capitation payment claims are coded as crossovers until Q1 2003.
			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.
			The amount charged is mostly missing.
		RX	The Other Third Party Payment (TPL) amount is always missing.
	Eligibility	1115 Waivers	Individuals in state group 960 receive family planning only benefits as part of Arizona's 1115 waiver. Prior to Q1 FY06, AZ mistakenly assigned these people to MASBOE 34 and 35 (poverty-related children/adults), rather than MASBOE 54/55 (1115 children/adults). The State fixed this in Q1 FY06, and began assigning them to restricted benefits code 6 (family planning only).
			Effective 2001, AZ 1115 expansion group also included single adults and childless couples.
			In FY05, AZ mistakenly 0-filled the waiver code fields for current Medicaid enrollees who were not enrolled in waivers. Instead, the waiver fields should have been 8-filled for this group.
			AZ had a Katrina Waiver approved on 3/6/06.
			From Q1 FY05 - Q4 FY06, AZ did not assign its family planning enrollees to waiver type F (family planning only). All enrollees in state group 960 (family planning only) should be reported to waiver type F. The state has been asked to fix this issue in FY07.
		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.

State	File Type	Record Type	Issue
AZ	Eligibility	Dual Eligibility Codes	AZ implemented a new MMIS in late 2005/ early 2006. During the transition, some aged and disabled enrollees were not all counted correctly. Enrollees in MASBOE 31 (poverty-related, aged) seem to have been most affected by this problem. This had a large impact on AZ's dual reporting in Q1 FY06, resulting in an undercount of roughly 8,000 full duals, and 15,000 partial duals, roughly 20% of AZ's total dual population. Unfortunately it appears that AZ is unable to remedy this reporting problem in MSIS. However, starting in Q2-Q4 FY06, AZ's reporting of aged enrollment and dual eligibility begins to improve. (MMA reporting for Q1-Q4 FY06 appears to be accurate.) In FY07 data, AZ dual data in MSIS returned to the expected levels, and these data are generally consistent with MMA data.
			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.
			Arizona shifted many dual eligibles from 01 (QMB-only) to 02 (QMB-plus, or full Medicaid) between Q2 and Q3 FY 2001. Specified Low-Income Medicare Beneficiary (SLMB) only (dual code 03) and QI enrollees (dual codes 06 - 07) were generally not included in MSIS reporting until Q1 FY 2003. Finally, AZ will not begin reporting to dual code 04 (SLMB-plus) until FY06.
		Foster Care	Arizona under-reported foster care enrollment in Q1 and Q2 1999. The problem was fully corrected in subsequent quarters.
		Managed Care	In FY07, AZ's MSIS managed care data compared well to the June 2007 CMS data. However, AZ had about 2,000 current enrollees whose managed care data were 0-filled instead of 8-filled.
			In FY04, FY05 and FY06, AZ reported substantially higher Behavioral Health Plan enrollment than CMS data (12 percent in FY04, 19 percent in FY05, and 10% in FY06). The state believes its MSIS BHP reporting is reliable.
			In FY 2001, CMS Medicaid managed care data showed higher HMO enrollment than MSIS; however, the CMS data included S-CHIP managed care enrollment, while S-CHIP children were not included in the MSIS counts. In addition, many LTC plans appear to be reported as HMOs in the CMS data. In FY 2002, the variation between the sources is within the expected range.

State	File Type	Record Type	Issue
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. In Arizona, Plan Type 08 is used primarily to cover persons with coverage through the Indian Health Service.. From 10/04 to 11/04, enrollment in comprehensive care plans dipped 14 percent, from 800,000 to 700,000 before increasing to 800,000 in 12/04. This temporary decline was due to a systems update related to HIPAA compliance. Arizona did not report enrollment in Behavioral Health Plans from FY 1999 to FY 2002. According to CMS data, there were about 50,000 BHP enrollees in Arizona in June 2002. The state began reporting BHP enrollment in FY 2003. However, the state had been submitting BHP Claims to MSIS all along. MSIS LTC enrollment of about 40,000 for June, 2005 is close to the count of 39,300 shown in June 2005 CMS LTC plans (although they are reported as MCO/HMOs). However, it is hard to compare enrollment in some of the smaller LTC plans across both data sources. In Q1 FY06, the number of MSIS LTC enrollees declined by about 7,000 compared to Q4 FY05. This appears to be related to problems with aged reporting in Q1-Q4 FY06. This problem is also reflected in the MSIS LTC enrollment in June 2006 of about 35,533, compared to 40,307 in CMS data.
		MASBOE	FY03: AZ began reporting SLMB only and QI enrollees in MSIS in October 2002, causing about a 10,000 person increase in the number of aged and disabled persons reported to MAS/BOE 31-32. These persons are assigned new state specific eligibility codes ACE and LTC. 2001: During 2001, Arizona extended full Medicaid benefits to the aged and disabled with income <100 percent FPL (reported in group 372). 2000: Effective Q3 FY 2000, each eligible in Arizona was assigned one and only one BOE during the year. Thus, enrollees who aged out of BOE 4 are not moved into BOE 5. Arizona reported increased enrollment in MAS/BOE 14 - 15 during FY 2000, attributable to a rapidly growing number of 1931 eligibles not receiving TANF benefits.

State	File Type	Record Type	Issue
AZ	Eligibility	MASBOE	2005: In FY05 Q1, a small number of people were reported to invalid MASBOE codes 01 and 02. These were individuals who died prior to the reporting period. 2005: In Q1 2005, the number of enrollees reported to MASBOE 32 increased 27 percent. AZ modified its eligibility determination system, thus increasing the enrollment of partial duals (codes 1, 3, and 6). 2005: Between Q4 FY04 and Q1 FY05, enrollment in MASBOE 44 increased 25 percent. This increase was due to a policy change which keeps newborns in SS groups 355 and 357 instead of moving them to 1931 family groups or MASBOE 14 (which occurred prior to Q1 FY05). 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. Since 1982, AZ has had a special 1115 waiver enabling the state to require all its enrollees to use HMO's. However, only those enrollees whose eligibility is tied to special provisions in the 1115 waiver are reported to MAS 5. 2001: Beginning in April 2001, Arizona extended full Medicaid coverage to single adults and childless couples in MAS/BOE 54/55. State groups 585 (<100 percent FPL), 587 (<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. 2001-2002: Between Q3 and Q4 FY 2001, Arizona had a considerable amount of shifting between MAS/BOE groups. The shifts stemmed from the introduction of new Key Codes, as well as a new hierarchy for determining Medicaid eligibilty. During FY02 Q1-3, growth continued across several of the child and adult groups. 2006: AZ implemented a new MMIS in late 2005/early 2006. During the transition, aged enrollees, and some disabled enrollees were not counted correctly. Enrollees in MASBOE 31 and 41 were most affected by this problem. MASBOE 31 and 41 declined by 14,000 and 6,000 respectively. As would be expected, these declines also affected dual eligible counts. This problem was fixed in Q1 FY07, with a noticeable increase in aged and disabled enrollment, especially in MASBOE 31-32.

State	File Type	Record Type	Issue
AZ	Eligibility	MSIS ID	In Q1 FY05, AZ changed the MSIS IDs for about 200,000 enrollees. Most of these enrollees had been using SSNs as their MSIS IDs, and AZ wanted all enrollees to be using the AZ Access ID, since AZ isn not an SSN state. CMS decided to allow AZ to make this change. AZ will be provided a cross reference file to MAX that identifies many, but not all, enrollees affected by this ID change.
		Private Health Insurance	In Q4 FY04, the number of enrollees with third party health insurance dropped one third from 46,000 to 32,000. In October 2004, AZ verified the private medical coverage of enrollees, and found that third party coverage had been terminated for many enrollees. Between Q4 FY05 and Q1 FY06, the number of enrollees with private insurance increased roughly 30 percent. The State began using a TPL contractor to verify and obtain more information than available in its Medicaid eligibility sources. In FY 1999, Arizona acknowledged that the number of persons with private health insurance was lower than it should be. They are making improvements to their TPL file, and the reporting increased somewhat in FY 2000.
		Restricted Benefits Flag	Arizona extends family planning only benefits to persons in state group 960 as part of its 1115 waiver. However, the state did not assign restricted benefits code 5 to individuals receiving family planning only benefits until FY 2003. In addition, these persons were not reported to MAS 5 until Q1 FY06. Instead, they were reported to MAS 3 by mistake. Effective FY06, AZ began using MAS 5 and RBF 6 for its FP only group. In MAX 2003-2005, family planning individuals could be remapped to MAS 5 using RBF code 5.
		Retroactive/Correction Records	AZ data show some seam effect issues, but these are generally resolved with retro/correction records.
		CHIP Code	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, CHIP coverage was extended to parents of CHIP children under a HIFA waiver. These S-CHIP adults are not included in MSIS. Between Q2-Q4 FY05, the number of people with CHIP flag = 0 exceeded the number in MASBOE 00. People with MASBOE 11-55 who are not enrolled in CHIP should have received CHIP flag = "1" and not "0". This issue was resolved by Q1 FY06.

State	File Type	Record Type	Issue
AZ	Eligibility	SSN	In our review of AZ's FY06 files, MPR compared AZ's reported SSNs to SSA's "high group test", and found that roughly 10 percent of enrollees had invalid SSNs. This problem likely affects older AZ SSN information in MSIS. AZ was asked to resubmit its FY06 MSIS files addressing this situation. In the approved FY06 files, AZ 9-filled roughly 25 percent of SSNs, a much higher percentage than expected. This problem was fixed in Q1 FY07.
		TANF/1931	Almost no one was flagged as a TANF recipient from Nov. 99 to Sept. 00. The state corrected this problem in FY01.
CA	All	MSIS ID	There are about 500,000 people in the Calendar Year (CY) 1999 MSIS files that have claims, but no EL record. Most of these are for dental capitation payments that are not usually made until the following year. Some of them are the result of the temporary ID given to preemptively eligible pregnant women. If they are later deemed to be eligible for Medicaid, they are assigned a new Medicaid ID that does not link back to the Temp ID.
	Claims	All	MSIS ID is missing on a few claims
		Capitation	The capitation claims for the hybrid PCCM program are reported with a Type of Service of 22 (PCCM capitation payment), even though California is now reporting that enrollment as "Other Managed Care." The capitation payment is $2.
		IP	Procedure codes 3 to 6 are not available from the state.
			There is a maximum of two diagnosis codes on IP claims.
			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 facilitates.
			A large % 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.
			DRG is missing as it is not used for reimbursement.
		LT	Diagnoses 2 to 5 are not available in the state source file, and therefore are not on the MSIS file.
			The percent with Patient Liability is lower than expected.
		OT	It often takes up to a year before the capitation paymens are finalized. They are not included in MSIS until they are finalized.
			Outpatient hospital claims have Service Codes, not UB-92 revenue codes

State	File Type	Record Type	Issue
CA	Claims	RX	The NDC field is 12 byte 8-filled for crossover drug claims as the NDC in unknown. This is the case for all CA files from 1999 through 2004.
			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.
		Waivers	Very few waiver claims, but state confirms that is correct. Detailed services not included.
	Eligibility	1115 Waivers	California introduced a very large 1115 Waiver program, Family Planning, Access, Care and Treatment (FPACT), in December 1999, which covers family planning benefits for working age women. Enrollment immediately exceeded one million persons.
			From FY05 Q1-FY05 Q3, CA incorrectly reported enrollees in its 1115 Family Planning Only waiver to waiver code 1 instead of waiver code F. This coding error was corrected in Q4 FY05.
			In FY05, CA implemented an 1115 waiver for evacuees of Hurricane Katrina. These evacuees are eligible for Medicaid from 9/05 through 1/06 and are assigned aid code 65 and MASBOE 54-55.
		Date of Death	All dates of death are 8-filled or 9-filled
		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.
			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.
			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.

State	File Type	Record Type	Issue
CA	Eligibility	Dual Eligibility Codes	From November 2004 to December 2004, roughly 8,000 duals (1% of full duals) who had been reported to MASBOE 11-12 and dual code 02, appear to have shifted to MASBOE 41-42 and dual code 08. In January 2005, this shift was reversed, and MASBOE/dual reporting was consistent with November. CA does not know why this shift happened.
		Foster Care	In July and August 2001, there is an unusual dip in foster care enrollment.
		HIC Numbers	In FY 1999, about 10,000 dual eligibles have missing Medicare Health Insurance Claim (HIC) numbers. This field should be 9-filled in the event that the HIC Number is missing. This problem was corrected in FY 2000.
		Managed Care	California reports four to five million enrollees in dental PHPs each month. Only about 300,000 of these enrollees are reported 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. Beginning with FY 2000, California reports enrollment in several hybrid PCCM plans in plan type 8 (other) since these are limited risk contracts and not true PCCMs. However, these are reported as PCCMs in the CMS report. The number of enrollees in managed care plan type 08 - other decreased to under 1000 per month in Q4 FY03 compared to over 30,000 in previous quarters. CA eliminated two plans at this time (Pacer County Managed Care Network, and Sonoma Partners for Health MC). From 2004 forward, MSIS and CMS administrative data consistently report some managed care plans differently. All of the enrollees CMS reports 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. 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 CMS administrative data. The numbers of enrollees in SCAN, Positive Health Care, and the Family Mosaic compare very well between CMS and MSIS.

State	File Type	Record Type	Issue
CA	Eligibility	MASBOE	2003: As a result of the Craig vs. Bonta decision, CA was required to provide enrollees leaving the SSI program with a full Medicaid eligibility determination, prior to loosing their SSI linked Medicaid coverage. As a result, about 40,000 enrollees were immediately affected by this change, and in Q4 FY03, shifted from MASBOE 21-22 to MASBOE 41-42. State groups IE and 6E were created for these enrollees.
			2002: Effective Q2 FY02, California begins to report women in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) group.
			1931 changes, beginning in FY 2000, are significant. First, California stopped reporting eligibles into MAS/BOE 16 - 17 as part of its 1931 changes. Instead, persons who would have been in these groups are reported into MAS/BOE 14 - 15. Second, some groups previously reported into MAS/BOE 24 - 25 were moved to MAS/BOE 14 - 15 as a result of the 1931 changes. Over FY 2000 and 2001, 1931 enrollment grew, while enrollment in MAS/BOE 24/25 declined.
			2004: In 2004, enrollment in MASBOE 24 declined, while enrollment in MASBOE 44 continued to expand, in part due to the CHDP changes started in 2003.
			CA covers all aged and disabled to 100% FPL.
			All years: CA has a few individuals (<10) reported to BOE 9 from time to time, with MAS 4 or MAS 9.
			2003-2005: 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 and 99 from FY03 - FY05. Reporting to MASBOE 49 continued through Q2 FY07.
			2003: Beginning in July 2003, CA implemented a Child Health and Disability Prevention (CHDP) program as a "gateway" to 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.

State	File Type	Record Type	Issue
CA	Eligibility	MASBOE	In Q3 FY07, CA stopped reporting enrollees to state group 7N (minor consent, age under 21, family planning only). This caused a 17 percent decline (5,000 enrollees) in MASBOE 35. The state verified that this group is no longer active.
		Race/Ethnicity	The race field is unknown for four to ten percent of the Medicaid population.
		Restricted Benefits Flag	Until Q1 FY06, FPACT eligibles were also assigned RBF code 5 (other). Beginning in Q1 FY06, FPACT eligibles are assigned RBF code 6 (Family Planning Only). These enrollees are only eligible for family planning benefits. Individuals assigned restricted benefits code 5 (other) are in hospice, and as such do not receive the "standard" package of Medicaid services. Beginning in 2008, CA is expected to begin implementation of 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. MPF enrollees will be assigned RBF code 8 in MSIS.
		CHIP Code	California reports its M-CHIP enrollees, but not 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.
		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.
		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 2007.
		Waivers	Enrollment in CA's Assisted Living Pilot Project waiver, a 1915c waiver, waiver ID 18, did not appear in MSIS until Q3 FY07. The wavier was implemented in March 2006 (Q2 FY06). Enrollees in the waiver were included in MSIS.

State	File Type	Record Type	Issue
CO	All	MSIS ID	There are some people with claims that don't link to the eligibility file. According to the state, many of these claims were paid for people who were retroactively determined not to be enrolled at the time of service. The state is unable to provide a crosswalk because once someone is disenrolled their eligibility information is deleted from their system. This situation became worse in 2004 with the implementation of a new system.
	Claims	Adjustments	There are both some positive credits and negative debits because the copay is deducted from line items.
		All	Some claims for CHIP only enrollees are included in the files through 2006. Most of these claims are in the OT file.
		IP	Colorado recodes CMS DRGs into state DRGs
		LT	The lower than expected percent claims with Patient Liability is due to switch from monthly to weekly billing
		OT	Lab/X-ray claims have diagnosis codes as that is how they receive them from providers.
			Colorado stopped paying PCCM capitation payments on June 30, 2004, but continued to show PCCM enrollment.
			There are very few claims with place of Emergency Room/Emergency Department (ER) in Q1 1999 because Colorado didn't start reporting ER separately until Dec 1998.
			In December 2003, Colorado's fiscal agent reported that the state has been "redefining" national HCPCS and CPT codes to meet its own needs for many years. Requested copy of redefined codes, as yet not received.
			The Service Code is missing on numerous claims because the UB-92 is used for Home Health (HH), waiver, hospice and outpatient hospital.
			There are more claims than expected with $0 because of the way cost sharing is applied.
			Colorado purchases private health insurance for some enrollees. The premium payments are Type of Claim (TOC) 2 and Type of Service 19
			There are several clms with amount paid = $99,999. This is a valid amount, not an improperly 9-filled field
		RX	All compound drugs are coded as "COMPOUND" in the NDC field.
			There are a lot of apparent duplicate claims in the 1999 RX files

State	File Type	Record Type	Issue
CO	Eligibility	County Codes	CO has one even numbered county code (014) representing Broomfield County in suburban Denver. In Nov 2001, Broomfield County, FIPS code 14 was officially created in the Census. The new county took parts of Boulder County (013), Jefferson County (059), and Weld County (123).
		Date of Death	The state does not report dates of death for any eligibles.
		Dual Eligibility Codes	Prior to FY03 Q1, a specific dual eligibility flag code could not be assigned to about 20 percent of the dual population. These persons received dual flag "09." 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. 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 02 (cause unknown). CO had major shifts in MASBOE enrollment in Q1 FY06. Enrollment in MASBOE 11-15 declined, while MASBOE 35 and 41-44 increased. CO said these shifts were not attributable to policy changes, but instead probably related to improved processing of eligiblity information in their new MMIS system. From Q1-Q4 FY05, CO assigned roughly 1,300 enrollees dual code 99. These enrollees should have received dual code 02 and restricted benefits code '1'. CO fixed this in Q1 FY06. From Q4 FY04 to Q1 FY05, the number of enrollees in dual code 03 fell 21 percent from 3,600 to 2,871. It is possible that the implementation of monthly dual coding contributed to this large decline, but the state has not verified that this change was expected. The number reported to dual code 03 returned to the previous level by Q4 FY05. In 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 to fix this in their FY06 files, but have not had the resources to do so. The state has said that this issue may gradually improve. In FY07, the number reported dual code 02 increased, but the majority of duals reported to MASBOE 11-12 continued to be dual code 08.

State	File Type	Record Type	Issue
CO	Eligibility	HIC Numbers	HIC numbers are 9-filled for about five percent of dual eligibles.
		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.
			In Q4 FY04, CO began reporting its PACE program to plan type 06 (PACE). Prior to Q4 FY04, the PACE program (plan ID 040008810001 was reported to plan type 01 (HMO).
			Between Q3 and Q4 FY05, enrollment in CO's behavioral health plans fell by over 40,000 (13 percent). This decrease occurred across several plans. The state was unable to explain.
			In 11/1/02, the United Healthcare and Kaiser HMOs were shut down. Effective 2/03, Community Health Plan of the Rockies was terminated as well. In June 2002, there is a discrepancy between the BHP enrollment count in MSIS compared to the CMS managed care report. Colorado reports that this discrepancy was caused by the state's failure to include two of its BHP plans (Jefferson Center for Mental Health and Access Behavioral Care: Pikes Peak) in the CMS managed care report. The FY03 MSIS data were 29 percent higher in BHP counts, and 14 percent higher in HMO counts. Nevertheless, the state asserts that its MSIS data are accurate.
			There is an unusual drop in all types of managed care enrollment (comprehensive, PCCM, and behavioral) in Q2 FY 2001, compared to Q1, Q3, and Q4 FY 2001 and FY 2002. The state could not explain why this occurred.
			Between months 2 and 3 of Q4 FY04, there was a large decrease in managed care reporting. This was caused by the large number of individuals determined not eligible for Medicaid during the implementation of a new MMIS
			From 2003 forward, Rocky Mountain HMO (Plan ID 04022018) is reported as a PIHP, not HMO, in CMS June data. It is reported as an HMO in MSIS. This continued in FY07.
			In June 2007, CO's MSIS data showed 90 percent more PCCM enrollment than CMS (cause unknown).

State	File Type	Record Type	Issue
CO	Eligibility	MASBOE	From Q1-Q4 FY05, enrollment in MASBOE 44-45 (state group 0433B) more than doubled. CO's new MMIS has assigned code '3' (transitional assistance) in byte 4 of the state specific code to more enrollees, but why this occurred is not known.
			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.
			During FY 1999 and FY 2000, Colorado mapped about 4,000 to 5,000 disabled individuals into MAS/BOE 32 inappropriately, since they are reported to qualify for full Medicaid benefits.
			Between Q3 and Q4 FY04, enrollment declined significantly. Adult enrollment fell 15% and children dropped 7%. The state converted to a new MMIS at this time, and during this process it was determined that many individuals were no longer eligible for Medicaid. Similarly, a large shift occurred from MASBOE groups 34 to 14, involving roughly 35,000 enrollees. The state's new MMIS system uses an automated process that applies eligibility rules more consistently than in the past. Child and adult enrollment rebounded through FY05, except that enrollment in MASBOE 35 declined 59% in Q1 FY05. The state was unable to explain this decrease. It was caused in part by an increase in the number of enrollees with a blank in byte 4 of the state specific code. A '7' value in byte 4 indentifies pregnant women.
			Regarding enrollment in MASBOE 49, CO indicated they have an edit in place which says that if a client is MASBOE 48 (foster care child) and is over the age of 21, they should be reclassified as MASBOE 49. We responded that CO should remain within MASBOE 48, regardless of age, as long as they are enrolled in Medicaid. This problem has been ongoing and persisted through FY08, but should be fixed accordingly in MAX.
			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 are over 40 years old, and likely not eligible. These problems continued in FY06 to Q2 FY08.

State	File Type	Record Type	Issue
CO	Eligibility	Retroactive/Correction Records	Colorado decided in April 2000 that they would use the delayed submission, rather than submitting retroactive records. They had initially elected to report retroactive eligibles in their MSIS application.
		CHIP Code	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 an 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.
		SSN	About eight to ten percent of eligibles have the SSN field 9-filled. This improved in Q4 FY04 with the implementation of the state's new MMIS system. In FY06, 7 percent of eligibles have the SSN field 9-filled.
		State-Specific Eligibility	From Q3 to Q4 FY04, there were large shifts in reporting by state specific code. These shifts were caused by the state's new MMIS system.
		TANF/1931	CO began 9-filling its TANF field in Q1 FY06. In Q1 FY05, MSIS reported 28% fewer TANF enrollees than ACF comparison data.
CT	All	MSIS ID	The MSIS 200-2002 capitation claims did not always carry the same MSIS ID as reported into the MSIS. This could not be corrected, however, it was only a small percentage of the claims.
	Claims	Crossovers	All crossover claims (IP/LT/OT) are in the OT file for FY 1999. Connecticut corrected the problem beginning with FY 2001.
		IP	Chronic disease hospital claims are in the IP file. This impacts UB-92 Revenue Codes, Patient Status codes and LOS
			The DRG and DRG grouper are missing as they are not used for reimbursement.
			In Q1 2003, 75 percent of the claims are adjustments, due to a rate change.
		LT	The Admission Date is always missing.
		OT	The majority of the FFS claims have a type of service of rehabilitation, PCS, HH and TCM. Most of the non-waiver enrollees are in HMO's so this distribution of services is reasonable for waiver enrollees.

State	File Type	Record Type	Issue
CT	Claims	OT	The percent of HH claims is high because the state is able to submit line item services instead of just a summary bill. In 2004 Q1 there is a big drop in the average Medicaid Amount Paid on original, FFS, non-crossover claims with Types of Service of 15 (Lab/Xray), 10 (Other Practitioners), 19 (Other Services) and also Program Type Home- and Community-Based Services (HCBS). That was the first quarter of a new system. The MSIS ID on HMO capitation claims do not match the EL file from 2000 through Q2 2002. The state resubmited the Q1 2002 and forward OT files with the MSIS ID corrected. According to the state, the MSIS ID on the HMO capitation claims is the same as on the EL file, except that in the OT file, it is right justified with leading zeros and in the EL file it is left justified. There are a few state-specific codes that have more than one definition, but the state only uses one Service Code Indicator so the correct definition for those codes can't be determined.
		RX	Date Prescribed is always missing.
	Eligibility	Dual Eligibility Codes	In FY2001, enrollment in QMB only, SLMB only, and QI programs increased, following a special outreach effort.
		Foster Care	Until Q2 FY 2002, a higher than expected proportion of foster care children were older than age 20.
		MASBOE	2006: For many years, CT reported state group F7 to MASBOE 44-45. This group is made up of enrollees who qualify for Medicaid based on old AFDC rules (Section 1931), and should have been reported to MASBOE 14-15. The state resisted this change because many enrollees in F7 do not receive "cash" benefits. As a result, this error was not fixed until Q1 FY06 MSIS. However, CY05 MAX was fixed with correction records (ME 7/21/08). In 2006, the key groups that remained in MASBOE 44-45 were FC, F3, and F4. These groups covered Ribicoff children (FC) and children/adults qualifying for Medicaid under transitional assistance and inadequate child support provisions. From month 3, Q3 FY05 forward, state groups FP, FR, and FU were moved into state group F7. As a result, in Q3-Q4 FY05, enrollment in MASBOE 14-17 fell to very small levels (<50). We expect this will be corrected in Q1 FY06 when CT fixes its state group F7 mapping.

<table>
<tr><th>State</th><th>File Type</th><th>Record Type</th><th>Issue</th></tr>
<tr><td>CT</td><td>Eligibility</td><td>MASBOE</td><td>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 quality for Medicaid are not reported to MAS/BOE 12.

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.

2006: Between Q3 and Q4 FY06 (June and July 2006) there was an additional shift from MASBOE 44-45 to MASBOE 14-15. This change was expected. In 2005, CT changed its Medicaid statutes to reduce its transitional Medicaid period from 24 months to 12 months. The law went into effect on July 1 2005, and as a result, many families receiving transitional Medicaid benefits became ineligible on June 30, 2006, resulting in large declines in state groups F3 and F4 (MASBOE 44 and 45). However, at the end of this transition period, eligibility redeterminations found that some of these familes still qualified for Medicaid under state group F7 (MASBOE 14 and 15), as the state had also increased the income limit for 1931 families from 100% FPL to 150% FPL. (Declines in MASBOE 44-45 also occurred in July 2005 data in MAX as a result of MSIS correction records).

2001: In FY 2001, enrollment in MAS/BOE 34 declined, while MAS/BOE 44 - 45 enrollment increased. This was due in part to changes in financial rules.

2005: Effective June 2005, CT reported the vast majority of adults to MASBOE 45. In addition, most children not qualifying under the poverty related rules are reported to MASBOE 44. CT's MMIS system does not have a separate code for identifying children and their parents qualifying for Meidcaid under the Section 1931 rules (who should be reported to MASBOE 14-15). Even before June 2005, it appears that many children and adults who likely qualified under the Section 1931 rules were reported to MASBOE 44-45.

2002: From Q1 to Q2 FY02, foster care (MASBOE 48) enrollment declined by 18% for an unknown cause. According to MAX data, correction records made this reduction effective in January, 2001 (Q2 FY01).</td></tr>
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State	File Type	Record Type	Issue
CT	Eligibility	MASBOE	2004: In FY04 Q3, CT changed how it counts income, shifting some aged/disabled from MASBOE 21-22 to MASBOE 41-42.
		Restricted Benefits Flag	Prior to Q1 FY06, CT reported a small number of full benefit duals to restricted benefits code '3' (partial duals) each quarter. This happened because the monthly restricted benefits code was not always consistent with the quarterly dual code. This problem was resolved in Q1 FY06 when CT implemented the monthly dual code.
			Beginning in 2008, CT is expected to begin implementation of 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. MPF enrollees will be assigned RBF code 8 in MSIS.
		Retroactive/Correction Records	Connecticut had an unusually high number of retroactive and correction records in Q1 and Q2 FY 2003 when it made some system adjustments.
		CHIP Code	Connecticut had an M-CHIP program until FY03; however, CT was not able to identify M-CHIP eligibles in its MSIS data. M-CHIP children belonged to certain state specific groups that also include non-CHIP children. As a result, these state-specific groups were coded as 9 (CHIP status unknown) for the CHIP indicator. The M-CHIP program phased out over time. In Q4 FY02, M-CHIP enrollment according to SEDS was 1,273 personmonths. There was no M-CHIP enrollment reported in SEDS FY03. CT stopped using CHIP code '9' in Q2 FY06.
			CT has an S-CHIP program, but they are not reported in MSIS.
		SSN	In each quarter of 1999, a few Social Security numbers are "0-filled" or "8-filled." They should be "9-filled" if unknown.
			CT reports about 600 to 700 duplicate SSN's each quarter.
		TANF/1931	Connecticut cannot identify its TANF population. The field is 9-filled for all eligibles.
DC	Claims	All	Other Third Party Payment (or Third Party Liability/TPL) is missing on all claims, except a very few in the RX file
		Crossovers	There are fewer than expected percent of crossover claims.

State	File Type	Record Type	Issue
DC	Claims	IP	The average length of stay is about eight days which is higher than expected. The state confirms it is correct. The average amount paid is also high.
			Up until 2002 Q4 some claims do not have UB-92 for accommodations due to partial hospitalizations, according to the state.
			The average amount paid per IP claim has always been higher than expected. Prior to 2003 it was around $10,000 and by 2003 Q1 it increased to about $12,000.
			There is a higher percentage of claims than expected with a Patient Status of 30 (Still a Patient).
			DRGs are not included on about one-third of the claims until Q4 2002 when they were reported on most IP claims.
		LT	Other Third Party Payment (or Third Party Liability/TPL) is not reported in the LT files.
			In 2003 Q3, Washington DC was unable to identify crossover claims and, since most claims in the LT files are non-crossovers, all the LT claims are reported as non-crossovers.
			Most LT claims had a diagnosis code of 799.9 until Q4 2002 when they are converted to "unknown."
			Around 1/4 of the claims have a type of service of ICF/MR.
			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.
			There are no crossover claims in Q4 2002.
		OT	The percent of claims with a Place of Service of 99 (Unknown) dropped from about 40 percent in 1999 to under 20 percent in 2002.
			In Q4 2000 the state starting submitting claims with state-defined Service Codes.
			There are fewer waiver claims then expected in 1999. DC does not have a large waiver program.
			There aren't any claims with a Program Type of 4 (FQHC).
			There were about 100,000 more claims in Q2 FY 1999 than in the other three quarters of the year.

State	File Type	Record Type	Issue
DC	Claims	OT	There are very few claims with Type of Service of 09 (Dental) in the OT file. Washington DC confirms that is correct.
			The distribution and payment for services varies widely from quarter to quarter. In Q1 2000 one provider submitted lots of old claims.
			There is an increase of about 200,000 claims in Q1 2000. They are mostly clinic claims and the state has no explanation.
			The average amount paid on clinic claims doubled in Q1 2003 as there were over 61,000 old (1999 to 2002) Washington DC Family Service claims paid in that quarter. The amount paid on those claims were either $452 or $646.
			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.
		RX	There are very few claims with a Program Type of 2 (Family Planning).
	Eligibility	1115 Waivers	DC implemented a 1115 on June 30, 2005 (Q4 FY05) called the "DC program to enhance Medicaid Access for Low-Income HIV Infected Individuals". This 1115 expands Medicaid benefits to HIV positive individuals who meet income criteria. Enrollees in this waiver are reported to state code 880 and MASBOE 55. Small numbers of enrollees were reported in state code 880 and MASBOE 55 as of Q3 FY05.
			DC implemented a Katrina 1115 waiver on 9/28/05. Starting in September 2005, DC mapped persons in its Katrina Waiver to MASBOE 51, 52, 54, and 55. These individuals were assigned regular 3 byte state specific codes, followed by 'H' in byte 4.
			DC implemented a 1115 waiver in 2/2003 expanding eligibility to childless adults between the ages of 50-64 with income at or below 50 percent FPL. These enrollees are in state group 370. However, this group was not reported to MASBOE 55 until Q1 FY05. Prior to Q1 FY05, enrollees in state group 370 were reported to MASBOE 25.

State	File Type	Record Type	Issue
DC	Eligibility	Dual Eligibility Codes	Effective July 2005, DC began disregarding income between 100-300% FPL for duals. As a result, from Q4 FY05, and moreso from Q1 FY06 forward, virtually all duals are reported to either dual code 01 or 02 in MSIS. MSIS reporting is inconsistent with MMA original data through July 2008, which continued to report roughly 1,500 full duals to dual code 08, and several hundered full duals to dual code 04 each month. MMA reporting also reported these individuals as being below 100% FPL, likely due to the income disregard. The numbers of total full and partial duals compared very well. As of August 2008, however, DC has reported its MMA data such that it is consistent with MSIS (reporting virtually all duals to either dual code 01 or 02). Retro records have corrected MMA data back through June 2008 but not before then.
			Before Q1 FY 2002, only 85 percent of DC's aged Medicaid population were reported as being dually eligible for Medicaid and Medicare. In addition, DC was not able to assign a specific dual eligibility code to 60 to 65 percent of its dual population. Instead, these eligibles were assigned dual code value 09. Also, until Q1 FY 2002, DC did not include the following groups of duals in its MSIS data: SLMB-only, QI-1, QI-2, QWDI. Information on these eligibles was not retained in DC's MMIS until Q1 FY 2002.
			In FY2002 Q1-2, DC's dual reporting correctly uses dual code 08. In FY02 Q3-4, DC did not use dual code 08, and erroneously used dual code 09. From FY03 Q1 forward, DC's dual reporting correctly uses dual code 08, and does not report any individuals to dual code 09. This inconsistency in reporting occurred because DC resubmitted its FY02 Q1-2 data to correct an MSIS ID problem, and simultaneously updated its dual reporting. FY02 Q3-4 data were not resubmitted because the MSIS ID problem had already been corrected.
		HIC Numbers	About 20 to 25 percent of the dual eligible population did not have valid HIC numbers until Q1 FY 2002.
		Managed Care	MSIS reports the "Health Services for Children with Special Needs" plan as an HMO. However, this plan is reported as a "Medical-Only PHP" in the CMS managed care report.
		MASBOE	The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL.
			A noticeable increase in aged enrollees occurred in Q1 FY 2002 when DC began reporting several restricted benefit dual groups for the first time.

State	File Type	Record Type	Issue
DC	Eligibility	MASBOE	During Q2 FY07, enrollment increased within MASBOE 55 from 901 to 1,894 persons. The state acknowledged this increase as expected, since enrollees from a state program previously ineligible for Title XIX funds were now covered by DC's Section 1115 Waiver for Childless Adults.
		MSIS ID	DC appears to have mistakenly changed its MSIS ID scheme in FY02. DC reran Q1-Q2 FY02, but the problem appears to have affected Q3 FY02 as well. DC claims that MSIS data before and after this period were not affected by this error.
		Private Health Insurance	DC reported a lower than expected proportion of eligibles with private health insurance (1.3 to 1.4 percent) until Q1 FY 2002.
		Restricted Benefits Flag	From Q1-Q4 FY06, DC also assigned restricted benefits code '3' (partial duals) to a very small number (<15) of nonduals and full duals. These enrollees should have received restricted benefits code '1' (full benefits). The state has been asked to fix this in Q1 FY07.
			From Q1 FY06 through Q4 FY06, DC assigned restricted benefits code '0' (not eligible) to over 4,000 enrollees in several MASBOE groups other than MASBOE 00. All of these enrollees should have received restricted benefit code '1' (full benefits). The state has been asked to fix this in Q1 FY07.
		Retroactive/Correction Records	DC does not use retroactive or correction records.
		CHIP Code	DC is reporting its M-CHIP data. DC does not have an S-CHIP program. From Q1 FY 2000 through Q2 FY 2002 (except Q1 FY 2001, when the numbers compared well), more M-CHIP children were reported in MSIS than the CMS SEDS system; however, DC maintains that the MSIS numbers are more reliable. After Q2 FY02, SEDS and MSIS were consistent.
			In Q1 FY06, SEDS M-CHIP reporting for DC appears to be unreliable. SEDS shows a 35 percent increase in Q1 FY06 compared to Q4 FY05, and then returns to normal levels in Q2 FY06. MSIS M-CHIP data appear to be reliable.
		SSI	Relative to the number of aged and disabled SSI recipients, DC reported 25 percent to 30 percent more eligibles under MAS/BOE 11 and 12 through FY 2000. Effective Q4 FY 2001, this problem begins to subside. In FY03 and FY04, MSIS counts were 14 percent higher (17 percent in FY06). Part of the discrepancy may be due to the fact that DC has a state-administered supplement.

State	File Type	Record Type	Issue
DC	Eligibility	SSN	About 3 percent of eligibles do not have valid SSNs.
		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. Nevertheless, it appears MSIS is continuing to report both state and federal numbers as if they were all receiving federal TANF assistance.
		Waivers	DC operates a waiver for HIV-positive enrollees seeking reimbursement for the purchase of water filters. Recipients are not formally enrolled in the waiver, and reporting is use-based. As a result, reporting to this waiver (waiver ID 09) is inconsistent. For example, in FY05, use of this waiver was reported in Q1, but not subsequent quarters.
		xREVIEW NOTE	Look for new restricted benefit flags we expect to see by Q2 or Q3 FY08.
DE	All	MSIS ID	There was a problem with the MSIS ID's on the claims and eligibility files for 2001 that was not able to be corrected.
	Claims	Adjustments	There are no adjustment claims in the Q4 2002 or Q1 2003 IP file due to system changes.
			There are very few adjustments (less than one percent). Delaware confirms this is correct.
		All	Delaware changed systems in Q4 2002. There are problems with claims for that quarter. Mostly, there is a shortfall of claims and a significant shift in the Types of Services reported and average amount paid for some services. Delaware believes that this will be remedied in future submissions.
		Crossovers	Beginning with Q4 2002, 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.
		IP	There aren't any claims with Program Type of 2 (Family Planning).
			The percent of claims without UB-92 Revenue Codes declined in 2000.

State	File Type	Record Type	Issue
DE	Claims	IP	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 Q2 1999.
			DRGs are not included as they aren't used for reimbursements.
			There weren't any claims with a Patient Status of 30 (Still a Patient) until 2002.
		LT	Leave days are not reported in the Q1 2003 LT file due to a system change.
			Other Third Party Payment (or Third Party Liability/TPL) is missing on all claims.
			There are no covered days on claims with a Type of Service of 04 (Inpatient Psychiatric Facility Services for Individuals Age 21 and Under).
			There are no claims with a type of service of IP Psych < 21 years starting with Q4 2003.
			There was a big increase in adjustments in Q2 1999 as that is when the claims are adjusted to accommodate rate changes.
		OT	There was a change in the distributions on some types of service from Q1 to Q2 1999 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.
			Starting in the 2003 Q2-4 OT files, about 50% of the claims have a type of service of 'other services'.
			The average expenditure for clinics doubled in Q4 2000 with no explanation, except perhaps it is a billing lag.

State	File Type	Record Type	Issue
DE	Claims	OT	Claims from school districts that have been providing a high volume of services from school nurses, school psychologists, PT/OT/ speech therapists,and transportation providers to Medicaid children. These claims were being assigned to about four State service categories (Other Practitioner, PT/OT/Speech, Other and Transportation) and the equivalent MSIS service types until we switched from locally assigned State codes to regular HCPCS/CPT-4 codes around the end of 2003.. When this happened the new codes did not automatically map to the internal or State service categories used for the old codes. They went to unknown in our State category of service crosswalk. And, these claims have stayed in the Unknown category until March 2005 when we added the new codes to the State category of service crosswalk.
			Switch to national HCPCS codes in late 2003 caused Delaware to lose the ability to easily report claims for therapy services provided by school districts into separate MSIS Types of Service -- PT/OT, Other Practitioner, and Transportation were all used for these services before. Until the end of 2005, Delaware will report all these services in TOS 19 because they don't have the resources to code each procedure code separately. This causes TOS 19 to greatly increase as a percent of the OT file.
			There is very large increase in the number of OT claims in 2003 Q3 as the state was catching up with a delay in processing due to a system change.
			Payments for PCCM services are service based and not paid as capitation claims.
			Starting with Q4 2002, the state began submitting Home Health services at the line item level resulting in more Home Health claims with a lower Medicaid Amount Paid.
			Claims with a Type of Service of 26 (Transportation) make up between 26 to 40 percent of all services. Starting with Q1 2003, there will be a transportation managed care program.
			Place of service is missing on the majority of claims.
		RX	New Refill Indicator is always missing.
			Date Prescribed is always missing.
			Some drugs are included in the NH bundled rate and not as individual drug claims.

State	File Type	Record Type	Issue
DE	Claims	RX	All compound drugs are coded as "COMPOUND" in the NDC field.
			The 2002 Q4 MSIS RX file was submitted with the incorrect MSIS ID's in some of the RX claims. CMS did not require the state to resubmit this file.
		TPL	There aren't any claims with Other Third Party Payment (or Third Party Liability/TPL) as Delaware is a "pay and chase" state
	Eligibility	1115 Waivers	Delaware's Diamond State Health Plan 1115 waiver program, which began in 1996, created a mandatory state wide managed care program. It also extended full Medicaid benefits to adults (including childless adults) with income to 100 percent FPL. The same waiver also extended family planning benefits (only) for 24 months to women leaving Medicaid (State Specific Group F3).
			DE had a Katrina Waiver approved on 3/6/06.
		County Codes	DE routinely (from FY99 forward) reports roughly 1,000 enrollees to county code 000. These cases are caused by enrollees who move out of state (for example into out-of-state LTC facilities) during a given quarter. As DE's system is designed to report last-known address, reporting a valid county code for these enrollees is problematic.
		Dual Eligibility Codes	Delaware has had difficulty coding the dual eligibility flag at the level of detail requested. Prior to Q1 FY03, only dual codes 02 and 09 were utilized for full duals. With the Q1 FY03 data, the state converted persons reported to dual code 09 to 08, but the state has never reported anyone to dual code 04.
			Until Q2 FY06, most QI-1's were reported as SLMB-only (dual code 03). Some sporadic coding (<10) to dual code 06 (QI-1) occurred over the years, but never the entire population. In Q2 FY05, DE began reporting new QI-1's to dual code 06, but full reporting did not occur until Q2 FY06.
			A few individuals (<50) are reported to MASBOE 31-32 and assigned restricted benefits code '3' (partial dual) are not yet assigned dual codes 01, 03 or 06, due to system delays in confirming Medicare status.
			Delaware moved to a new MMIS system in Q3 FY 2002 with EDS.
		Managed Care	In Q4 FY 2002, the number of HMOs dropped to one.

State	File Type	Record Type	Issue
DE	Eligibility	Managed Care	In Q1 FY03 the state began to report enrollment in a transportation PHP. These individuals are assigned managed care plan type '08'. This transportation plan is not reported in CMS MC data. DE did not start reporting its Primary Case Management (PCCM) enrollment until 2002. Somewhat unusual, DE pays for PCCM services as they occur (FFS), and not on a risk basis. DE's PCCM plan (Diamond State Partners) is reported in the CMS administrative data as an "other" PHP (Prepaid Health Plan). From FY 1999 to FY 2002, the majority of eligibles were enrolled in two HMOs as part of the state's 1115 demonstration. Delaware began to report PCCM enrollment as well in Q4 FY 2002; however, this is not reported in CMS managed care data.
		MASBOE	Effective 1/02, Delaware began to change its coding so that only TANF and 1931 eligibles (state group 71) were reported to MAS/BOE 14 and 15, while transitional assistance eligibles (state group 81) went to MAS/BOE 44 and 45. Since transitional assistance eligibles were previously reported to MAS/BOE 14 - 15, this caused an increase in MAS/BOE 44 - 45 enrollment in Q2 FY 2002. However, in Q3 and Q4, enrollment in MAS/BOE 14 - 15 expanded due to growth in the 1931 program.

State	File Type	Record Type	Issue
DE	Eligibility	MASBOE	During FY 1999, several changes occurred in eligibility mapping and eligibility policy which make it difficult to track Delaware's eligibility counts by MAS/BOE group for FY 1999. For Q1 1999, Delaware reported some 1931 eligibles to MAS/BOE 44/45 since they were included with transitional assistance eligibles in aid category 81 (all 1931 eligibles should have been reported into MAS/BOE 14/15). Then, effective 1/99, the state started using a new classification approach for eligibility. In the new classification approach, all 1931 eligibles were correctly reported into MAS/BOE 14/15. However, transitional assistance eligibles were also reported into MAS/BOE 14/15 effective 1/99 (instead of MAS/BOE 44/45). As a result of these changes, the number of eligibles in MAS/BOE 44/45 sharply declined in Q299. Researchers should be aware then that the types of eligibles mapped into MAS/BOE 14/15 and 44/45 are not consistent during 1999. Further complicating any analysis, the state expanded its interpretation of 1931 eligibility rules beginnning in 1999. As a result, the number of children and adults reported into MAS/BOE 34 and 35 declined somewhat in Q2, while the numbers in MAS/BOE 14 and 15 appeared to grow by a commensurate amount. The patterns finally stabilize in Q3 and Q4 1999. Over time in FY 1999 and 2000, as a result of the 1931 expansion, we see an increasing number of eligibles in MASBOE 14-15 who are not TANF eligibles. Initially, a few groups could not be correctly mapped to MAS/BOE due to coding constraints. These include eligibles in 1619(b), some foster care children, and some 1931 eligibles. However, the state fixed its 1931 reporting effective 1/02 and began to report 1619(b) eligibles (state group 20) in Q4 FY 2002. 2006-2007: Between Month 3 of Q3 FY06 and Month 3 of Q4 FY06, the number of enrollees in MASBOE 44 and 45 fell by roughly 8,000. At the same time, the number of enrollees in MASBOE 14 and 15 increased by 6,000 enrollees. This shift was caused by a State Plan Amendment, implemented in July 2006, that provides a more generous earned income disregard for Section 1931 families. As a result, the number of enrollees reported to Work Transition (MASBOE 44/45) fell. This shift continued in Q1-Q3 FY07; enrollment in MASBOE 14/15 and 44/45 is consistent from Q3 FY07 forward. DE has a state-administered SSI supplement. In addition, most disabled SSI recipients over age 65 appear to be reported to MASBOE 11.

State	File Type	Record Type	Issue
DE	Eligibility	Restricted Benefits Flag	In Q1-Q2 FY06, DE erroneously assigned restricted benefits code '1' (full benefits) to all enrollees reported to dual code '06' (QI's). These enrollees should have received restricted benefits code '3' (restricted-partial dual). (Can be fixed in MAX). The state corrected this issue in Q3 FY06.
			Prior to Q1 FY05, enrollees in state group F3 (in MAS/BOE 54 - 55) are assigned restricted benefits code 5 (other). They only qualify for family planning benefits. From Q1 FY05 forward, these enrollees are assigned restricted benefits code 6 (FP - only).
		Retroactive/Correction Records	DE submits retro/correction records.
		CHIP Code	Deleware's S-CHIP program is not being reported into MSIS.
			In Q4 FY 2002, Delaware added an M-CHIP program for infants 186 to 200 percent FPL. This program was not reported to the CMS SEDS system until FY04.
		SSN	A few SSNs were 0-filled in FY 1999 and FY 2000. They should be 9-filled.
			The state routinely reports 5-10 percent of enrollees without an SSN. Most of these enrollees are children under the age of 6. The state would like to improve this, but has said that they are limited in what they can do to improve SSN reporting.
		TANF/1931	Beginning with Q4 FY 2000, Delaware 9-fills TANF status.
		Waivers	Presumably the Delaware Katrina Waiver is no longer operating, since enrollment dropped to 0 starting with Month 3 of 2006 Q2.
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.
	Claims	IP	There are a very large percentage of adjustment claims in most quarters, possibly due to frequent rate changes.
			In 2003, the percent of claims without ancillary codes is higher than expected.

State	File Type	Record Type	Issue
FL	Claims	IP	Florida does not report DRGs.
			Large expenditures are reported on service tracking claims - often amounting to more than is reported on FFS claims.
		LT	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.
			Patient Status is missing on most claims.
			Diagnosis codes are missing on many claims.
			There continues to be a small percentage of LT claims with an unknown Adjustment Indicator
			Admission Date are missing on nearly all of the claims.
		OT	Some PHP and HMO capitation payments reported as Service Tracking claims.
	Eligibility	1115 Waivers	FL had a Medicaid reform 1115 waiver approved 10/05, which was implemented in 2 counties in September 2006. The demonstration involves the operation and provision of managed care plans in certain geographical areas. The waiver also allows FL to offer different benefits (varying the amount, duration, and scope of services) to the demonstration populations than to the categorically needy. According to FL, however, there has been virtually no receptivity to the program by Reform recipients. Regarding the employer sponsored insurance cost sharing provision of the waiver, as of April 2008, there were 26 individuals who opted to participate. FL has not made any decision regarding whether to discontinue the program or to re-promote it. Regarding the ehanced benefits account provision of the waiver, Medicaid enrollees who practice healthy behaviors accrue credits in an account, which can then be used to purchase OTC rpoducts from a Medicaid-enrolled pharmacy. While these are uniquely reported to MSIS, FL indicated that there is not a way to identify current reporting in MSIS.
			Florida's Family Planning Waiver ended 9/30/03, which caused a major decline in adult enrollment in October 2003. However, the state began a new Family Planning Waiver in May 2004. The new waiver allowed retroactive enrollment back to December 2003, explaining enrollment from Dec. 2003 - April 2004.
			In 10/02, FL began to implement a Pharm Plus Waiver extending RX benefits to aged with income from 88% -120% FPL. This program ended when Part D Medicare was implemented (1/06).

State	File Type	Record Type	Issue
FL	Eligibility	1115 Waivers	FL implemented a Katrina 1115 waiver on 9/23/05. Katrina enrollment information in MSIS appears to be reliable for Q1 FY06 and Q4 FY06; however, Katrina enrollment for Q2 and Q3 FY06 is not reliable.
		County Codes	Florida used state county codes instead of Federal Information Processing Standards (FIPS) county codes in FY1999 and FY 2000. The state has supplied MPR with a crosswalk that links together their state codes with the FIPS codes.
		Dual Eligibility Codes	Florida extends full Medicaid benefits to the aged and disabled with income below 90 percent FPL, accounting for the somewhat lower than expected proportion of QMB-only dual eligibles.
			Florida has a slightly lower than expected proportion of aged dual eligibles until FY03.
			From FY99 forward, FL reported a small number of enrollees in MAS 2 to dual code 06. By FY05, this number had increased to roughly 2,000 per quarter. All enrollees who were state group NS, but received dual code 06 should have been assigned dual code 08. This error occurred because FL was using the dual code closest to the beginning of the quarter for these enrollees. This error was fixed in MSIS starting Q1 FY06.
			Use of Dual Code 09 was approved for FL's Pharm Plus enrollees until 1/06.
			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 poverty related duals, 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.
		Header	Quarterly Backups and Valids EL files contain three header records.
		HIC Numbers	Roughly 3,300 dual eligibles have blank HIC numbers in Q1 FY 1999.
		Managed Care	Beginning in Q4 FY07, FL stopped reporting enrollees in its disease management plan to plan type 08. The state expects to resume reporting of these enrollees to plan type 8 when a new EDS system will be implemented in Q4 FY08.

State	File Type	Record Type	Issue
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 to identify DMO enrollees in MSIS than is used for the June CMS data, accounting for the somewhat different results (in FY04 and FY05). PCCM enrollment in MSIS is substantially undercounted because those enrolled in both a PCCM and a behavioral health plan are counted in CMS data as enrolled in both while they are only reported as belonging to a behavioral health plan in MSIS data. This problem continued as of Q3 FY2008, although we are requesting the state report to both plan types where applicable in future files. Starting in FY05, FL has a Transportation Plan for all Medicaid eligibles. FL is currently unable to report enrollment or expenditures for this plan. This plan is reported in CMS administrative data. Florida ceased reporting to Plan Type 8 (disease management) for admistrative reasons and will not resume until June 2008, but the program continues. In Q4 FY04, FL included "Atlantic Dental" (Plan ID 015035500) in its Managed Care data, reporting it to plan type '02' (Dental). For many years (through FY05), 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 report. From the start, this entity has been reported to Plan Type 07 (PCCM), along with "Children's Medical 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. As mentioned above, Florida generally codes enrollees in its MediPass plan to Plan Type 07 (PCCM). However, until Q1 FY03, enrollees with mental health MediPass providers were coded to Plan Type 03 (BHP). This was confusing, since these BHP/PCCM providers were listed on the PCCM Provider ID file, not the regular Managed Care Provider ID file. Until June 2003, MSIS reported fewer enrollees in Plan Type 03 than CMS managed care data, but the state believed that the MSIS numbers were accurate.

State	File Type	Record Type	Issue
FL	Eligibility	Managed Care	Each month in FY1999, a few hundred ineligible persons (who are mapped to MAS/BOE 00) received PLAN TYPE = "88" and PLAN ID = "88888888888". Persons who are ineligible for Medicaid during a month should receive PLAN TYPE = "00" and PLAN ID = "000000000000." 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. In month 2, Q3 FY04, enrollment in Plan Type '08' (other) spiked from 65,000 in month 1 to 175,000. Enrollment fell back to 73,000 in month 3, Q3 FY04. The state explained this spike as a one time reporting error to FL's MMIS that could not be fixed. 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.
		MASBOE	2002: Effective 10/02, Florida began to implement an 1115 Pharm Plus waiver demonstrating for the elderly called SilverStar Pharmacy. These persons only qualify for pharmacy benefits. This program ended in January 2006 when the Medicare Part D program was implemented.

State	File Type	Record Type	Issue
FL	Eligibility	MASBOE	2003-2006: Florida reports roughly 10 to 15 percent more SSI eligibles (in MAS/BOE 11 and 12) than does SSA over the same period of time. This may occur in part because FL has a state-administered optional SSI supplement program. In FY07, however, MSIS counts were within 6 percent of SSI counts.
			2001: In Q4 FY01, enrollment in MASBOE 55 (Family Planning) dropped by over 25 percent. (cause unknown).
			1999-2000: In FY 1999 and FY 2000, the age sort for MAS/BOE 31 was not working properly and about 8,000 individuals under age 65 were mapped to MAS/BOE 31 who should have been mapped to MAS/BOE 32.
			2002: In Q3 FY02 persons in state group MX_D were mismapped to MASBOE 94 instead of 44. Women with breast cancer (state group MB_C) were mismapped to MASBOE 95 in Q3 FY02 and MASBOE 35 in Q4 FY02. They should be mapped to MASBOE 3A. This was fixed in FY03. In July and August 2002, enrollment in MASBOE 22 surged. The state had reduced its income thresholds for the aged and disabled, but litigation forced FL to reinstate individuals who lost eligibility for two months. They were reported into state group NS_D. In all disabled MASBOE groups (12,22,32 and 42), a sizeable proportion of enrollees are over age 65. Researchers may want to remap these individuals to the aged groups (11,21,31 and 41).
			The state provides full Medicaid benefits for the aged and disabled up to 90 percent FPL.
			2005: In January and May of 2005, large shifts in enrollment occurred, moving individuals from MASBOE 21-22 to MASBOE 31-32. These shifts corrected themselves the following months. These shifts occurred when the 1st of the month fell on a weekend. When this occurred, these people were not marked as having met their spend-down immediately, and were reported to MASBOE 31-32, even though they were marked as having met their spend-down later in the month. This glitch appears to have existed for many years. The state has been encouraged to report MASBOE using information from the end of the month instead of the first in their FY06 data.
			FL reports some disabled who are over 65 years of age to MASBOE 32 and 42.

State	File Type	Record Type	Issue
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 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. In addition, the one person who was reported to MASBOE 52 should be remapped to MASBOE 51.
			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 continues through Q1 FY08.
			In FY02 through Q1 FY04, some persons 65+ were mapped to MASBOE 22, 23 and 42.
		Race/Ethnicity	In FY06 and FY07 data, FL reported the ethnicity of 8-9 percent of enrollees as unknown.
		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.
		CHIP Code	Florida reports enrollment in its M-CHIP and S-CHIP programs. The enrollment reported in its S-CHIP program, however, is incomplete and only for eligibles ages 1 to 5 who have transferred from Medicaid. Enrollment in the M-CHIP program has declined over time, and was only about 2,600 per month in FY08.
		State-Specific Eligibility	Enrollment in the SLMB state-specific eligibility groups "SLMBA," "SLMBD", and "SLMB" drops from about 21,000 total at the end of FY 1999 to 14,000 total at the beginning of FY 2000. Enrollment stays at this level until the beginning of FY 2001 when it jumps to around 30,000. The state acknowledges this problem, but is unable to explain it.
		TANF/1931	Florida cannot identify TANF recipients. All eligibles receive TANF = 9, indicating that their TANF status is unknown.

State	File Type	Record Type	Issue
FL	Eligibility	Waivers	FL had major errors in its Katrina reporting for Q2 and Q3 FY06. Data are not reliable for waiver type "A" and waiver ID 21.
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 ID's with the old ID's 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 ID's.
	Claims	All	Adjustments are not properly coded from Q1 1999 - Q2 2003. During that time all adjustments had an Adjustment Indicator of Void regardless of the type of adjustment. The Medicaid Amount Paid field on those claims had either negative or positive amounts.
			In July-Sept 2006 a new HMO started resulting in the reduction of the number of FFS claims.
			Georgia submitted claims for S-CHIP enrollees even though there weren't supposed to be included in MSIS. CHIP claims can be identifed by first selecting CHIP only enrollees from the PS file and then pulling claims for those people.
		IP	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.
			There are very few claims with a Program Type of 2 (Family Planning)
		LT	The percent of claims with Patient Liability is lower than expected.
			There is no reported Other Third Party Payment (or Third Party Liability/TPL).
			Over 10 percent of the claims have a Medicaid Amount Paid of $0 until Q4 2003. It is unusual for such a high percentage of original non-crossover claims to have a zero Medicaid Amount Paid. The state has no explanation.
			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.
			There are no diagnosis codes on the file prior to Q2 2003. Most diagnosis codes in Q2 have a lenth of 3. This was corrected starting with Q3 2003. Also, very few claims have Leave Days.

State	File Type	Record Type	Issue
GA	Claims	OT	Capitation claims for non-emergency transportation were not included in the OT files until Q2 2005.
			Over one quarter of the original, FFS claims have a Place of Service of 99 (Unknown).
			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.
		RX	NDC code is missing on a few void claims in 1999 and 2000, making those claims difficult to adjust properly. That field is either blank-filled or 11-byte 9-filled (instead of 12 bytes).
			There aren't any Family Planning claims.
		CHIP Code	CMS has determined that GA has been submitting S-CHIP claims in MSIS since FY03. CMS has asked GA to resubmit FY05 and FY06 claims data. This issue will not affect MAX.
	Eligibility	1115 Waivers	GA implemented an 1115 Katrina waiver on 9/28/05. However, GA has not been able to identify these enrollees in MSIS. They are reported in MSIS, but are not assigned waiver type 'A' (disaster related) or a waiver ID. The state contractor (ACS) has a list of Katrina enrollees, and will be submitting a cross-reference file to CMS for use in MAX.
		County Codes	From Q1 FY02 through Q4 FY02, GA erroneously stopped using FIPS county codes. The state was asked to submit a list of the codes they used during this time period; however, they were not able to figure out what coding scheme was used. Thus, county code data during this period are not reliable.
			In Q1 FY 2000 to Q3, Georgia over-reported enrollees of state codes 90 and 91 (the state CHIP groups) into county code 009. The reported enrollment levels in 009 returned to normal in Q4 FY 2000. The state claims to have resolved the problem through correction records.
		Data System Change	In Q1 FY03, GA changed its data contractor from EDS to ACS.
		Dual Eligibility Codes	GA began reporting monthly dual data in Q1 FY06. In October 2005, the distribution by dual code shifted somewhat, with more full duals being reported to dual code 02 and 04, but the vast majority of full duals continued to be reported to dual code 08. By the end of FY06, MSIS and MMA dual data were reasonably consistent.

State	File Type	Record Type	Issue
GA	Eligibility	Dual Eligibility Codes	Until Q1 FY03 GA coded about 72 to 90 percent of its dual eligible population with Dual Eligibility Flag = 09 (individual is entitled to Medicare, but reason for Medicaid eligibility is unknown). In addition, dual eligibility was undercounted until Q1 FY03 (when ACS took over GA's MMIS). SLMB-only and QIs were not reported until then.
			In February, 2004, a cost of living adjustment resulted in a large decrease in the number of enrollees reported to dual codes 03 and 06.
			In Q2 FY04, GA corrected an important error in its dual coding that began about Q2 FY03. All persons in state groups 460 and 660 were assigned dual code 01 and RBF code 3. All persons in state groups 466 and 661 were assigned dual code 03 and RBF 3. All persons in state group 662 were assigned dual code 06 and RBF 3. By mistake, many of these persons were reported as full duals from Q2 FY03 through Q1 FY04; however, they were assigned RBF 3.
			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.
		HIC Numbers	Roughly six to ten percent of non-dual eligibles have valid HIC numbers. This is a higher proportion than expected.
		Managed Care	Each month in FY 1999, some eligibles with Plan Type = 01 (comprehensive managed care) have 8-filled Plan IDs.
			Georgia's Grady Memorial Hospital HMO ceased 1/00.
			In FY01 through Q1 FY08, GA's managed care data were not always consistent with the CMS managed care data. The CMS managed care reports in 2001-2007 included about 3,000 individuals in a Mental Health PHP 1915b waiver program (preadmission screening and annual resident review/ PSARR). GA erroneously reported enrollees in this plan to plan type 07 (PCCM) in MSIS. These individuals should have been reported to plan type 03 (BHP). From Q2 FY08 forward, PSARR enrollees will be reported correctly. PSARR enrollees can be identified using waiver ID PR for making this correction in MAX.

State	File Type	Record Type	Issue
GA	Eligibility	Managed Care	In June FY06, GA began enrolling many child and adult Medicaid enrollees in HMOs, but only a few disabled, and no aged enrollees. Enrollment in HMOs resulted in a decline in PCCM enrollment. A second round of new HMO enrollment took place in September, 2006, increasing HMO enrollment even more. The June 2007 CMS Medicaid Managed care report erroneously included S-CHIP managed care enrollees, resulting in a poor comparison with MSIS managed care data. GA is confident that MSIS HMO reporting is accurate.
			The state is unable to report MSIS eligibility for its NET (transportation) waiver. According to CMS documentation, virtually all of GA's Medicaid and S-CHIP population is eligible for NET with only a few exceptions. In June 2001, CMS reported 1,273,133 persons eligible for NET services. In June 2006, enrollment was 1,290,814 according to CMS data.
			PCCM counts are not very consistent between MSIS and the CMS reports. In FY02, for example, CMS showed 1,043,154 PCCM enrollees, compared to 677,148 in MSIS. In FY07, GA reported 118,000 PCCM enrollees in MSIS, compared to 24,000 in the CMS administrative reports. GA feels that the PCCM reporting in MSIS is accurate, however, they have been asked to review PCCM reporting, given the erroneous inclusion of PASSR
			From Q1 FY05 - month 2 of Q3 FY06, GA reported a very small number of enrollees to Plan Type 1 (HMO). These were erroneous entries, and the state plans on fixing them with correction records.
		MASBOE	1999-2003: From FY99 through Q2 FY03, Georgia exhibits a seam effect 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. This problem also affects other fields, most notably Plan Type. It is improved somewhat by their submission of retroactive eligibles, but not entirely resolved.
			2000: In FY00 and FY01, some persons in state group 90 (S-CHIP) were erroneously mapped to MASBOE 32.
			2000: In Q4 2000, a few individuals were assigned an invalid MAS of 6 or 7.
			2001: During January to April of 2001, GA reinstated a large group of former TANF recipients into Medicaid in MAS/BOE 14-15, accounting for a short-term dramatic increase in enrollment.

State	File Type	Record Type	Issue
GA	Eligibility	MASBOE	2001: In August 2001, GA terminated its special family planning program (state specific group 77), causing an abrupt decline in MAS/BOE 35. 2001-2002: In Q4 FY01 and in FY02, GA mistakenly 0-filled the Plan ID, Plan Type, and restricted benefits fields for about two thousand persons (per month, per field) who were assigned a MAS/BOE other than 00. 2004: Between Q1 and Q2 FY04, there was a decline in MASBOE 21-22. This appears unrelated to the decline in July 2004 in state group 283. Cause unknown. 2006: As of January 1, 2006, individual applying for GA's family Medicaid program, had to present proof of income (W2, pay stub, or tax return) before they can begin receiving benefits. This policy does not apply to pregnant women or newborns. GA has also implemented strict citizenship verification requirements for enrollees. It is likely that these new verification requirements contributed to the gradual decline in enrollment seen in Q1-Q4 FY06 in MASBOE 14-15, 24-25, 34-35, and 44-45. 2004: In February, 2004 the number of enrollees reported to MASBOE 31 and 32 fell by 12 percent and 10 percent respectively. The state contributes this to Cost of Living Adjustments, and sees a similar drop in state financial records. This drop also affected partial dual enrollment in dual codes 03 and 06. 2006: In Q2-Q4 FY06, child enrollment in Medicaid declined significantly (13 percent). These declines were offset by increases in S-CHIP enrollment. 2004: In July 2004, GA ended an optional program that extended Medicaid coverage for nursing home services to people with incomes that otherwise would disqualify them for the program but are too low to cover long-term care. These people had been reported to state group 283 (LTC Aged, Medically Needy), in MASBOE 21. As a result of this cut, enrollment in MASBOE 21 fell by 1,500 (50 percent). It is unclear whether these individuals were removed completely from Medicaid, as enrollment in MASBOE 41 increased by roughly 1,500 in July 2004. 2001: GA Medicaid child enrollment is undercounted in FY2001 for reasons explained below under "CHIP Code".

State	File Type	Record Type	Issue
GA	Eligibility	MASBOE	2001: Child and adult enrollment increased noticeably in July, 2001. While some of the increase may be related to the TANF reinstatement in January-April 2001, more likely most of the increase occurred as GA corrected earlier reporting problems. No policy changes were identified that would account for major enrollment increases in July 2001.
			2003: In 2004, ACS became GA's MMIS contractor, replacing EDS. As a result, the state specific coding system was changed effective Q1 FY03. This had little effect on MAS/BOE with two exceptions: In Q1 FY03 GA included SLMB-only and QI enrollees for the first time, thus increasing enrollment in MASBOE 31-32. In addition, enrollment in several of the disabled groups increased noticeably. This may have occurred because the file was cut at a later date.
		MSIS ID	In FY06, GA decided to fix a problem involving 6,000-7,000 enrollees with duplicate MSIS IDs by merging their records. Since the number involved is relatively small compared to overall enrollment, nothin will be done for earlier MSIS files. However, GA will be sending a cross-reference file documenting their efforts which will be used to merge any duplicate records in 2004-2006 MAX.
		Restricted Benefits Flag	Effective Q1 FY03, restricted benefits code 4 (Pregnancy related) was only assigned to presumptively eligible pregnant women in MASBOE 35. Before this, it was assigned to almost all pregnant women in MASBOE 35.
			Effective Q1 FY06, GA began assigning rbf '5' to presumptively eligible women in MASBOE 3A.
			In FY03 through FY04 Q1, GA has a problem reporting duals who have multiple aid codes in their state system. For example a dual could be assigned state code 660 (QMB only) and 210 (nursing home, aged). As a result, 5,000 individuals were mistakenly assigned full dual codes 02 or 08 and restricted benefits flag 3. These persons should have been assigned partial dual codes. ACS (state contractor) developed a hierarchy of state codes and dual codes to correct this problem effective Q2 FY04.
			Prior to Q1 FY06, GA did not always assign RBF '2' (restrict-alien) to aliens receiving emergency services, but did report these individuals to MSIS. These individuals were reported to state groups 870 and 873. Prior to Q1 FY03, these individuals were reported to state groups 72 and 73. No reporting to RBF 2 occurred from Q1 FY03 through Q4 FY05.

State	File Type	Record Type	Issue
GA	Eligibility	Restricted Benefits Flag	Beginning in Q4 FY00 through July 2001, many persons in state group 77 mapped to MASBOE 35 were assigned restricted benefits flag 9 (unknown). They were family planning enrollees. All persons in state group 77 should have been assigned restricted benefits code 5 (other) and MASBOE 55. This program was terminated in July 2001. In addition, from October 2000 through September 2002, about 100,000 children reported to MASBOE 34 were assigned restricted benefits code 9 by mistake.
		Retroactive/Correction Records	Georgia decided to report retroactive records, despite the fact that they said they were going with the delayed submission in their MSIS application.
		CHIP Code	In Q1 and Q2 FY07, the MSIS and SEDS comparison of S-CHIP enrollees was very bad. GA confirmed that SEDS reporting was inaccurate, and planned to resubmit SEDS data. The Q4 FY06 and Q3 FY07 comparisons were fine.
			Georgia uses Dental Health Administrative Consulting Services (DHACS) to manage its S-CHIP program (called Peach Care). DHACS submits enrollment information on S-CHIP children (in groups 90 and 91) to the state's MMIS system (managed by EDS through FY02 and then ACS effective FY03). In addition, DHACS submits enrollment information on children who apply for S-CHIP, but are found to be eligible for regular Medicaid (group 71). The children in this Medicaid group are called Peach Care Plus, since they qualify for the regular Medicaid benefits package. In FY 2001, two errors occurred in the DHACS reporting to the MMIS. First, monthly enrollment information was not reported. Instead, DHACS reported children who were ever enrolled during the quarter. In MSIS data, these children were shown as enrolled all 3 months of the quarter. Second, children in group 71 identified by DHACS were erroneously counted as S-CHIP children, not regular Medicaid children. In MSIS, they were assigned to MAS/BOE 00 and CHIP code 3, when they should have been assigned MAS/BOE 34 and CHIP code 1. As a result of these errors, Medicaid enrollment is undercounted and S-CHIP enrollement is overcounted in FY 2001. In addition, children in groups 71, 90 and 91 identified by DHACS are reported as enrolled in all three months each quarter, when they may not have been enrolled the entire quarter. The number of children in group 71 who were erroneously reported as S-CHIP instead of Medicaid ranged from 200 in Q1 FY2001 to almost 46,000 per month by Q4 FY 2001.

State	File Type	Record Type	Issue
GA	Eligibility	CHIP Code	Beginning with FY03 data, S-CHIP enrollment appears to be correctly coded. There are still some problems of consistency with SEDS; however, the state asserts the MSIS S-CHIP data are more reliable.
			GA does not have an M-CHIP program. Its S-CHIP program began in FY99, but was not reported into MSIS until FY2000. However, there were problems of data reliability until FY2003. As a result, researchers should not use the S-CHIP data or rely on the state specific codes 90 and 91 used for S-CHIP until FY03.
			Several problems occurred with CHIP coding during the FY00-FY02 period. First, the numbers of children assigned to the S-CHIP state groups (state codes 90-91) were not consistent month-to-month over this period. Second, S-CHIP code 3 was not consistently assigned to persons in the S-CHIP groups. In some quarters, all Medicaid enrollees were assigned S-CHIP code 3. In other quarters, S-CHIP children were mistakenly assigned CHIP code 0. In addition, regular Medicaid children (in state group 71) were sometimes erroneously assigned S-CHIP code 3.
		SSN	Until Q1 FY03, Georgia had a problem with SSNs assigned to more than one enrollee (for example, 33,677 in Q1 FY 2001) that appears to be caused by outside agencies providing data for the MMIS.
			GA reports about 7 percent of its enrollment without SSNs. Most of these enrollees are children under the age of 14, and are reported to MASBOE 34 or 44. The state says it is reporting all SSNs provided them by outside agencies, and will not be able to improve reporting.
		TANF/1931	Georgia cannot accurately identify TANF recipients. The field is 9-filled for all eligibles.
HI	Claims	All	From Q1 2000 - Q4 2002, some eligibility files have the wrong MSIS ID, resulting in a failure to link with claims. This was corrected beginning with Q1 2003.
			The 1999 to 2001 files contain very few adjustment claims and they are all voids with $0 paid. The files that Arizona received from Hawaii were supposedly mostly adjusted. They believe that the $0 paid voids, actually had a negative amount paid that wasn't allowed in their system, so they were converted to $0. For this reason, it isn't possible to create correctly adjusted claims. The 2002 files have negative amounts paid on void claims, but the resubmittal claims still have $0 paid. This was fixed starting with the 2003 files.

State	File Type	Record Type	Issue
HI	Claims	All	Arizona is creating the Hawaii MSIS files. They took over what HMSA had in their legacy files for 1999 to 2002 and there are many problems/missing information in those files. Starting with 2000, Arizona took over the MMIS processing as well and they expect all these problems to be fixed.
		IP	From 1999 to 2004 there is a higher than expected percentage of claims without UB-92 Revenue Codes and a slighter longer length of stay. This appears to reflect the inclusion of some long stay hospital claims in this file.
			There are a few claims with an invalid Patient Status. This will be fixed in the 2000 files.??was it??
			2000: Medicaid Amount Paid on resubmittal adjustments is somethimes $0.
			There are a few claims in the 1999 files with an invalid Patient Status.
			Covered days are not reported in the 1999 files.
			2000: It appears that there may be some claims from long stay hospitals in the IP file, as about 15 percent of the claims show Patient Status 30 (Still a Patient) and they are missing UB-92 Revenue Codes for ancillary services. Also, the average number of days stay is 9 which is higher than expected.
			Other Third Party Payment (or Third Party Liability/TPL) is basically not reported in the 1999 files.
			The state does not report DRGs.
			2000 to 2001: There are about 50 percent fewer IP claims based on comparison to the Q1 2003 file.
			Very few of the IP claims in the 1999 to 2001 files are flagged as crossovers. Hawaii believes the crossover claims are in the file, but just not identified as such. The Medicare Coinsurance Payment and Medicare Deductible Payment amounts are carried as separate line items. This was corrected starting with the 2002 files.
		LT	1999 to 2001: Leave days are not reported.
			Charge is always missing in the 1999 files.
			In 2002 Q4 there was a huge increase in the number of LT claims without covered days and with a Patient Status of 01 (Discharged to Home). This is a result of the conversion process and are actually old claims for non-bundled services that were not previously included in the file.

State	File Type	Record Type	Issue
HI	Claims	LT	No covered days are reported in the 1999 files.
			2000: There are no crossover claims.
			There are no Leave Days in the 1999-2001 files.
			There are no claims in the file with a Type of Service of IP Psych < 21 although the state covers that service.
			Patient Liability is missing in the 1999 to 2001 LT files. In 2003 it is mostly a negative amount.
			2000: There are very few resubmittal claims and the amount paid is $0. ??see different wording on this LT comment vs. on OT comment and make consistent??
			2000: There are no claims with a Type of Service of 02 (Mental Hospital Services for the Aged) or 04 (Inpatient Psychiatric Services for those Under Age 22).
		OT	Starting in Q1 2008 most of the dental claims disappeared from the OT files. This is under investation by HI.
			In 1999 there are very few claims with a Program Type of 4 (FQHC). However HI has FQHCs.
			The outpatient hospital claims don't have UB-92 Revenue codes, even though they are billed on a UB-92 in the 1999 files. This will be fixed in the 2000 files.
			There aren't any claims with a Type of Service of 13 (Home Health) in 1999.
			Quantity of Service is always missing in the 1999 files. This will be fixed in the 2000 files.
			The most frequent Service Code in the OT file is Z9020 (taxes). The taxes are carried as separate line items on Hawaii claims. These claims will be included in the 1999 files, but should be ignored except for reporting expenditures. This will be fixed in the 2000 files. ??was it fixed??
			Some of the CPT-4 codes have an invalid length of seven in 1999.
			In 2003 there was a switch in reporting OPD claims. Prior to 2003 the Medicaid Amount Paid on the header was repeated on each line item, over stating the expenditures. Beginning in 2003, HI began submitting a header claims with the total amount paid and line item claims with services but no amount paid.

State	File Type	Record Type	Issue
HI	Claims	OT	The files do not include waiver claims through Q4 2002, as they were processed by a different state agency. Full reporting started in Q2 2003.
			There is a separate line item for taxes on and they are included in the 1999 files as separate claims.
			2000: The amount paid on adjustment claims (resubmittals) is usually $0.
			1999 to 2002: The files do not include claims with Program Type of 6 or 7 (Home and Community Based Waivers) or 3 (Rural Health Clinic).
			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. This means that there will be a higher percent of claims with $0 paid.
			All capitation payment claims are coded as crossovers from 1999 to Q1 2003.
			Amount Charged is always missing in the 1999 files.
		RX	Starting in Q1 2007 most of the RX claims disappeared from the RX files. This is under investigation by HI.
			There are a large number of RX claims with old dates of service submitted in Q3 2006. They are mostly for 2005.
			Quantity of Service is often missing in the 1999 files.
			The fill date is reported in both the Fill and Prescribed Date fields. The state will correct starting with Q2 2005.
	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 partipants 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.

State	File Type	Record Type	Issue
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). Roughly 80 percent of aged eligibles are reported as being duals in FY 2000. This improved to 86 percent by FY 2003. We generally expect 90% or more of eligibles aged 65 and older to be dually eligible. In FY 1999, roughly 50 percent of dual eligibles in Hawaii received flags 08 or 09. This proportion fell to less than 10 percent in FY 2000. Prior to Q1 FY06, HI determined quarterly dual enrollment by using month 3 dual coding only. As a result, individual who were assigned a dual code of 01-09 in month 1 or 2, but dual code 00 in month 3 were reported to quarterly dual code 00. This ended in Q1 FY06, when HI began using monthly dual codes. In Q1 FY06, the number of enrollees with dual code 08 increased by approximately 2,000 as a result of this change. Between four and five percent of persons in BOE 4 - 8 are reported as dual eligibles in FY 1999. We generally don't expect to see any duals in these BOEs. The state corrected this problem in FY 2000. 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 through Q3 FY07. 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. 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.
		Foster Care	In FY00 Q4, foster care enrollment averaged about 3850 children/month (these children are reported into state groups H41 and H42 and mapped to MASBOE 48). However, in FY01 Q1, foster care enrollement drops to less than 300 children/month. Then, in Q2 FY01, foster care enrollement rebounds, with 3,984 children reported in January 2001.

State	File Type	Record Type	Issue
HI	Eligibility	HIC Numbers	In FY 1999, between 54 to 57 percent of Hawaii's dual eligibles had valid HIC numbers. This problem was corrected in FY 2000.
		Managed Care	During FY02, HI incorrectly reported enrollees to MC codes '02' and '08'." These enrollees should have been reported to '88' as HI's dental programs are all FFS as of 10/01. And the persons reported to plan type 08 were not really in managed care.
			The Queens HMO ended in 4/02, and the Kapiolani HMO ended in 7/02.
			Through FY06, MSIS MC data consistently shows lower HMO enrollment than CMS MC data. The state has explained that this occurs because state-only enrollees are mistakenly included with the CMS managed care data.
			HI's PACE program is not a full PACE, rather it is a "Pre-PACE" program operating under a waiver, it is not reported as managed care type 06 (PACE). It is correctly reported to managed care plan type 01 (HMO).
			Each month in FY99, 100-400 eligibles with Plan Type 88 (Not Applicable) receive valid Plan IDs. Persons with Plan Type 88 should receive Plan ID 888888888888.
			In FY03 and FY04, HI BHP enrollment counts were 12 percent higher in MSIS than the counts in the CMS managed care survey (cause unknown). However, HI's BHP program is small, and this difference only represents about 500 enrollees.
			From Q1 FY03 forward, persons are assigned the following plan ID's: DEN001, DEN003, EMGSVC, NONPAY, QMBONY, QNAFFS, TRANSP. However, these are all FFS, so the plan type field is 8-filled. HI has been asked not to report individuals to these Plan ID's from FY04 Q2 forward.
			Most dental managed care ended 10/01, with only low levels of dental managed care reported subsequently.
		MASBOE	In the third month of FY99 Q4, enrollment drops by about 8,000 in MAS/BOE 14 and rises by the same amount in MAS/BOE 34. According to the state, this is a correction of problems in FY99 Q1-3. The data in FY00 should be consistent with what we see at the end of FY99.
			From FY04 Q1 forward, HI reports 50-60 persons to MASBOE 99 who have some monthly data elements with values >0.

State	File Type	Record Type	Issue
HI	Eligibility	MASBOE	From Q1 FY03 - Q4 FY07, HI has reported roughly 100 individuals 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 have asked to state to adjust its age sort, and to continue reporting these enrollees to valid MASBOE groups.
			Through Q4 FY02, many persons over age 65 were reported to MASBOE 32.
			Each month in FY 1999, 100-200 eligibles in valid state-specific eligibility groups are mapped to MAS/BOE 00. These eligibles should be mapped to a valid MAS/BOE group.
			In Q1 FY 2003, enrollment is no longer reported to MAS/BOE 35, since the H03 group includes both pregnant women and adults covered under the 1115 waiver. This group is now mapped to MAS/BOE 55.
			In FY01 Q1, HI erroneously reported that enrollment in MASBOE 48 dropped to less than 300 per month, compared to about 4,000 per month in previous and subsequent quarters.
			Since FY 2000, Hawaii enrollment data have shown a seam effect, with enrollment the highest in month one of each quarter and the lowest in month three. Generally, enrollment rises significantly in month one of each quarter.
			In Q1 FY 2003, child and adult enrollment shifted somewhat from MAS/BOE 34 - 35 to MAS/BOE 14 - 15, when HI corrected the reporting for 1931-related groups H45 and H61. This will be fixed in MAX effective 2002.
			From FY02 Q1- FY02 Q4, persons in state groups H48 and H50 (BCCPTA enrollees) should have been mapped to MASBOE 3A, not MASBOE 31.
			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.
			In FY01 Q1, HI erroneously reported enrollment levels of 43,000 in HI QUEST(H03), compared to levels of 35,000-39,000 in previous and subsequent quarters. It appears that foster care and M-CHIP children may have been reported to H03 by mistake in FY01 Q1.

State	File Type	Record Type	Issue
HI	Eligibility	Restricted Benefits Flag	From Q1 FY05 - Q3 FY07, HI assigned roughly 400 individuals to restricted benefits code '9', unknown. Most of these individuals are reported to MASBOE 55. It appears that all enrollees with rbf '9' should be reported to rbf '1'.
		CHIP Code	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.
			From FY02-FY03, HI reports more M-CHIP enrollees than SEDS. The state cannot explain this discrepancy. In Q1 FY04, the comparison improved when the level of enrollment in SEDS increased to be consistent with MSIS. It appears that M-CHIP reporting in MSIS has been reliable.
			Eligibility codes for M-CHIP changed from H55 and H58 to H71 and H72 effective 12/01/03.
			In Q1 FY01, HI erroneously reported that M-CHIP child enrollment dropped to about 500 per month, compared to 3,000-4,000 per month in previous and subsequent quarters. However, this appears to be fixed with correction records.
		SSI	HI is a 209b state.
		TANF/1931	Hawaii 9-fills the TANF field for all eligibles.
IA	Claims	IP	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.
		LT	Diagnosis Codes are missing on most claims.
	Eligibility	1115 Waivers	IA implemented a Family Planning waiver on 2/1/06 (state eligibility code 906). From Q2-Q4 FY06, Family Planning enrollees were reported to MAS 5 and RBF 6, but were not reported to Waiver Type F, or a waiver ID. In Q1-4 FY07, Iowa improved Family Planning program reporting by assigning these individuals to Waiver Type F and Waiver ID W1. However, the state did not report consistent counts to RBF 6 and Waiver Type F. These discrepencies disappear in FY08. (But, the numbers may still differ slightly sometimes because some Family Planning Waiver Recipients change categories month to month from Family Planning Waiver to a blend of Iowa Care and Family Planning and/or normal Medicaid.)

State	File Type	Record Type	Issue
IA	Eligibility	1115 Waivers	IA implemented a large 1115 waiver called IowaCare on July 1, 2005 (Q4 FY05). IowaCare expanded the Medicaid eligible population to 1) all individuals 19-64 with family incomes to 200 percent FPL, 2) newborns and pregnant women with income at or below 300 percent FPL, and 3) emotionally disturbed children who need home based care who would be eligible for state services if they were institutionalized, and have income below 300 percent of the SSI benefit or a family income of less than 250 percent FPL. Persons in groups 1 and 2 are considered 1115 expansion enrollees. Persons in group 3 were originally supposed to be in a 1915(c) waiver, but CMS decided to "roll them in" to the 1115 waiver instead. However, for MSIS waiver reporting, this group is treated like a 1915(c) waiver. These individuals should be reported to waiver type 3, waiver id H1 and may be in any MASBOE group. However, IA did not begin reporting to waiver ID H1 until Q1 FY07. Persons in group 1 and 2 should be reported to waiver type 1, ID X1, and MASBOE 54-55. They are reported to state codes 60E, 60P, 60H, and 60T. However, they were not reported to waiver type 1 and waiver ID X1 in MSIS until Q1 FY07. This waiver coding problem can be fixed in MAX using the state codes. IowaCare will place these individuals in Managed Care entities. Enrollees will have some cost-sharing, not to exceed 5 percent of income.
		Dual Eligibility Codes	Effective Q2 FY04, IA will no longer use Dual Code 09. All 09's will be reported as 02, 04, or 08 (Full Duals). In Q1 FY05, the number of duals fell by 4 percent. In addition, the number reported to dual code 02 increased while reporting to dual code 08 declined. One improvement was that almost all SSI duals began to be reported to dual code 02. However, from Q1-Q4 FY06, this improvement was accidentally reversed during the implementation of the monthly dual code, and roughly 4,000 SSI duals were reported to dual code 08 instead of dual code 02. The state planned to fix in Q1 FY07 and in that quarter the number in dual code 02 increased and the number of dual code 08 decreased.

State	File Type	Record Type	Issue
IA	Eligibility	Dual Eligibility Codes	Through FY06, IA reported higher enollment in dual code 02 in MSIS, and lower enrollment in dual code 08 compared to the corresponding MMA monthly files. Both MSIS and MMA reported a comparable number of full duals, but IA has had difficulty accurately reporting QMB-Plus duals in MMA. It is unclear if the state will be able to improve its MMA reporting. When the state corrected its dual reporting in MSIS, it was unclear whether they will be able to correct the MMA numbers. By the end of Q4 FY 2008, IA MMA and MSIS comparisons of dual code 02 counts improved to within 6 percent. Discrepancies between the two sources on dual code 08 remained.
		Managed Care	In 2003, several HMOs were terminated, with many (but not all) enrollees shifting to PCCMs. HMO enrollment declined further in FY04. By February 2005, HMO enrollment was cut back to only one plan - Coventry Health Care. In September 2008, IA implemented a PACE plan (0701947). PACE operates in Cherokee, Ida, Monoma, Plymouth, Sioux, and Woodbury counties. In Q2-4 FY 2007, IA reported about 28,000 full duals to behavioral health plans. The state explained that their eligibility system assigns disabled full duals under 65 to Iowa Plan behavioral health plans which includes both mental health and substance abuse. The disabled are included the same as the non-disabled members for enrollment in this plan.
		MASBOE	Prior to Q1 FY05, IA had a recurring problem with reporting enrollees under age 65 to BOE '1'. All of these individuals <65 should have been mapped to BOE '2'. In April 2005, IA adjusted its mapping to report most SSI disabled enrollees age 65 and older to MASBOE 11. IA also has a state-administered SSI supplement program for persons receiving residential or in-home health related care. In FY05, IA had a small seam effect, with enrollment lowest in month 3 of each quarter. This occurred in all BOE groups. This pattern was not present in earlier years. In Q1 FY 1999, between 100 to 180 CHIP eligibles (state eligibility group 920) were mapped to MAS/BOE 64. This problem was corrected in subsequent quarters. FY 2007, Iowa began reporting state codes 373 and 889 to MASBOE 3A. The state explained that these codes were incorrectly reported in earlier years to MASBOE 34.

State	File Type	Record Type	Issue
IA	Eligibility	MASBOE	A report from the Center on Budget and Policy Priorities indicated that Iowa experienced enrollment declines attributed to new citizenship documentation requirements in the second half of 2006. Previous to the requirement, Medicaid enrollment has been steadily increasing. However, enrollment declines did not appear in Q4 FY06 MSIS data.
		Private Health Insurance	From Q4 FY04 to Q1 FY05, roughly 1,500 enrollees shifted from having private health insurance code '2' (third party) to code '4' (third party and state).
			Roughly 15 percent of Iowa's Medicaid population was reported to have private health insurance. This is a greater than expected proportion.
		Race/Ethnicity	From Q1 FY05 forward, when new race/ethnicity coding was implemented, IA has reported most hispanics as having no race information. IA did report that a few thousand Hispanics had more than one race, but it did not identify the races of these individuals. Similarly, IA indicated that about 3,000 non-Hispanics had more than one race, but failed to indicate the specific races. As a result, it is impossible to know the race codes for all hispanics and for the non-hispanics who had more than one race. In addition, the combined race/ethnicity information is unknown for 20 percent of IA enrollees.
			Race was reported as "unknown" for 20% of enrollees in FY05 and FY06. This issue has been raised with the state, and they have responded saying that IA Medicaid applications have language explaining that applicants do not have to answer race and ethnicity questions, and that their eligibility is not affected by their race. In addition, effective August 1, 2007, face to face interviews are no longer a required part of the application process, which will likely increase the number of enrollees with "unknown" race and ethnicity.
		Restricted Benefits Flag	In August 2008, Iowa started enrolling people in 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. MPF enrollees are assigned RBF code 8 in MSIS.
			In February 2006, IA implemented a Family Planning-only expansion as part of an 1115 waiver. These individuals are assigned restricted benefits code '6'.
		CHIP Code	Iowa reports its M-CHIP children in MSIS. The state does not report its S-CHIP children.

State	File Type	Record Type	Issue
IA	Eligibility	SSI	IA reports most of its SSI disabled enrollees over age 65 to MASBOE 11 (cash, aged).
		TANF/1931	Effective FY 2001, Iowa began 9-filling the TANF flag. TANF data for earlier quarters are not reliable.
		Waivers	See 1115 waiver anomaly for discussion of MSIS reporting for 1915(c) waiver related to emotionally disturbed children.
			Iowa Plan is a 1915(b) waiver for enrollees related to freedom of choice for persons receiving mental health and substance abuse services.
	General Info	Date 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.
ID	All	All	There was a change in the MSIS IDs just prior to FY Q1 1999. Therefore, the linkage with claims and eligibility records from prior quarters will be incomplete.
	Claims	IP	DRGs are not reported in the IP files.
			There are no claims with a Program Type of Family Planning.
		LT	Almost 20 percent of the claims have a Type of Service of 05 (ICF/MR), which is much higher than expected.
		OT	The PCCM capitation expenditures are reported as service tracking claims in the 2004 Q4 through 2005 Q4.
			Until 2007 Q1 IL did not submit PCCM capitation claims or enrollment. They are supposed to resubmit all 2007 and 2008 OT claims and EL files to correct.
		RX	ID reports compound drugs as "COMPOUND" in the NDC field.
	Eligibility	1115 Waivers	ID implemented a Katrina Waiver on 9/28/06.
			ID implemented an "Access Card" 1115 demonstration in 2005 that did not expand eligibility for M-CHIP and S-CHIP children, but it 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 are not reported in MSIS.

State	File Type	Record Type	Issue
ID	Eligibility	County Codes	Until Q1 FY03, ID failed to report any enrollees in Blaine County (013). About 900 enrollees per month were reported beginning with Q1 FY03 data. It is not clear what county code assignment these enrollees received prior to Q1 FY03.
		Date of Death	The state does not submit date of death information.
		Dual Eligibility Codes	ID routinely assigns a small number of enrolleed dual code 99. Dual code 99 is used when when there is a mismatch between Medicaid eligibility and Dual eligibility. For example, a client has Medicaid eligibility for the month but the dual eligibility code for that client is a Medicare only code (01, 03, etc.). This combination does not make sense so the dual code is set to 99. When this happens, it is usually a timing issue where ID has not received the updated dual code yet.
			Prior to Q1 FY06, ID did not use dual code 03, 04 and 06 (SLMB-Only, SLMB-Plus, and QI-1). SLMB-Plus enrollees were reported to dual code 08, and it appears that SLMB-Only and QI-1 enrollees were previously not included in MSIS reporting or assigned a dual code. Starting in Q1 FY06, these individuals were correctly assigned dual code 03, 04 or 06, and were mapped to MASBOE 31 and 32.
			The majority of ID's MASBOE 42 enrollees are children and thus we don't expect them to be Medicare-eligible.
			Until FY03, Idaho reported that only 50 to 60 percent of eligibles ages 65 and older were dually eligible for Medicare and Medicaid. This increased to 90 percent in Q1 FY03. Similarly, 22 to 26 percent of disabled eligibles in BOE 2 were reported as dual eligibles until Q1 FY03, when the proportion increased to 36%. This increased to 41 percent by Q3 FY06.
			In Q2 and Q3 FY06, ID used blank dual codes for roughly 154,000 enrollees. All of these individuals should have received dual code 00. This problem was fixed in Q4 FY06, although a new minor problem occurred. About 20 individuals had the dual code 9-filled.
		HIC Numbers	Because Idaho is an auto accrete state, there is fluctuation in the percentage of duals with valid HIC numbers. The percentage typically ranges from 91% to 97%, but was 83% in FY03 Q1, and 81% from Q2 FY03-Q4 FY04. From FY05 forward, the percent of duals with valid HIC numbers has consistently been over 99 percent.
		Managed Care	The state does not have any fully capitated managed care. They do have PCCMs, however.

State	File Type	Record Type	Issue
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).
			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 data. 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.
		MASBOE	2006: In Q1 FY06, ID began to report SLMB-Only and QI duals, causing an increase in MASBOE 31-32.
			2006: Effective 7/06 in MSIS data, ID began to implement a Medicaid Modernization Plan, allowing them to provide benchmark or equivalent coverage benefits to the vast majority of their Medicaid enrollees (children and their parents), as well as S-CHIP enrollees. Medicaid enrollees in these plans are assigned RBF 7. ID is also modifying its state specific eligibility codes for these groups (see revised crosswalk). In addition, all Medicaid children will eventually be reported to MASBOE 34 (except foster care and disabled children). This includes M-CHIP children. S-CHIP children will continue to be reported to MASBOE 00. Benefit changes include some copays and the use of personal health accounts. Individuals will also be allowed to chose private plans (through premium assistance) instead of Medicaid.
			ID requires SSI recipients to seperately apply for Medicaid. All SSI recipients who apply should qualify since the eligibility requirements do not differ.
			2001-2002: Periodically, Idaho reported a higher than expected (roughly three to five percent) number of eligibles in BOE 1 who are under age 65. This problem phases out by the end of FY 2001 but reappeared in Q2 FY 2002. FY03 looks ok.
			2006-2007: In Q4 FY06 and Q1 FY07, roughly 25 individuals under age 25 were reported to MASBOE 15.

State	File Type	Record Type	Issue
ID	Eligibility	MASBOE	1999: In FY 1999, the number of eligibles in MAS/BOE 11 and 12 was roughly half of the number of SSI recipients reported by the SSA. Some difference may result because SSI recipients in Idaho have to apply separately for Medicaid. In addition, State-Specific Eligibility Group 54, which includes SSI eligibles (and some non-SSI eligibles, as well) were mapped to MAS/BOE 42. This problem was corrected in FY00.
			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.
			2007: Enrollment shifts by MASBOE continued in 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 <5 children to MASBOE 44.
			2000: In FY 2000, the eligibles in state specific eligibility group 54 were moved to MAS/BOE 12. As a result, the number of eligibles in MAS/BOE 11-12 is more equivalent to the number of SSI recipients if state supplements are considered as well.
			2001: There was a six percent increase in the number of eligibles in October 2001. The state believes that the increase is the result of economic hardship at that time; however, retroactive coverage and correction records eventually smoothed out this difference.
			2002: Idaho reported a higher than expected number of enrollees to MAS/BOE 44-45 through FY02. This occurred because many 1931 eligibles were reported to MAS/BOE 44-45. In FY03, state group 53 was remapped to MASBOE 14-15, correcting this problem, and retro-records were submitted.
		MMIS	ID's MMIS contractor is Unisys.
		MSIS ID	The state changed their MSIS IDs starting with FY 1999 so the MSIS ID's will not link with the pre-1999 files.

State	File Type	Record Type	Issue
ID	Eligibility	Private Health Insurance	In Q4 FY06, private health insurance coverage increased even more, perhaps related to the implementation of the Medicaid Modernization plan, which allows individuals to opt for private coverage. Idaho reports that about 18 to 25 percent of eligibles have private insurance. This proportion is much higher than in other states.
		Race/Ethnicity	In FY03 Q1, Idaho submitted retro records for FY02 Q4 which changed 6000 individuals from "hispanic" to "white." This represents roughly 25% of those individual who were originally coded as hispanic in FY02 Q4. This change was made due to the Census Bureau's change in the definition of hispanic. MSIS coding will be changing to incorporate multiple races and ethnicities in Q1 FY05.
		Restricted Benefits Flag	Minor problem: About 75-125 persons in MASBOE 31-32 in Q4 FY06-Q1 FY07 had the restricted benefits code 0-filled. They should have been assigned restricted benefits code '3' (partial dual). 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. They have never used 2. In Q4 FY06, ID began assigning restricted benefit code '7' to enrollees in its "alternative benefits" benchmark plan.
		Retroactive/Correction Records	In 2008, ID had a large volume of retro/correction records, but analysis showed the state was reliable in its use of retro/corrections. Before Q1 FY 2002, ID had a technical problem that prevented their submission of retroactive records. The state submitted a high volume of retroactive records in FY 2002 (about 100,000 each quarter) to compensate. IDs procedure for submitting retroactive and correction records results in lower levels of retros in quarters run shortly after the previous quarter and higher levels when a large time span elapses between submissions. This does not impact data quality, simply the flow of when retros are submitted.
		CHIP Code	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). Effective Q4, FY04, ID began an S-CHIP program, and reports this S-CHIP group into MSIS. Until Q4 FY06 ID's S-CHIP program covered children 150-185 percent FPL.

State	File Type	Record Type	Issue
ID	Eligibility	CHIP Code	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 S-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 S-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, S-CHIP covers all children (0-18), 133-185 percent FPL, a slight contraction from phase 1.
			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 are not included in ID's MSIS data. ID estimates that roughly 1,400 children participate in "Access Card" each month, which explains the differnce between MSIS and SEDS S-CHIP reporting. Almost no M-CHIP children participate in the "Access Card" program. Thus, S-CHIP enrollment is somewhat undercounted in MSIS data from Q1 FY05 forward, but M-CHIP enrollment continues to be reliable.
		TANF/1931	Minor problem: About 75-125 persons in MASBOE 31-32 in Q4 FY06 - Q1 FY07 had the TANF field 0-filled. The TANF field should have been 9-filled for these individuals.
			Idaho 9-fills the TANF flag for all eligibles.
		Waivers	In Q2-Q3 FY06, ID reported a small number of enrollees (about 30) to waiver IDs 07, 08, and 09. These waiver IDs were not present on the state's waiver crosswalk. The state has informed us that these are old codes that should have been deactivated, and are end dated 3/31/05.
			Although it did not have any enrollees as of Q3 FY08, ID's HCBS/ISSH waiver is still a valid waiver that could be assigned to an individual.

State	File Type	Record Type	Issue
ID	Eligibility	xREVIEW NOTE	This serves as a "placeholder" indicating that Idaho has been approved for providing an Alternative Benefit Package via Medicaid. Be sure to check previous reviews for Idaho to see if a note has been sent regarding this coverage and RBF 7, or if we still need to confirm specifics with the state (date of implementation and who is being covered) and then make sure we update the anomalies accordingly.
IL	Claims	Adjustments	There are no crossover adjustment claims due to the way the Illinois system processes crossover claims.
		All	The claims files include claims for CHIP only enrollees until FFY 2006.
			The number of claims varies by month and quarter due to state billing cycles. There is an especially big drop in the number of claims in the Q1 and Q2 2003 files due to a state budget problem that delayed the payment of claims.
		IP	The adjustment sets need to be linked together using Beginning Date of Service instead of Ending Date of Service.
			The number of covered days equals the length of stay on only about 17 percent of the records.
			Procedure Code Modifiers 1 through 6 are always missing, but this is reasonable since modifiers are rarely applicable for IP procedure codes.
		LT	Other Third Party Payment (or Third Party Liability/TPL) is always missing.
			Patient Status is mostly missing
			The average Medicaid Amount Paid per day for Mental Hospital for the Aged claims was very high in early years (probably because some of these claims were actually service tracking claims). However, at least by 2003, these claims show a low daily rate, more similar to standard nursing facilities than to other psychiatric hospitals or institutions.
			Up until Q3 2001, Illinois incorrectly classified claims for Inpatient Psych Under age 21 with a Type of Service of 07 (Nursing Facility).
		OT	There are no dental capitation payment claims in any files in 1999. There are very few FFS dental claims until 2002 when they increased to about three percent.

State	File Type	Record Type	Issue
IL	Claims	OT	In 2001, 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). 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.
		RX	There are no adjustment claims in 1999.
			There are no NDC codes on credit adjustment claims, making it difficult to properly adjust the files.
	Eligibility	1115 Waivers	From Q1-Q4 FY05, children in the following state groups were mistakenly reported to MASBOE 00 and assigned S-CHIP code '3': 94RL00, 94RM00, 94RN00, 94RO00, 94RP00, 94R000, 94R100, 94V000, 94V100, 94V200. They should have been reported to MASBOE 54 and assigned CHIP code '1'.
			In Q3 FY02, Illinois began enrollment in a 1115 waiver Senior Care program, extending drug benefits to aged enrollees with income up to 200 percent FPL. IL's Senior Care pharm plus program stopped covering Medicare beneficiaries in January 2006, when Part D began (Q2 FY06). The state began an SPAP to provide wrap-around benefits for affected enrollees. However, the pharm plus program continued to serve aged non-duals after Part D began. These enrollees are reported to state groups RXSRC2 and RXSRC3, and are assigned restricted benefits code '5'. Enrollees in these groups were never Medicare enrollees, but they were mistakenly assigned dual code '09 through Q4 FY06. Effective Q1 FY07, they were correctly assigned dual code 00.
			Then, IL's "Kidcare" 1115 HIFA waiver was implemented in Q1 FY03 (October 2002). Reported to MSIS as 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. 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. The waiver also eliminated co-payments on generic drugs for Medicaid eligible adults in the demonstration.

State	File Type	Record Type	Issue
IL	Eligibility	1115 Waivers	IL's family planning program (state groups 94FP00 and 96FP00 reported to MASBOE 55) was added in Q4 FY04, as part of yet another 1115 waiver (Waiver id A3, Waiver Type F). Enrollees in this program are assigned restricted benefits code '6' from Q1 FY06 forward. In addition, in Q1-Q4 FY05, IL mistakenly reported Medicaid waiver enrollment for many of its S-CHIP enrollees (CHIP code 3). Since S-CHIP enrollees are not considered to be Medicaid enrollees, they should not be reported as enrolled in Medicaid waivers. For persons with CHIP code 3, Waiver Types 1, 2, and 3 should be coded with "0" (Individual was not eligible for Medicaid this month) and all three (monthly) Waiver ID fields should be coded as "00" (individual is not eligible for Medicaid during the month). IL has been asked to use correction records to fix this problem from Q1 FY05 forward, but it does not look like these changes were made. This problem was fixed in Q1 FY06.
		Dual Eligibility Codes	In Q1 FY06, IL moved roughly 2,000 duals in MASBOE 21-22 from QI-1 (06) to other full benefit dual (08). These are QI enrollees who met their spend-down. From the inception of its Senior Care Pharm Plus waiver program in Q3 FY02, IL was unable to get accurate Medicare information for many of the aged in MASBOE 51. Until Q1 FY05, dual code 09 was used for most aged Pharm Plus enrollees, but 25-33 percent were assigned dual code 00. This caused the percent of duals age 65 and older to be lower than expected. In FY05, IL dramatically improved its dual reporting, especially for the Pharm Plus population. However, as noted below, non-dual pharm plus enrollees should not have been assigned dual code 09. In July 2002, approximately 6,000 persons moved to QMB + from QMB only when the state increased its medically needy eligibility level from 85 percent to 100 percent FPL for aged and disabled enrollees. In Q2 FY06, IL shut down most of its Pharm Plus program, as Part D Medicare was implemented. The remaining Pharm Plus enrollees in state group RXSRC2 and RXSRC3 are not Medicare eligible. These enrollees are not duals, and should be reported to dual code 00 and restricted benefits code '5', not dual code 09. The correct dual code was assigned in Q1 FY07. The error appears to have affected 3,000-10,000 Pharm Plus enrollees in most quarters (5 percent of Pharm Plus enrollees) from the beginning of the Pharm Plus program in Q3 FY02 through Q4 FY06.

State	File Type	Record Type	Issue
IL	Eligibility	Dual Eligibility Codes	In FY 2002, Illinois did not have reliable dual status data for enrollees in its 1115 senior care waiver. These enrollees were assigned dual code 00 rather than 99. Prior to Q1 FY06, IL undercounted partial duals in MSIS by roughly 10,000 per quarter. Using MMA files as a comparison, it was found that IL was not reporting partial duals who failed to meet spend-down. IL fixed this issue in Q4 FY07, and submitted correction records back to Q1 FY06, extending the correction. 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. Between Q4 FY06 and Q1 FY07, IL improved its reporting of QI duals who met their spend-down. As a result, roughly 3,000 duals shifted from dual code 06 to dual code 08. In July 2002, IL increased its medically needy eligibility level from 85 percent to 100 percent FPL for aged and disabled enrollees. At that time, approximately 6,000 persons moved to QMB+ from QMB-only. Between Q3 and Q4 FY04, there was a large drop in the number of enrollees assigned dual code 09 and enrolled in MASBOE 51. Every year IL requires its Pharm Plus enrollees to reapply for Pharm Plus eligibility. Most of the people dropped from the rolls either died, moved out of state, are no longer eligible, or qualified for Medicaid under dual codes 01-08. In Q1 FY06 - Q3 FY07, IL reported roughly 4,500 duals to MASBOE 00 each month. 4,000 of these enrollees were reported to dual code 02. These individuals are not eligible for Medicaid, and should have been reported to dual code 00. IL fixed this in Q4 FY07, submitted correction records back to Q1 FY06 fixing this issue.
		HIC numbers	The percentage of duals with valid HIC numbers dropped to 70 percent when Illinois began its prescription drug waiver in Q3 FY 2002.
		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. We asked the state to clarify whether it currently has a PCCM plan.

State	File Type	Record Type	Issue
IL	Eligibility	Managed Care	In Q4 FY06, Managed Care plan " AmeriGroup" (Plan ID 541761812001) ended. A small level of enrollees will continue to be reported to the plan for a few months. These are pregnant women who were already enrolled before the plan ended.
			Illinois reports enrollment in Plan Type 08 (Other). These plans consist of Primary Health Providers and Managed Care Community Care Networks (MCCN). These plans provide different services than comprehensive managed care plans. 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 Q1 FY06, two managed care plans ended: Chicago HMO (ID 362835382001) and Humana (ID 61101013183001).
		MASBOE	2000-2001: There were two expansions in Q4 of FY 2000 in Illinois -- a Medically Needy Expansion and an OBRA 86 expansion (the OBRA 86 expansion covered aged and disabled eligibles to 70 percent FPL; this was later raised to 85 percent, and then to 100 percent in FY 2003). The codes for expansion were not ready by Q4, however, so those eligibles are lumped in with the Medically Needy expansion eligibles. Beginning in FY 2000 q1, new groups 11EXP1 and 23 EXP1 are mapped to MAS/BOE 31 and 32; groups 11EXP2, 22EXP2, and 23EXP2 are mapped to MAS/BOE 21 and 22. It appears that enrollment in MAS/BOE 31 to 32 decreased in Q4 FY 2000, in spite of these expansions. There was some offset in MAS/BOE 21 - 22, however. MAS/BOE 21 - 22 enrollment may continue to increase in the future. State law requires that the Medically Needy standard be raised to 100 percent FPL effective 7/02. Enrollment in MAS/BOE 14 - 17 and MAS/BOE 44 - 45 declined across FY 2001, but was offset by increases in MAS/BOE 34 and 25. This shift was a result of a Department of Human Services initiative to redetermine eligibility. Many enrollees were moved from MAS 1 and MAS 4 to either MAS 2 (primarily adults) or MAS 3 (primarily children).
			2006: Between Q4 FY05 and Q1 FY06, almost all enrollees in MASBOE 44 (IL's zero grant population) were redetermined, and found eligible for a grant larger than zero. As a result, roughly 15,000 enrollees were moved from MASBOE 44 to 14. In addition, enrollment in MASBOE 14 increased between Q4 FY05 and Q1 FY06 when applicants to the All Kids program were found to be TANF eligible.

State	File Type	Record Type	Issue
IL	Eligibility	MASBOE	2006: Between Q4 FY05 and Q1 FY06, roughly 55,000 adults shifted from MASBOE 25 to MASBOE 45. These individuals were at the end of their Medicaid benefits period, and were found eligible for a Medicaid Medical Extension. 2006: Between Q4 FY05 and Q1 FY06, IL implemented a system of identifying waiver enrollments, and increased the number of supportive living facilities (SLF) that provide services under the state's SLF waivers. As a result, there was a large increase in enrollment in MASBOE 41-42 (18,000 enrollees). 2004: In each month of Q1-Q3 FY04, rougly 15,000-18,000 enrollees over age 20 were reported to MASBOE 34. This problem existed to a smaller extent in FY03. This was caused by a programming error in the state's age sort. This issue was resolved in Q4 FY04, and correction records were submitted back to Q4 FY03. It appears that the individuals in MASBOE 34 over age 20 were not eligible for Medicaid. FY07: IL reported several thousand SLMB-only partial duals to MASBOE 21 and 22. IL submitted correction records to move these individuals to MASBOE 31 and 32. 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. 2005: As discussed elsewhere, IL in FY05 mistakenly reported about 8,000 children to MASBOE 00, and S-CHIP code 3 who should have been reported to MASBOE 54 (and S-CHIP code 1). Because Illinois is a 209(b) state, the number of persons reported into MAS/BOE 11 and 12 is lower than ordinarily expected. Also relevant, Illinois reports SSI recipients who do not qualify for a state supplement into MAS/BOE 21 and 22 effective Q3 FY 2001.

State	File Type	Record Type	Issue
IL	Eligibility	MASBOE	2002-2003: In FY 2002, Illinois experienced several shifts in MAS/BOE enrollment, which the state believes are the result of its move to a new database. The shifts included a decline in MAS/BOE 14 to 17, which was offset by increases in other groups, particularly TMA enrollees in MAS/BOE 44 to 45. In addition, there were some increases in 41 to 42 due to a more accurate reporting of waiver participants. In Q4 FY 2002 and Q1 FY 2003, there are major shifts in MAS/BOE enrollment for aged and disabled, as the state implemented coding changes with its new system. The eventual impact is a major increase in MAS/BOE 31-32 and declines in MAS/BOE 21-22 and 41-42.
			2005: The implementation of a system change in September 2004 caused an undercount of disabled SSI individuals in FY05. As a result, MSIS shows a shift from MASBOE 12 (state group 230SSI) to MASBOE 22 (state group 2399999). The new system has been corrected to improve the identification of disabled SSI enrollees in Q1 FY06 forward, resulting in a shift from MASBOE 22 and 32 to MASBOE 12. There is currently no way for the state to fix the errors in FY05.
			2006-2007: In each quarter of FY06 and FY07, roughly 300 individuals in MASBOE 00 were also assigned non-zero values in other monthly fields, including TANF, Restricted Benefits, Health Insurance, and Managed care. These fields should be 0-filled for all enrollees in MASBOE 00. The state corrected this issue in FY08.
			2004: In Q2 FY04, IL had an abrupt decrease in MASBOE 45 with a commensurate increase in MASBOE 25. This was caused when the state caught up on redeterminations for persons ending TMA coverage. (state groups 3422ME and 3622ME).
			2005: From April to June 2005, enrollment in MASBOE 51 increased by 15 percent. The state attributed this increase to the annual Spring reapplication process.
			2004: The introduction of a new Family-Planning Only 1115 Waiver in Q4 FY04 resulted in a large shift from MASBOE 35 to MASBOE 55, as well as an expansion in adult enrollment. However, by mistake, the restricted benefit codes for the FP only group were not updated through FY05.
			2004: In Q4 FY04, IL had a decline in MASBOE 51 and an increase in MASBOE 31, as many Pharm Plus enrollees appear to have transferred to traditional Medicaid coverage when they were up for redetermination.

State	File Type	Record Type	Issue
IL	Eligibility	Private Health Insurance	IL has some seam effects in its private insurance data, but this appears to be smoothed with correction records in MAX data.
			Between Q1 and Q2 FY06, there was a large drop in the number of enrollees with private insurance. Over 90 percent of this drop was caused by Pharm Plus duals no longer being included in MSIS due to the start of Medicare Part D.
		Restricted Benefits Flag	In June 2002, IL began using Restricted Benefits Flag 5 (other) for its Pharm Plus enrollees.
			Beginning in Q4 FY04, enrollees in the new Family Planning Only waiver were assigned Restricted Benefits Flag 1 (full benefits) by mistake. FP only enrollees should receive Restricted Benefits Flag 6 (restricted, FP-only). The state fixed this problem in Q1 FY06.
			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.
			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."
			Until FY 2002, between 80 to 93 percent of eligibles with RBF = 4 (restricted benefits on the basis of being pregnant) are mapped to MAS/BOE 34, 35, 44, and 45. We generally expect that at least 95 percent of eligibles with RBF 4 will be mapped to those MAS/BOE groups. By FY 2002, the reporting was in the expected range most months.
		Retroactive/Correction Records	In FY 2001, Illinois submitted about 1800 correction records each quarter that erroneously disenrolled persons in the file seven quarters prior. This problem was resolved in Q1 FY 2002. Thus, Q1 FY 2000 is the last quarter to have enrollees erroneously disenrolled through correction records. In Q3 to Q4 FY 2002, some correction records on the file were lost (about 70,000 per quarter). These records were primarily for Q1 to Q3 FY 2002. The state was not able to provide any explanation about the content of these records.
		CHIP Code	One problem occurred in Q4 FY04 with the MSIS M-CHIP data. By mistake, two groups of children were not identified as M-CHIP children who should have been (state groups 3460P4 and 3660P4). This should be corrected in MAX

State	File Type	Record Type	Issue
IL	Eligibility	CHIP code	Prior to Q1 FY06, IL accidentally reported Restricted Benefits Flag and TANF flag information for S-CHIP enrollees. All monthly fields (other than CHIP code and state specific eligibility code) should be 0-filled for these enrollees.
			IL is reporting both its M-CHIP and S-CHIP programs. In Q1 FY 2003 Illinois implemented adult coverage under its S-CHIP program but SEDS reporting for adults did not begin until Q4 FY 2003, but MSIS reporting for S-CHIP adults began in Q1 FY03.
			FY07: Total MSIS CHIP count appears to be okay. The discrepancy between MSIS and SEDS coding of unborn children, however, seems to be ongoing
			We also know of a problem with MSIS S-CHIP counts in FY05. By mistake, children in several groups (listed under 1115 anomaly note) were reported to MASBOE 00 and assigned CHIP code '3'. They should have been reported to MASBOE 54 and assigned CHIP code '1'.
			From the start there have been differences in the numbers of M-CHIP and S-CHIP children (as well as adults) reported to MSIS, compared to the data in the CMS SEDS system. We know of some problems with the SEDS data over the years. Some of the SEDS data just look wrong (Q3 FY01- Q3 FY02 for M-CHIP and S-CHIP children, and all of FY03 for M-CHIP children). IL did not start reporting S-CHIP adults to SEDS until Q4 FY03, even though MSIS reporting for this group began in Q1 FY03. In addition, IL officials told us that some state groups should not have been included with the SEDS S-CHIP counts in more recent years. And, we know there is a difference in recent years in how unborn S-CHIP children are counted in MSIS and SEDS-unborns are counted as children in SEDS, while their moethers' enrollment is reported in MSIS. Nevertheless, by FY05, MSIS M-CHIP and total S-CHIP counts (combining children and adults) are within 11-12% of the counts in SEDS. Both M-CHIP and S-CHIP counts in MSIS in FY05 are lower.
		SSI	In Q1 FY06, IL acknowledged that Medicaid enrolls fewer SSI enrollees than expected. The exact percentage is unknown. However, IL's status as a 209(b) state also contributes to the low number of SSI enrollees.

State	File Type	Record Type	Issue
IL	Eligibility	SSN	Illinois consistently reports a high level of SSNs with duplicate records (i.e., two records with the same SSN). In Q4 FY 2001, IL reported 5,500 SSNs with duplicate records. This problem likely existed prior to this quarter, but we do not have data for those time periods. The level of duplicates reached 20,000 by the end of FY 2004. The problem is caused by several State programs (such as SeniorCare) that issue more than 1 recipient ID for the same SSN. The state is trying to correct the problem.
		TANF/1931	IL MSIS routinely reports higher TANF enrollment than ACF administrative data. (12% in 2006). IL has informed us that MSIS includes "0-Grant" enrollees excluded in the ACF counts.
IN	All	MSIS ID	There is a small mismatch between the MSIS ID's in the MSIS files from 2004-2005. Those are mostly encounter claims.
	Claims	IP	There aren't any claims with a Program Type of 2 (Family Planning).
			Around 10% of the inpatient claims do not have ancillary services.
			In 2005-2006 the covered days were greater than LOS because the admission date instead of beginning date of service was used and the states calculation of covered days is not the same as the MSIS calculation. This does not reflect on how the claims are paid.
			The percent of claims without ancillary UB-92 revenue codes has been increasing over time. It was two percent in Q1 2000 and seven percent in Q4 2000 and nine percent in Q4 2002.
		OT	There is a large shift from Type of Service Rehab to Physician starting with 2008 Q1. This is the result of moving one service code in the state crosswalk.
		RX	The Date Filled is also in the Date Prescribed field.

State	File Type	Record Type	Issue
IN	Eligibility	1115 Waivers	In January 2008, Indiana implemented an 1115 waiver called the "Healthy Indiana Plan" (HIP). The waiver expanded Medicaid eligibility for parents of children enrolled in Medicaid or CHIP with incomes between 23 and 200% FPL, and for pregnant women 150-200% FPL. The waiver also provides coverage for childless adults <200% FPL. HIP offers HSAs and preventive care to all enrollees. After enrollees spend $1,100 of their annual HSA, they are covered by a managed care plan for the rest of the year. Enrollees in HIP are reported to MASBOE 55, and restricted benefits code 'B' (HSA). Undocumented aliens who receive emergency services under the waiver are still reported to restricted benefits code '2'. IN reports HIP participants to state codes HCN, HCY, HNN, and HNY.
			IN implemented a Katrina 1115 waiver on 10/21/05 (waiver ID KT, waiver type A). IN reported enrollees to this waiver through April 2006 (Q3 FY06, Month 1).
		County Codes	Indiana 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 (see 3/31/08 correspondence).
			Indiana submitted files using state county codes instead of FIPS county codes in FY 1999. The state gave us a crosswalk that links together state codes and FIPS codes. This problem was fixed in Q1 FY 2000.
		Dual Eligibility Codes	IN began using the monthly dual code in Q1 FY05. When the monthly dual code started, it was noticed that the quarterly dual code only included duals with dual eligibility in month 3 of each quarter. As a result, roughly 5,000 enrollees who had dual eligibility in months 1 and/or 2, but not month 3, were not counted as duals by the quarterly dual code. From Q1 through Q4 FY05, enrollees with monthly dual codes in Month 1 and 2 should be assigned a quarterly dual code that corresponds with the last non-zero dual code they received each quarter. This problem disappeared in Q1 FY06, when MSIS started relying soley on the monthly dual code.
			Before Q1 FY05, a small number of full duals (roughly 500) were assigned restricted benefits flag 3 (partial duals), and a few partial duals (roughly 100) were assigned restricted benefits flag 1 (full benefits). This issue was resolved in Q1 FY05 with the implementation of the monthly dual code.

State	File Type	Record Type	Issue
IN	Eligibility	Dual Eligibility Codes	From FY99-FY04, enrollees reported in MSIS as full duals consisted of dual eligibles who were full duals with no spend down target, dual eligibles who had a spend down target and had met that target, and dual eligibles with a spend down target who had not met their target. This third group was included by mistake from FY99 - Q4 FY04. These individuals should have been reported as partial duals. Looking at the crosswalk and the Table 8a, it does not appear possible to distinguish duals who met their spend-down with those who didn't meet spend-down but were reported as full duals anyway. In Q1 FY05, IN reported roughly 9,000 fewer enrollees to dual code 02, and 6,000 more enrollees to dual codes 01 and 03 in an effort to correct this problem. In MMA files prior to 1/2007, members who had not met their spend down target were omitted from the file. This means that partial duals were undercounted in MMA. IN improved their MMA reporting starting in January, 2007, and from January 2007 forward, partial dual counts were consistent with MSIS.
			Indiana assigns dual flag 08 to about 23 percent (27,000 persons in Q1 FY03) of its dual population. Indiana explained that these persons have Medicare Part B, but don't fall into any of the other dual categories. This proportion fell somewhat in Q2 FY04.
		Managed Care	In month 3, Q3 FY04, IN began to implement a new law making participation in "Risk Based Managed Care" mandatory. As a result, enrollment began to shift from PCCMs to HMOs. This change is being phased in, and is expected to continue for several quarters. In January 2001, two new HMOs were introduced, causing a shift in HMO enrollment by plan. In Q3 FY04 there was a large discrepancy in PCCM counts between MSIS and CMS administrative data. IN believes that CMS administrative data is incorrect, and that MSIS correctly states the number of PCCM enrollees. IN explained that CMS "double counts" PCCM enrollees who also participate in Chronic Disease Management. EDS does not include CDM particiaption because individuals in this program are already members of Medicaid Select or the Primestep PCCM program. Providers do not receive any extra compensation from the State for members of Chronic Disease Management. This discrepancy was present in Q3 FY05, but disappeared by Q3 FY06.

State	File Type	Record Type	Issue
IN	Eligibility	Managed Care	In Q2 FY05, IN began reporting enrollees to a new comprehensive managed care plan (Plan Type 1), called CareSource Indiana (ID 700410350). In Q3 FY05, IN added another plan, Molina (ID 900601440). HMO enrollment grew in FY05, because IN expanded mandatory enrollment in HMOs to counties where it had previously been optional. It appears IN is gradually moving all children, pregnant women, and low-income families to HMOs, while only Medicaid Select (aged, and blind/disabled) enrollees remain in PCCMs. In Q1 FY08, PCCM enrollment declined from 66,000 in October 2007 to about 37,000 in November 2007. PCCM enrollment remained at about 35,000-40,000 through Q3 FY08. In Q4 FY08, enrollment increased to about 50,000. IN explained that PCCM enrollment declined when the state implemented CareSelect, another PCCM program. CareSelect has 2 plans in Indiana: MDWise PCCM (800680500) and Advantage (800238220). Both of these are plan type 7. CareSelect plans do not receive a capitated fee; however, a per member, per month administrative fee is paid to CareSelect providers. All other claims are FFS under these plans. Q2 FY07: Enrollment in 3 HMO managed care plans stopped--Harmony Health (600307700), CareSource (70041350), and Molina (900601440). Most enrollment switched to the MDWise HMO (500307680). Anthem (400752220) also started enrolling members in Q2 FY07. When PCCM enrollment dropped in November 2007 (see note above), almost all duals were moved to traditional Medicaid. Through Q4 FY08, however, several hundred duals remained in PCCMs. IN clarified that duals remain in CareSelect until the system recognizes their Medicare assignment. When a member's Medicare assignment is inserted and the system determines their dual eligibility, their Care Select assignment gets end-dated. Due to these members being a part of the Care Select plan before they were Medicare assigned, they are counted and reported as 'Plan type -7.'

State	File Type	Record Type	Issue
IN	Eligibility	MASBOE	2005: In Q1 FY05, Indiana began to report the SSI disabled age 65 and older into MAS/BOE 11. IN improved how it reports enrollees to 11, 12, 41, 42, and 31, 32. Prior to Q1FY05, IN relied on aid category, regardless of spend-down/dual eligibility status to assign MASBOE. From Q1 FY05 forward, IN began assigning MASBOE using dual status, money grant, and spend-down, as well as aid category. IN feels that this produces a more accurate picture of its Medicaid population. However, this changed mapping cannot be reproduced for MAX due to limited state code information. 2001: In Q4 FY2001, Indiana began enrolling women in MAS/BOE 3A under the BCCPTA provisions. 2000: During FY2000, about 500 people were incorrectly mapped to MAS/BOE 01 and 04. Indiana is a 209(b) state. This explains why the total number of SSI eligibles reported into MAS/BOE 11 and 12 was lower than the number reported by the Social Security Administration for many years. Also, starting in 2005, IN reported SSI disabled over 65 to MASBOE 11. 2006: Between Q1 and Q2 FY06, roughly 9,000 enrollees shifted from MASBOE 41/42 to MASBOE 31/32. The state verfied that this shift was caused by changes to how spend-down is being handled. This shift also impacted the dual distribution, increasing the number of partial duals substantially. 2005: Between Q2 and Q3 FY05, roughly 2,000 enrollees shifted from MASBOE 41/42 to 31/32. The state verified this shift, and explained that IN has changed how it handles 209(b) spend-down, making it more difficult for enrollees to meet their 209(b) spend-down requirements. 2008: In Q2 FY08, Indiana started reporting to MASBOE 55. The state confirmed that these are participants in the 1115 Waiver that started in January 2008 (HIP). 2005: In Q1 FY05, IN began reporting enrollees in state groups DWN and DWY to MASBOE 42. These enrollees are working disabled individuals eligible for Medicaid Buy-In through the state's MedWorks program. This program began on July 1, 2002. Prior to Q1 FY05, these enrollees were reported to MASBOE 00. Starting in Q2 FY09, IN plans to implement a presumptive eligibility program for pregnant women. The state will update the eligibility crosswalk with a new aid category that maps to MASBOE 45. These enrollees will also be assigned RBF 4.

State	File Type	Record Type	Issue
IN	Eligibility	MASBOE	2003: IN's Q1 FY03 file shows a larger than usual increase in enrollment across several MAS/BOE groups. This resulted from the delayed submission of FY03 data as a result of the MMA.
		Private Health Insurance	Prior to FY03 Q1, Indiana reported about 12 percent of its eligibles with private health insurance which is higher than other states report. The state confirmed that this proportion is correct, although it falls somewhat in more recent years.
		Restricted Benefits Flag	In January 2008, IN implemented an 1115 waiver that offers HSAs to eligible individuals. These enrollees are assigned restricted benefit code 'B' (HSA).
			Prior to Q1 FY05, a small number of full duals (approximately 500) were assigned restricted benefits code '3' (restricted - partial dual) in some months. Similarly, roughly 100 partial duals were assigned restricted benefits code '1' (full benefits) in some months. IN determined that these assignments occurred when an individual had both full and partial dual status during a quarter. This problem ended when the state implemented monthly dual codes in Q1 FY05.
			In Q2 FY08, IN began reporting Psychiatric Residential Treatment Facilities Grant Program enrollees to RBF 'A'
			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. MFP enrollees will be assigned RBF code 8 in MSIS. As of Q4 FY08, IN reported no enrollment to RBF 8. The Division of Aging plans to start transitioning clients into the program in January 2009.
		Retroactive/Correction Records	In some quarters, Indiana has a large volume of correction records. Analysis of Q2 and Q4 FY 2002 corrections showed that the majority of the correction records did not change any key data elements.
		CHIP Code	In most quarters during FY03 and FY04, MSIS S-CHIP counts were 13-14% lower than S-CHIP counts in SEDS. The state was not able to explain why this level of difference occurred. From Q2 FY04 forward, MSIS S-CHIP counts are slightly higher than SEDS (<10 percent). M-CHIP counts were OK.
			In Q2 FY07, IN appears to have erroneously reported its M-CHIP enrollment as S-CHIP enrollment (and vice-versa) in SEDS. MSIS reporting is fine.

State	File Type	Record Type	Issue
IN	Eligibility	CHIP Code	Indiana is reporting M-CHIP into MSIS. The M-CHIP program covers children <19 years old up to 150% FPL. Its S-CHIP program was implemented 1/1/2000 and reported into MSIS effective Q2 FY2000. However, S-CHIP children have the state specific code field 0-filled. The S-CHIP program covers children from 150-200% FPL. In Q4 FY02, there is a 25 percent discrepancy between MSIS and SEDS S-CHIP counts. The state believes that the 2002 SEDS numbers are erroneous.
		TANF/1931	When IN started 9-filling the TANF data field effective Q1 FY05, the state inadvertently 9-filled the TANF field for several thousand persons with MASBOE 00 in months 1 and 2 of each quarter. In addition, we noticed that in Q1-2 FY08, IN 0-filled the TANF data field for current enrollees. In Q3, IN correctly 9-filled the TANF filled for all current enrollees. However, through Q4 FY08, IN continued to 9-fill the TANF field for several thousand persons in MASBOE 00 in months 1 and 2. The state anticipates that this will be corrected in the FY09 files.
			Due to ongoing problems with their TANF reporting, IN requested permission to 9-fill its TANF flag from CMS. This change went into effect in Q1 FY05.
			In FY02, there is a -18 percent discrepancy between MSIS and ACF TANF counts. In FY03 Q1, this discrepancy is -28 percent. EDS responded that the ACF counts include some assisted guardianship enrollees that are not reported in MSIS data, as well as other enrollees in families where someone is getting SSI.
		Waivers	In FY08, IN changed the waiver id and type code twice for the state's TANF waiver. Prior to FY08, IN coded the TANF waiver with type '2' and ID '2A.' In Q1 FY08, IN switched to type '2' and ID '3A.' In Q2 FY08, IN changed it to type '1' and ID '4A.'
KS	All	MSIS ID	KS erroneously in 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 idently 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).
	Claims	All	KS included state-only claims in the MSIS files from 1999 Q1 through 2002 Q4. These state only claims can not be identified in the remaining files, but are among those claims that don't link the the eligibility files.

State	File Type	Record Type	Issue
KS	Claims	LT	There is a higher percent of claims with $0 Medicaid Amount Paid than expected due to the application of spend-down.
			The expected percent of claims with Patient Liability is lower than expected, but state verifies that it is correct.
			The file contains mostly weekly bills.
			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.
		OT	There were very few HMO capitaion claims in Q1-3 2002. They started reporting them again at the expected level in Q4 2002.
			Kansas uses some local diagnosis codes.
			KS stopped reporting Family Planning in 2004 forward.
			The state system does not carry UB-92 Revenue Codes on outpatient hospital claims, but all outpatient hospital claims have Service Codes.
		RX	The date filled is also reported in the date prescribed field.
	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.
			Until Q1 FY03, some persons in MAS/BOE 41 - 42 were reported to have restricted benefits related to their dual status (QMB-only, SLMB-only, or "other" dual eligibles). These are potential spend-downers who are incorrectly mapped, as discussed below. From Q1 FY03 forward, the number affected by this problem is much lower (<10 per month).
			Until Q1 FY03, dual eligibles were somewhat undercounted in Kansas due to a reporting quirk. With correction records, the state sometimes 0-filled the dual flag for dual eligibles who had died to include the period when they were alive.
			In FY06, 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. The pattern continued in the FY07 files.
		Foster Care	Foster care is under-reported in MAS/BOE 48 prior to February 2000 when the number of foster care children almost doubles.

State	File Type	Record Type	Issue
KS	Eligibility	Managed Care	In December 2003, KS increased access to PCCM providers by changing the distance parameters of participation. This resulted in a large (9%) increase in enrollment.
			KS has a BHP - ASO (Administrative Services Only) benefit which covers only administrative costs of coordinating mental health benefits, not benefits themselves. This plan is not recorded in Claims or Eligibility data.
			Managed care enrollment patterns changed during FY 1999. To start, from Q1 to Q2, two of the three HMOs in Kansas withdrew from Medicaid. Then, in April, 1999 (the start of Q3), the remaining HMO changed ownership, meaning that a large group of eligibles had to be reassigned to a new plan ID#.
			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 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.
			Kansas officials have acknowledged that they overcounted managed care enrollment in MSIS for FY 1999 to FY 2002 data. MSIS managed care data, effective FY2003 are more reliable.
		MASBOE	2003: Effective Q1 FY03, KS made several MASBOE changes. Some children and adults previously mapped to MASBOE 24-25 are now mapped to MASBOE 44-45. KS believes MASBOE 24-25 enrollment was higher than it should have been in the past. Also, potential spend-downers who were also QMB-only, SLMB-only, or QI were previously mapped to MASBOE 41-42 in error. This was fixed beginning Q1 FY03, and caused an increase in MASBOE 31-32.

State	File Type	Record Type	Issue
KS	Eligibility	MASBOE	2002: The state believes enrollment was under-counted in Q1 to Q3 FY 2002 due to a problem with the submission of retroactive and correction records. 1998-1999: From 12/98 through 4/99, Kansas had problems distinguishing between children in MAS/BOE 14 and 34. The state reports that this was related to implementation of their S-CHIP program (they were trying to make sure children leaving welfare would not be inappropriately terminated from Medicaid). As a result, some children (about 12,000 by 4/99) were mapped to MAS/BOE 34 who should have been mapped to MAS/BOE 14. This problem was corrected effective 5/99. 2003: Effective Q1 FY03 KS changed MASBOE mapping so that SSI disabled age 65 and older are mapped to MASBOE 11, not MASBOE 12. 2002: During FY2002, KS changed how it reported its Work Transition program, so that more eligibles qualified under the 1931 provisions, causing a shift in enrollment from MASBOE 44-45 to MASBOE 14-15 during FY2002. 2001: During FY01 Q2, Kansas took steps to reinstate Medicaid coverage to persons inappropriately terminated during welfare reform. These persons were mapped to MAS/BOE 24/25. This coverage only lasted three months unless persons were otherwise eligible. A report from the Center on Budget and Policy Priorities indicted that Kansas experienced enrollment declines attributed to new citizenship documentation requirements in the second half of 2006. The Kansas Health Policy Authority reported that between 18,000 and 20,000 applicants and previous recipients do not have health insurance since the requirement was established. About 16,000 of these peoeple are waiting to be enrolled or reenrolled, however there are massive delays due to a backlog related to documentation requirements. However, MSIS data only show modest declines in enrollment during the July-September 2006 period (children -4,000 and adults -2,000). 2000: Beginning in April 2000, Kansas changed their nursing home criteria. Rather than using the Medically Needy criteria, the state used the 300 percent institutional rules. As a result, enrollment increased in MAS/BOE 41, 42, and 44 and fell in MAS/BOE 21, 22, and 24.

State	File Type	Record Type	Issue
KS	Eligibility	MASBOE	1999-2001: From October 1999 through November 2001, Kansas reported QMB-only and SLMB-only eligibles who were potential spend-downers to MAS/BOE 31 - 32. Then, beginning in December 2001, through FY02, these potential spend-downers were mapped to MAS/BOE 41 - 42, a mistake. Since potential spend-downers are not considered Medicaid eligibles, these individuals should not have been reported as enrolled in Medicaid with full benefits. Persons in this group are reported in state-specific codes MSSDOA, MSSDAB and MSSDAD. With the implementation of its new system in FY 2003, Kansas mapped potential spend-downers in these groups to MAS/BOE 31 - 32. Potential spend-downers who do not qualify for restricted Medicaid benefits related to Medicare cost-sharing will not be included in MSIS reporting.
		Private Health Insurance	Prior to Q1 FY03, KS under-reported private insurance recipients.
		Race/Ethnicity	Beginning in Q1 FY03, KS began reporting Hispanic enrollees to Race Code 7 (Hispanic/Latino and 1+ races) instead of Race Code 5 (Hispanic/Latino). KS also began using Race Code 8 (more than 1 race, not Hispanic/Latino)
		Retroactive/Correction Records	Although KS has submitted retro-records in the past, the state has not used them since Q4 FY02.
			During FY 2001, Kansas implemented retroactive enrollment to previous quarters for many persons inappropriately terminated during welfare reform.
		CHIP Code	KS plans to implement an M-CHIP expansion. They will expand coverage to pregnant women and infants to 200% FPL. KS plans to report this group to MASBOE 34. We asked when MSIS will begin to include these enrollees.
			Kansas does not report S-CHIP children.
		TANF/1931	The state reports that they did not correctly implement 1931 rules. There are relatively few non-TANF 1931 eligibles. During FY2001, the state started to implement changes.
			Effective Q1 FY 2002, Kansas TANF data are not reliable. The reported number in MSIS is below the number of expected recipients, and in FY03 Q1 KS began began reporting all individuals to TANF flag '1.' Effective FY06 Q1, the state began 9-filling the TANF field at MPR's request.

State	File Type	Record Type	Issue
KS	Eligibility	Waivers	Starting in January 2007, KS has an approved alternative benefit plan. The program will include working disabled individuals who buy into Medicaid because their earnings disqualify them from SSI. Kansas's Working Healthy initiative involves a single alternative benefit plan. The statewide approach targets the working Medicaid buy-in population with developmental disabilities, physical disabilities, or traumatic brain injury. Enrollment is optional. In addition to regular Medicaid benefits, participants may receive individualized assessments, personal assistance services, independent living counseling, and assistive services. As of Q4 FY07, KS reports no enrollees in this plan.
			In FY05 and FY06, it appears that a small number of individuals reported to MASBOE 00 were not reported to waiver type 0 (not eligible for Medicaid) and waiver ID 00. It is unclear if these individuals were reported to waiver type 8 (not enrolled in a waiver) or if they were reported as enrolled in a waiver. All enrollees in MASBOE 00 should be reported to waiver type 0 and waiver ID 00.
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.
	Claims	IP	DRGs are not reported in the IP files.
			There is a substantial drop in the number of FFS crossover claims starting in FFY 2003 Q2.
		LT	The state does not pay for leave 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.
			The 2007 LT files erroneously flag most of the claims with a Program Type of Waiver.
		OT	Almost everyone is enrolled in transportation managed care, but there are still some FFS claims for transportation.
			Dental service codes are flagged as state specific. They can be converted to HCPCS by replacing the leading '0' with a 'D'.
			The 1999 files do not include PCCM capitation claims. They are reported beginning with 2000 but are somewhat under reported.
			In 1999 the file does not include capitation claims.

State	File Type	Record Type	Issue
KY	Claims	OT	There are no claims with Program Type 2 (Family Planning).
			There are many claims without Service Codes as Kentucky uses the UB-92 claim form for HH, hospice, and outpatient hospital billing.
	Eligibility	0-filling	In FY2000, between 200 - 400 persons each month in MAS/BOE 00 have the following fields blank-filled: TANF, Restricted Benefit Flag, Plan Type 1-4, Plan ID 1-4, and CHIP Code.
		1115 Waivers	KY implemented an 1115 Healthcare Partnership in 1996 that tried to establish Medicaid managed care throughout the state. This 1115 did not include any eligibility expansion.
		Dual Eligibility Codes	Between Q4 FY06 and Q1 FY07, KY reported a shift from dual code 02 to dual code 08, affecting roughly 8,000 full duals. Then, in Q4 FY07 these duals shifted back to dual code 02. The state contact explained that the shift in Q1 FY07 (from dual code 02 to 08) was an error that occurred when the state switched its MMIS system. The Q4 FY07 data accurately represent KY's dual population.
			Between Q4 FY05 and Q1 FY06, the number of full duals increased about 6 percent. All of the increase occurred in dual code 02 (QMB Plus). And, about 6,500 duals also shifted from dual code 08 (other full dual) to dual code 02. The state has not explained these changes.
			From FY03 Q1 through Q4, roughly 20,000 individuals with MASBOE 00 were assigned a dual code, generally '08'. These individuals should not be counted when determining the number of duals.
			Prior to FY2001 Q4, Kentucky's dual eligibility data are incorrect and should not be used. The state was over-reporting the number of disabled and children who were dually eligible.
		HIC Numbers	Kentucky fixed its dual eligibility flag in Q4 FY 2001. After that time, about 12 percent of the state's non-dual eligibility population have valid HIC numbers.
			From Q1 FY06 through Q4 FY06, KY reported very few duals with valid HIC numbers (<1 percent). This was fixed in Q1 FY07.
		Managed Care	Beginning in FY06, many "other" plan IDs were reproted in KY's data. We assume these are all transportation plans, but we do not have an updated Plan name/ID number list. In FY08, KY reported as many as 250 "other" plans.

State	File Type	Record Type	Issue
KY	Eligibility	Managed Care	KY does enroll full duals in the HMO managed care plan. A reduced capitation rate is paid for the full duals. In addition, full duals do receive transportation managed care benefits (plan type 08).
			Beginning in Q4 of FY 2000, Kentucky phased out the use of Kentucky Health Select (Plan ID 9690005500), a comprehensive managed care plan. The individuals were moved into the state's Medicaid PCCM. Kentucky added a new region to its transportation plan '08' in July 2002. However, MSIS reporting did not reflect this new region (about 100,000 enrollees) until October 2002. Then, from December 2002 to April 2003, the state temporarily shut down the transportation plan for this region, before returning services in May 2003.
			By Q4 FY99 Kentucky had reported that about one-third of eligibles each month are enrolled in Plan Type 8, which is a special capitation plan for transportation services. By Q4 FY02 two thirds of eligibles each month were in the transportation plan, following a sharp increase in July 2002. CMS annual managed care data does not include KY's transportation plan.
		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.
			In Q1 FY08, KY added two new eligibility groups (MMW101 and MMW201) and reported these enrollees to MASBOE 99. These groups should be mapped to MASBOE 42. KY corrected this reporting in resubmitted Q1-2 FY08 files.
			Through FY02, Kentucky exhibited a seam effect from quarter-to-quarter, whereby enrollment declined from the first month in the quarter until the last, and then jumped in the first month of the next quarter. The state submits a significant proportion of retroactive eligibles and correction records, however, which may smooth out enrollment trends.
		MMIS	FY08 Q1-2: KY submitted additional files for Q1-2 after we approved them. We reviewed the new files and they replaced the previously submitted files.

State	File Type	Record Type	Issue
KY	Eligibility	Restricted Benefits Flag	In May 2006, KY implemented broad Medicaid reform under the 2006 Deficit Reduction Act. Through multiple state plan amendments, KY established four benefit packages tailored for different enrollee populations, encompassing all Medicaid enrollees. While the benefit packages do not limit the amount, duration, and scope of mandatory services, they do differ in service limits for non-mandatory services, and cost sharing. The reform also includes voluntary disease management and the option for Medicaid eligible adults to "opt-in" for premium assistance for employer based insurance. Medicaid eligibles who choose premium assistance may opt out at any time for their appropriate Medicaid benefits package. KY is supposed to be an Alternative Benefit Plan state, using restricted benefit code '7'. However, KY has informed us that under its plan, all Medicaid enrollees could be considered as falling under the alternative benefit plan. Therefore, KY is not using restricted benefit code '7'.
		CHIP Code	Between Q4 FY05 and Q1 FY06, KY's S-CHIP enrollment increased 18 percent, and remains at that level through Q4 FY07. This increase did not appear in the CMS SEDS reporting. From Q1 FY06-Q4 FY07, KY's MSIS files report 12 to 20 percent more S-CHIP enrollment than SEDS. In KY MSIS data for Q1-4 FY03 and Q1 FY04, about 150,000 records reported to MASBOE 00 were included by mistake. These MASBOE 00 records were for enrollees in a state program, not Medicaid. These were in addition ot the approximately 20,000 records for S-CHIP enrollees who were correctly reported to MASBOE 00 and assigned CHIP code 3 for S-CHIP. To fix this problem, CMS decide to delete all the MSIS records for persons only reported to MASBOE 00 for this period, without recognizing that they would by mistake delete most of the S-CHIP records as well. Thus, S-CHIP enrollment is under-reported in the MSIS data saved at CMS for FY03 and part or all of FY04. Even though the valids table suggest that full and reliable S-CHIP data exists for FY03 and FY04, most of these records were mistakenly deleted by CMS. This cannot be corrected in MAX. A few thousand children continue to be indentified as S-CHIP children in the saved MSIS data, but these are likely children who had some regular Medicaid enrollment, in addition to S-CHIP enrollment. This issue was fixed in Q1 FY05, and MSIS S-CHIP reporting appears reliable in FY05.

State	File Type	Record Type	Issue
KY	Eligibility	CHIP Code	Kentucky reported only M-CHIP enrollment in FY 1999. Beginning in FY 2000, the state also reported their S-CHIP data. However, S-CHIP counts for FY03 and FY04 are not reliable.
			In Q4 FY06, CMS SEDS data showed a 27 percent decline in M-CHIP personmonths of enrollment compared to Q3 FY06. This decline appears to be an error. In Q1 FY07, SEDS reporting rebounded to the Q3 FY06 level. MSIS M-CHIP reporting remained consistent during this time, and was consistent with with SEDS in Q3 FY06 and all of FY07.
			In Q1-3 FY08, MSIS reported fewer person-months of MCHIP and CHIP enrollment than SEDS reported. KY explained that the MSIS counts are correct. The state recently cleaned up its CHIP data and the SEDS report did not yet reflect the corrections. KY is unsure when SEDS will be correct.
			There is a discrepancy between the M-CHIP and S-CHIP counts in MSIS 2001 data and SEDS 2001 data. The state expects that their MSIS correction records will eliminate this discrepancy. Counts for subsequent years are consistent. However, as noted elsewhere, S-CHIP data for FY03 and FY04 are not reliable.
		SSN	From FY99-FY04, about four percent of eligibles did not have valid SSNs. In FY05, 2 percent of eligibles did not have SSNs. In FY06 and FY07, KY reported 100 percent of enrollees with a valid SSN, primarily because the data were submitted very late. However, KY did not report any enrollees with both temporary MSIS IDs and SSNs in FY07. Also in FY07, KY changed the type of number they reported to the Temp ID field. Previously, KY reported a pseudo-SSN. But, in FY07, KY started using a unique Medicaid Identifier instead. Starting in Q1 FY08, KY data uses psuedo-SSNs as temp ids and records include both SSNs and temp ids.
		TANF/1931	From FY03 forward, KY's MSIS data show about 12-20 percent fewer TANF recipients than TANF administrative data (cause unknown). KY began 9-filling TANF in Q1 FY07.
		Waivers	FY05-FY06: KY reported no enrollment for waivers MC, PC, and TN. In FY07 KY explained that the waivers were no longer valid. However, we do not know when exactly the waivers expired.
			KY expects that MFP enrollment will appear in MSIS data in Q1 FY 2009
	Encounter	IP	There are no Procedure Codes on encounter records.

State	File Type	Record Type	Issue
KY	Encounter	IP	There is only one Diagnosis Code per encounter record.
		OT	Service Codes are missing on about nine percent of the encounter records.
			There are no encounter records for waiver services.
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.
		SSN	Louisiana is an SSN state, but prior to mid 1999 they did not verify SSN and were internally using a Medicaid ID number that contained county code, EL group, etc. The new EL system checked the accuracy of the SSN. As a result, there are some people in the PSF with more than one MSIS ID and some claims had an MSIS ID not found in the EL file.
	Claims	Encounter	Louisiana currently doesn't have a managed care program.
		IP	The file does not contain DRGs.
			The Procedure Date Principal (that goes with the Procedure Code Principal) is missing.
			There is a large percent of crossover claims. Louisiana verifies that this is correct.
			There are more claims than expected with Patient Status of 30 (Still a Patient) because they generate lots of interim bills.
		LT	The Admission Date is missing on most records.
			Diagnosis Codes are missing on most claims.
			There are diagnosis codes on less than 75 percent of the claims.
		OT	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.
			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.

State	File Type	Record Type	Issue
LA	Eligibility	1115 Waivers	NC implemented a Family Planning waiver (ID# "FP") in October 2005 (Q1 FY06) and started reporting these enrollees to MASBOE 55 and restricted benefits flag 6. LA had an 1115 waiver for Katrina evacuees approved on 11/10/05. This waiver allowed the state to use expedited eligibility rules, special financial standards, and up to 5 months of eligibility for Katrina evacuees. These evacuees were reported to category of assistance '11' (in bytes 4 and 5 of the state specific eligibility group). LA had an FP only waiver approved in 6/06. Implementation began in 10/06.
		County Codes	From FY1999 to FY2000 Q1, Louisiana incorrectly used a state-specific county code. This problem was corrected in FY2000 Q2. The state supplied MPR with a crosswalk, linking together the state and FIPS county codes.
		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). After the QI-2 program ended in Q4 FY02, LA continued to report small numbers of enrollees to dual code '07' through Q3 FY05. From Q1 FY03 forward, these enrollees should not have been reported in MSIS. In Q1 FY05, LA began reporting full duals to dual coes 04 and 08. Prior to Q1 FY05, virtually all full duals were reported to dual code 02. The disribution by dual code was not completely consistent between MSIS and MMA in FY05; however, the total dual count was very close. MSIS and MMA dual coding became very consistent by Q3 FY06. In FY07, 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. Each month, LA identifies dual eligible status for all enrollees. However, 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 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.

State	File Type	Record Type	Issue
LA	Eligibility	Dual Eligibility Codes	From Q1 FY1999 to Q3 FY 2000, Louisiana's MMIS system did not include the following groups: SLMB, QI1, QI2, QDWI. Beginning in Q3 FY 2000, these groups are included in the state's EL file.
		Managed Care	In the latter half of FY 2002 through Q1 FY04, Louisiana MSIS data shows significant growth in PCCM enrollment. This growth is also reflected in CMS managed care data. During this time, LA expanded its PCCM program to more of the state.
			Louisiana did not report any managed care enrollment in FY 1999, although the state was running a PCCM plan at this time (enrollment in the plan in June 1999 was approximately 44,000, according to CMS managed care data). Beginning in Q1 FY 2000, the state reported PCCM claims in its OT file for this group, but the state did not begin reporting PCCM enrollment in its EL file until Q2 FY 2000.
			In Q4 FY07, LA started a PACE plan. The plan will operate in Baton Rouge and New Orleans. There will be one plan and two providers. We asked the state to send us the plan name and identification number.
		MASBOE	2007: According to the Kaiser Family Foundation, in early 2007 LA was working hard to re-enroll roughly 67,000 children in Medicaid and LaCHIP who lost insurance during the Katrina evacuation or whose parents did not re-enroll them for other reasons. The state has implemented several changes to its application process to make it easier for parents to enroll their children, including shorter applications, and eliminated the face-to-face interview.
			In FY07, LA reported dramatic enrollment shifts in several MASBOE groups. In particular, aged enrollment jumped from about 100,000 to about 260,000. And, disabled enrollment fell from about 175,000 to about 30,000. The state explained that there were some errors in their crosswalk. They corrected these errors and resubmitted the files.
			2006: Between Oct. and Nov. 2005 (Q1 FY06), LA reported many small shifts among MASBOE groups. The state attributed these changed to Hurricane Katrina.
			2003-2004: From Q2 FY03 until Q3 FY04, LA reported over 1000 enrollees under age 65 to MASBOE 41.

State	File Type	Record Type	Issue
LA	Eligibility	MASBOE	In FY07, LA reported about 20 to 30 records to blank MASBOE fields. The state explained that these records had clerical data-entry errors. In the future, LA will map 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 ever be able to eliminate this group. 2005: SSI disabled enrollment increased by 5% in October 2004 (Q1 FY05). This could possibly have occurred because the FY05 file was processed at a much later date than usual. 2006: A report from the Center on Budget and Policy Priorities indicted that Louisiana experienced enrollment declines attributed to new citizenship documentation requirements in the second half of 2006. In September and October of 2006, Louisiana had a net loss of more than 7,500 children in its Medicaid program, according to the CBPP report. 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. 2005-2006: From September to November 2005, LA assigned category of assistance code '11' (in bytes 4-5 of the state specific eligibility code) to identify LA Katrina evacuees. These enrollees were assigned to multiple MASBOE groups. This contributed to substantial enrollment growth, which remained even after the special coverage ended in December 2005. However, by the summer of 2006, total enrollment had retuned to the pre-Katrina level. One other pattern of interest is that SSI disabled enrollment dropped by 6 percent in November 2005, and did not recover through FY06. 2006: SSI counts in MASBOE 11-12 were 12% higher than SSI administrative data in FY06. This difference occurred because 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 (this occurred in earlier years as well). 2007: In April, 2007, LA simplified its application process, particularly for children, in an effort to re-enroll in Medicaid and M-CHIP approximately 67,000 children who lost health insurance as a result of Hurricane Katrina, or whose parents did not renew their benefits for other reasons.

State	File Type	Record Type	Issue
LA	Eligibility	MASBOE	2007: As of October 2006 (Q1 FY07), LA will report enrollees in its Family-Planning Only 1115 waiver expansion to MASBOE 55.
		Private Health Insurance	In Q1 FY 2003, Louisiana corrected some problems with how it coded private insurance. This resulted in a 13 percent reduction in the number of people reported to have private coverage.
		Race/Ethnicity	In FY07, LA reported that 1,655 persons had "more than one race" in the field "Race Ethnicity Code." However, the state reported no persons to more than one race in the expanded codes. LA explained that they have been using the old race/ethnicity code to populate the new, expanded race codes. The old code has a category for persons of more than one race, but does not indicate which races the person is identifying. The state is working to start collecting more detailed race information for new enrollees.
		Restricted Benefits Flag	LA extended FP only (RBF 6) benefits effective October 2006 (Q1 FY07). In FY07, each month some full-dual eligibles and a few non-dual eligibles received RBF 3. The state is working with its eligibility staff to sort out this issue.. Most of the enrollees assigned restricted benefits code 5 (other) are eligible through the medically needy provision. However, some persons assigned code 5 are in the poverty-related pregnant woman group 35. These women may have restrictions related to substance abuse. Most of the women in MAS/BOE group 35 are assigned restricted benefit code 4.
		CHIP Code	Louisiana reports its M-CHIP children in MSIS. The M-CHIP data differed greatly from the numbers in SEDS until FY 2001, but the state assured us that MSIS data were more reliable. There was a discrepancy between SEDS and MSIS M-CHIP counts, again, in Q4 FY 2001 and Q1 FY 2003; the rest of the FY03 data look fine. The state generally insists that MSIS counts are more reliable than SEDS. In March 2008, CMS approved an expansion to LA's M-CHIP program (LA CHIP), to include children from families earning between 200-250% FPL. Families will have to pay a $50 monthly premium, and most services have 10% coinsurance.

State	File Type	Record Type	Issue
LA	Eligibility	CHIP Code	In Q3 FY07, LA started reporting an S-CHIP program. The program covers unborn children who are ineligible for Medicaid, with family incomes of up to and including 200% of FPL. Enrollees are reported to state groups 3C703A and 3C703C (and mapped to MASBOE 00). The state incorrectly reported monthly fields for these enrollees and we asked them to correct this reporting. Louisiana had plans to expand its CHIP program to cover pregnant women to 200 percent FPL beginning 1/03. This expansion did not occur as stated in LA's Title XXI fact sheet. The expansion took place as part of an expansion of regular Medicaid.
		SSN	In FY 2005 and FY 2006 (and possibly earlier), LA was incorrectly reporting individuals who lacked valid SSNs. For most of these individuals, LA was reporting pseudo-SSNs (9-digit temporary SSNs that started with a '9' in the first byte of the SSN field) in the MSIS SSN field. For a smaller number of individuals without SSNs (100 -300 records), LA was entering 13-digit LA recipiency ids in the MSIS temp id field. We identified this problem when we ran a high-group test in 2008. We asked the state to correct this issue by 8-filling the SSN field for all persons who lack a valid SSN. And, we asked the state to start entering the 9-digit pseudo-SSN in the MSIS temp id field. We prefer that LA use the 9-digit pseudo-SSN as the temp id because this is the temp id that LA uses for its claims files. In the FY 2007 MSIS files, LA correctly 8-filled the SSN field for all persons without a valid SSN. However, the state started reporting the 13-digit recipiency id (instead of the pseudo-SSN) in the MSIS temp id field. This switch in the MSIS temp id field creates problems for linking these files with previous files. We asked LA to resubmit FY 2007 files with the pseudo-SSN in the temp id field. We also asked them to continue to 8-fill the SSN field when they lack a valid SSN for an individual. The state will continue to use the pseudo-SSN as the MSIS temp id in the future. LA also sent CMS a cross-reference file covering FY04-FY06 MSIS. This cross-reference file includes the permanent ID (which was mistakenly entered in the SSN field), as well as the valid SSN, along with gender and DOB.

State	File Type	Record Type	Issue
LA	Eligibility	TANF/1931	TANF enrollment in MSIS and ACF are not consistent at times. The numbers are very similar in FY 1999, but by FY 2001, the ACF numbers are much smaller than those in MSIS. This problem results from the fact that DHH does not automatically disenroll TANF individuals when notified by DSS. The DHH policy is to extend eligibility for TANF individuals until they are able to determine an appropriate Medicaid disposition. DHH policy requires the individuals to remain in their Aid-Category/Type-Case classification (03/01) for up to six months until they can be re-classified. In Q1 FY 2003, ACF and MSIS data on TANF enrollment were very close again. The Q1 FY04 MSIS and ACF TANF data compare well, but the number of TANF enrollees in MSIS declined rapidly between Q2-Q4 FY04. In FY05-FY06, MSIS reported roughly 20 percent fewer TANF enrollees than ACF. The state has been asked to consider 9-filling its TANF field in future files.
			In FY07, LA began 9-filling the TANF field.
		Waivers	In FY07, LA began reporting to MASBOE 55. These individuals are assigned to state groups 3B540A, 3B540C, 3B540C, and 3B640C. Individuals in these state groups are enrollees in the Family Planning Waiver that the state implemented in October 2006. These individuals were also assigned to RBF 1; we asked the state to assign them to RBF 6.
			Since FY05, LA incorrectly 0-filled the waiver ID and waiver type fields for many current enrollees each month. We asked the state to correct this reporting.
MA	Claims	Capitation	Behavioral Health Organization (BHO) capitation claims are incorrectly shown as Type of Service 22 (PCCM capitation claims), until Q1 2005.
			PCCM payments are only made if there is actually a PCCM visit.
			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.
		LT	There are no leave days on the files.
			There are very few Diagnosis Codes on the files.

State	File Type	Record Type	Issue
MA	Claims	OT	The number of Home- and Community-Based Services (HCBS) claims (identified by Program Type 6 and 7) vary considerably by quarter due to the billing and submission cycle and is considerably lower than expected. This is the result of the failure of state software to identify all waiver services. This is being corrected in FY 2007. Most services to children under age 21 have a Program Type of 1 (EPSDT). About 1/3 of the original, non-crossover claims do not have a Place of Service. Most of these claims are outpatient hospital department claims (Type of Service 11) or Lab and X-ray (Type of Service 15) claims. MA makes an estimated payment to managed care organizations and then later adjusts the amount based on the MCO reports on enrollment. These were submitted as service tracking claims until 2006 Q3 when the state began reporting them as individual adjustment claims. Supplemental payments are reported as service tracking claims.
	Eligibility	1115 Waivers	Massachusetts operates an 1115 waiver program for the disabled, children, and adults, which began in 1995. Under this program, eligibility for MassHealth's Standard benefit package is extended to pregnant women and children under the age of 1 with incomes at or below 200 percent FPL; children ages 1-18 with incomes at or below 150 percent FPL; parents of children under age 19 with incomes at or below 133 percent FPL; and disabled adults ages 19 -64 with incomes at or below 133 percent FPL. The waiver extends eligibility in the MassHealth CommonHealth package to disabled children through age 18 with incomes over 150 percent FPL; working disabled adults, no income limit; and non working disabled adults with incomes over 133 percent FPL. The waiver extends eligibility in the MassHealth Basic package to adults through age 64 who are long-term unemployed with incomes at or below 133 percent FPL. The waiver also provides premium assistance for children age 1-18 with incomes between 150-200 percent FPL, and adults under age 65 with incomes under 200 percent FPL who have access to employer sponsored insurance. For those children age 1-18 with incomes between 150-200 percent FPL, the waiver allows the state to pay the cost of buying in to the state's MassHealth Standard benefit. In 2000, the waiver was expanded to provide eligibility to individuals with HIV under age 65 who are not institutionalized and have incomes up to 200 percent FPL.

State	File Type	Record Type	Issue
MA	Eligibility	1115 Waivers	Q1 FY07: MA reports enrollment to a new 1115 waiver (id = 'N'). MA previously used this id to identify the state's HCBS DMR waiver. We asked the state for more information about the new waiver and also to confirm that they no longer use id 'N' for the DMR waiver. MA had a Katrina Waiver approved on March 6, 2006, but no waiver enrollment was ever reported in MSIS
		Dual Eligibility Codes	Prior to Q1 FY05, the majority of the full dual eligibles population receives the flag 08 (09 before Q1 FY03). Many of these 08 duals probably belong in 02 or 04, but the state was unable to determine their correct dual code. In Q1 FY05, MA began reporting most full duals to dual code 02. In Q2 FY05, MA began reporting small levels of enrollment to dual code 04; however, when we compare the FY06 MSIS dual distribution to the monthly MMA file, we believe that most SLMB - plus duals continue to reported to dual code 02 or 08 instead of dual code 04 in FY05 and FY06. Until FY06, Massachusetts reported very few eligibles with dual code 01, since the state provides full Medicaid benefits to all aged/disabled up to 100 percent FPL. Also, because Massachusetts provides full Medicaid benefits to all blind/disabled up to 133 percent FPL in its 1115 Waiver program, the state reports very few blind/disabled with dual codes 01 or 03. This changed in Q1 FY04-forward, when MA started reporting many SLMB and QI-1 partial duals to dual code 01 (see following notes). From Q2 FY04 through Q1 FY07, MA did not report any QI1 duals (dual code 06 and aid code 88 - bytes 1 and 2 of the state specific code). This was inconsistent with the original Q1 FY04 MSIS data and January 2006 MMA data, which each reported roughly 3,500 QI1 duals each month. In December 2006, MMA data, QI-1 enrollment was >5,000. In addition, MA submitted correction records in Q2 FY04 removing QI-1 enrollees from Q2 FY03 - Q1 FY04. MA explained that it will now code all partial duals with incomes less than or equal to 100% FPL to dual code 01. MA continues to use dual code 03 for SLMB-only duals who have incomes greater than 100% FPL.

State	File Type	Record Type	Issue
MA	Eligibility	Dual Eligibility Codes	In Q1-Q4 FY05 and Q1-Q4 FY06, MA reported several thousand duals in state groups 2401CA, 2409CA, 2501BA, 2501CA to dual code 01. MA's crosswalk and past reporting indicate that these are SLMB-only duals. The state explained that it now assigns all SLMB-only duals with incomes less than or equal to 100% FPL to dual code 01. Retro records submitted in Q1 FY05 extended this change to Q1 FY04. MA still reports SLMB-only with income >100% FPL to dual code 01.
			As several of the anomalies above suggest, dual reporting in MA's MSIS and MMA files do not compare very well from the implementation of Part D in January 2006, forward. The state explained that the MSIS counts are more reliable. MA updated its dual coding and these updates appeared in MSIS before they appeared in MMA. The most recent MMA corrections occurred in January 2007. The state is unsure when the MMA counts will compare well to the MSIS counts.
			The QI2 program expired at the end of Q4 FY02. From Q1 FY03 forward, enrollees should not be reported to state group 89 or dual code 07.
		Foster Care	Massachusetts is under-reporting the number of children in foster care.
		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.
			MA pays PCCM providers only if they render a service. This is not exactly managed care, but there are a few other states that do it the same way.
			In FY06, MA reported several thousand full duals to managed care plans, including BHPs, PCCMs, PACE, and comprehensive plans. The state explained that most of this enrollment was in error. SCO/PACE plans are the only managed care plans that MA duals should be enrolled in. MA plans to correct this coding to put dual eligibles only in SCO/PACE plans. In Q1 FY07, however, MSIS still showed several thousand full duals in managed care.
		MASBOE	2005: Prior to Q1 FY05 disabled enrollees age 65 and older were reported to BOE '2' (disabled). In Q1 FY05, the state began reporting all enrollees age 65 and older to BOE '1' (aged). The state used correction records to extend this change back to Q1 FY04.

State	File Type	Record Type	Issue
MA	Eligibility	MASBOE	2006: In each month of Q1-Q4 FY06 and Q1 FY07, MA reported roughly 8,000 individuals in MASBOE 00 to non-zero values in several monthly fields, including the TANF and restricted benefit fields. The state planned to 0-fill all monthly fields for individuals in MASBOE 00, but these problems continued into FY07.
			The state provides full Medicaid benefits for the aged up to 100 percent FPL and the disabled up to 133 percent FPL.
			2006: In the summer of 2006, CMS approved a new Medicaid 1115 waiver for MA, permitting the state to move ahead with health reform. In July, 2006, the state restored many optional benefits for adults (eyeglasses, dental, etc.) and expanded child coverage from 200 percent FPL to 300 percent FPL. The state is also making plans for "Commonwealth Care" which will provide coverage to all adults to 300 percent FPL.
			2003: In FY03 Q2, MA corrected its MASBOE mapping, moving all enrollees in MASBOE 35 to MASBOE 55. Enrollees mapped to MASBOE 35 in all previous quarters were incorrectly mapped.
			2003: In FY03 Q2, MA corrected its MASBOE mapping, moving 20,000 individuals from MASBOE 14 to MASBOE 34. It also appears that retro/correction records back to 1/02 included this shift as well.
			2003: Between March 2003 and April 2003, MA dropped 32,000 enrollees previously coded to MASBOE 55. This was part of a cost savings project.
			Correction records for Q4 FY05 moved over 8,000 enrollees from a variety of MASBOE groups to MASBOE 00. Over 5,800 of these individuals were in MASBOE 45. The state explained that these were S-CHIP enrollees. MA corrected its MSIS S-CHIP coding and moved these individuals to MASBOE 00.
		Race/Ethnicity	More than 20 percent of eligibles are coded with an unknown race.
			Q1 FY07: MA reports inconsistent enrollment across the race categories.

State	File Type	Record Type	Issue
MA	Eligibility	Restricted Benefits Flag	Many (25,000-75,000), but not all enrollees in MASBOE 44/45 and 54/55 are assigned restricted benefits code '5' (restricted-other), while others receive restricted benefits code '1' (full benefits). Enrollees in state groups 37, 38, 41, 51, 59, 60, 61, 70, 72, 77, 78, 79, 82, 84, 86, 95, 97, AB, AM, AN, AR, and ED should receive restricted benefits code '5'. Groups 37, 38, and 61 are limited packages. Groups 41, 51, 60, 95, AR and ED have federally funded emergency services. Group 59 is a time limited HIV family-assistance benefit. Group 70 is buy-in only. Group 72, 77, 78, 79, and 97 are premium assistance. Group 82, 84 and 86 are HIV family assistance programs. Group AB is a time limited package. Groups AM and AN are essential packages.
			In Q2 FY06, it appears that MA greatly improved its use of restricted benefits code 2 (alien - emergency services only). From Q2 FY06 forward, roughly 25,000 enrollees are assigned rbf 2 each month. In prior quarters, only 1,500 were assigned rbf 2 each month. Retro/correction records appear to extend this improvement back to Q1 FY05. Then, correction records for Q4 FY05 moved about 20,000 enrollees from RBF 5 to RBF 2. The state explained that some of these changes were correct and others were erroneous. Specifically, aid categories (62, 64, 66, 67, 68, 69, TT, TU, TV, TW, AR, AS, AT, AU, and AV) were all moved CORRECTLY to RBF 2. However, MA moved aid categories (16, 65, AW, AX, AZ, BA, BC, BD, and BE) to RBF 2 in error. MA will correct this coding. We asked whether the state plans to submit correction records for the coding changes that occurred in error.
			In FY06, MA assigned RBF 3 to about 1,000 full duals and a small number of non-duals. MA planned to change the coding in the FY07 files to ensure that all full duals receive RBF 1 and all partial duals receive RBF 3. However, in the Q1 FY07 file, the inconsistency continued. We asked the state whether the dual flag or the RBF code was correct.
		Retroactive/Correction Records	In Q1 FY03 MA submitted about 1 million retro/correction records for Q1-Q4 FY02. These records disenrolled 186,000 individuals (145,000 in the January - March 2002 period). It seems likely that the vast majority of these disenrollments were erroneous.
			From Q2-Q4 FY04, MA submitted retro records that erroneously disenrolled the QI-1 group (dual code 06, and aid code 88) for Q2 FY03 forward. This mistake will supposedly be fixed with FY05 correction records.

State	File Type	Record Type	Issue
MA	Eligibility	Retroactive/Correction Records	Massachusetts decided to report retroactive records, despite the fact that they said they were going with the delayed submission in their MSIS application.
		CHIP Code	Massachusetts reports children in both its M-CHIP and S-CHIP programs in MSIS. The MSIS data are close, but do not exactly track, SEDS data. The state insists that the MSIS data are more reliable. Until Q2 FY03, a small group of CHIP children were reported in MAS/BOE 35 who may have aged out of coverage; the state is supposed to fix this problem with correction records. Some M-CHIP children are also correctly reported to MASBOE 52. In Q2 FY 2002, persons in state-specific eligibility groups AA01AA, AA01BA, and AA01CA (all mapped to MAS/BOE 44 - 45) were incorrectly assigned a CHIP code of 2 (M-CHIP) when the code should have been 1 (no CHIP). The state addressed this problem through correction records. Correction records for Q4 FY05, moved about 6,700 S-CHIP enrollees out of S-CHIP and into other CHIP codes. MA re-evaluated all of its CHIP codes and made those corrections. In Q4 FY04, the state included several new S-CHIP codes: AW01AA, AW07AA, AX01AA, AX08AA, AX09AA. The state informed us that a typo occurred, and codes with 'AX' should have been called 'AZ'. Nonetheless, these new codes are for cases where if the individual had an emergency service, Title 21 would pay the claim. These state groups expanded rapidly through FY05. As a result, MSIS began reporting higher S-CHIP enrollment than SEDS in Q3 FY05. These enrollees are not included in SEDS data, which explains some of the discrepancy between SEDS and MSIS in Q3 and Q4 FY05. In addition, from Q4 FY04 through Q4 FY05, these codes were erroneously reported to MASBOE 44. In Q4 FY04 this was a small issue, affecting very few enrollees, but by Q4 FY05, over 14,000 enrollees were affected. All S-CHIP enrollees should have received MASBOE 00. Effective July 1, 2006 MA expanded S-CHIP eligibility to 300 percent FPL.

State	File Type	Record Type	Issue
MA	Eligibility	CHIP Code	As noted above, MSIS and SEDS reporting are not consistent. The state has found several discrepancies between MSIS and SEDS reporting, including: MSIS reporting uses income buckets that are more restrictive than SEDS. Generally, MSIS reports more M-CHIP enrollment and less S-CHIP enrollment than SEDS through Q2 FY05. SEDS only specifies the beginning income level, leaving the ending income level open-ended. In addition, MSIS checks for TPL more rigorously than SEDS. For enrollees in state groups 40, EA, EB, EE, EF, and EK, MSIS looks at two separate TPL fields, where SEDS only looks at TPL declaration as of the application date. MA made some updates to SEDS reporting in June 2007, and expects that SEDS and MSIS should compare well in Q3 FY07.
			In Q3-Q4 FY05, MSIS showed a large increase in S-CHIP counts, which was not reflected in SEDS. In Q1 FY06, S-CHIP counts fell 16 percent, and were comparable with SEDS. Correction records submitted in Q1 FY06 removed the increase seen in Q3 and Q4 FY05 MSIS. By the end of FY06, MSIS and SEDS M-CHIP and S-CHIP reporting compares very well.
		SSI	Until Q1 FY05 enrollment in MASBOE 11 was about 2/3 of the SSI aged enrollment reported in SSA administrative data. MPR has repeatedly requested clarification from the state about this. However, beginning in Q1 FY05, MA changed its age sort for mapping to MASBOE 11-12. As a result the comparison to SSI data looks much more reasonable.
		SSN	In FY06, we noticed that MA reports about 10 percent of enrollees with missing SSNs. MA explained that it does not require enrollees to provide SSN data. They currently include all SSNs that they collect and verify with CMS. Prior to Q4 FY02, Massachusetts has roughly 1,000 SSNs assigned to more than one record. The state reduced this problem in Q4 FY 2002 to fewer than 500.
		TANF/1931	Until Q2 FY03, the number of monthly TANF recipients reported in MSIS is considerably higher than ACF administrative data on TANF for the same period. Until Q1 FY03, then the MSIS TANF counts are lower. Effective Q2 FY03, TANF counts in MSIS were lower that ACF administrative data, but were within the 10% margin.

State	File Type	Record Type	Issue
MA	Eligibility	Waivers	All years: MA cannot ID waiver recipients using their eligibility system. To ID waiver populations, they read claims and identify waiver enrollees w/waiver proccodes. After IDing waiver claims for the cycle, MA unduplicates the enrollees receiving the services by history number and flags enrollees accordingly.
MD	Claims	All	MD reports Medicaid expenditures on encounter claims through Q1 2004.
			MD included S-CHIP claims in the MSIS files until Q1 2005.
			Nearly two-thirds of the Medicaid recipients are enrolled in the HealthChoice Program. The remaining one-third tend to be either sicker (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.
		IP	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 that state Medicaid Programs reimbursement principles. Other hospitals in the state are reimbursed on a per-diem basis and many are subject to cost settlement.
			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 includsion of some per-diem hospitals for the sicker population. These hospitals only receive a room and board charge.
			In FFY 1999, a higher than expected percentage of original, non-crossover FFS claims have a Patient Status of 30 (Still Patient) because the IP file contains Chronic and Rehab hospitals in addition to acute-care hospitals.
			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. See above comment about types of enrollees included in FFS.
		LT	Many LT claims do not have diagnosis codes.
			There are no crossover LT claims.
			Maryland does not report leave days.

State	File Type	Record Type	Issue
MD	Claims	LT	The Admission Date is not a required field on continuing stays. As a result, the Admission date is missing on many claims in 1999, but is reported on most claims during later years.
		OT	The distribution of claims, by Type of Service, is unusual due to the high percentage of individuals enrolled in managed care. Most of the original, non-crossover FFS claims are for Home Health, Physical/Occupational Therapy or Rehabilitation. There are very few lab, dental or transportation claims
			There was a large increase in the number of outpatient hospital claims in Q4 1999.
			There was an increase of almost one million claims in the Q2 FY 1999 file over the number of claims in the Q1 OT file. This was the result of another agency sending in a large batch of old mental health claims in Q2. Most of these claims have a Type of Service of 33 (Rehabilitation Services).
			In 2007/2008 about 40% of the claims have a Program Type of Waiver. This may be the result of line item waiver claims.
			The PHP capitation claims were submitted with a type of service of 20 instead of 21 until 2007 Q3.
		RX	There are no Family Planning claims.
	Eligibility	1115 Waivers	MD had a Katrina waiver approved on 11/10/05. This waiver ended.
			In July 2006, MD implemented another expansion to its Health Choice 115, providing limited primary care health benefits to uninsured adults not otherwise eligible for Medicaid, with incomes <116% FPL (program is called PAC). This is a Medicaid expansion, but not M-CHIP. MD confirmed that enrollees will be 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 October 2002, MD converted its state pharmacy plan to become part of its ongoing 1115 waiver program (Maryland HealthChoice). This pharmacy assistance plan covers children and adults, as well as aged and disabled individuals.

State	File Type	Record Type	Issue
MD	Eligibility	1115 Waivers	The 1115 MSIS pharmacy assistance programs covered 2 different groups. The MD Pharmacy Assistance Program (MPAP) (which began in October 2002) was reported to state groups S08-S10, and covered all individuals to 116% FPL. QMB-only individuals getting MPAP coverage are reported to S08, while SLMB-only individuals are reported to S10. All other individuals were reported to S09. Persons getting MPAP coverage had a $5 copay per prescription. The MD Pharmacy Discount Program (MPDP), which started in July, 2003, covers Medicare beneficiaries with income <175% FPL who have too much income/resources to qualify for the MPAP program. These individuals are reported to state codes S16-S18. Their cost sharing is higher. They have a 65% copay, plus a $1 processing fee per prescription. This MPDP program ended in January 2006, with the implemention of the Part D program. The Pharmacy Assistance Program (MPAP) ended for duals in April 2006, but continued to cover non-dual adults through June 2006.
			MD has had a long running 1115 program called Maryland HealthChoice. The program was first implemented in 1997. Initially, this 1115 converted many enrollees to a managed care system. Since then, the program has expanded over the last ten years to include MD's PharmPlus program, family planning, and as discussed below, limited benefits to uninsured adults were added in July, 2006.
		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 researchers might want to recode these persons into county "007."
		Dual Eligibility Codes	From FY03 - Q4 FY04, MD reported roughly 30,000 individuals to dual code 99. These are enrollees with unconfirmed Medicare status. Most of them are adults, and likely not Medicare beneficiares. This problem began to improve in Q2 FY04 when MD began assigning enrollees in state group S16 dual code 09 (pharm plus). MD worked closely with CMS to improve its EDB match, and in Q1 FY05 stopped using dual code 99.
			MD has determined that all persons in State group S16 should have been assigned dual code 09. MD began reporting enrollees in State group S16 to dual code 09 in Q2 FY04. Persons reported to S17 and S18 should be assigned dual code 03. Enrollment in S16, S17, and S18 stopped in January 2006 with the implementation of the Part D program.

State	File Type	Record Type	Issue
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. MD's dual reporting for enrollees in its pharmacy assistance and pharmacy discount programs (MAS 5) has been problematic. MD correctly reported many MAS 5 enrollees with dual codes 01, 03, 06, and 07. However, many aged enrollees were assigned dual codes 99 and 00, while none were assigned dual code 09 until Q2 FY04 (although retro records appear to have converted some duals in dual code 99 to 09). In CY03, CMS authorized some states (including MD) to use dual code 09 for pharm plus program duals not reported to other dual codes. In addition, even after Q2 FY04, a high proportion (18 percent) of persons 65 or older were assigned dual code 00 or 99. Aged persons assigned dual code 00 or 99 were in MAS 1 and MAS 2, as well as MAS 5. The State worked with CMS to improve its identification of Medicare beneficiares , and correction records back to Q3 FY02 appear to have been submitted, based on MAX data. In Q1 FY05, only 7 percent of aged were reported to dual code 00, a substantial improvement.
		HIC Numbers	Almost 27,000 non-duals have HIC numbers (about six percent of the non-dual population).
		Managed Care	From Q4 FY07 forward, CMS MMA counts include PAC plans (see 1115 waiver note) as PAHP plans. MD reports these plans to MSIS as HMOs (plan type 1). In Q1 and Q2 FY06, MS 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 eligbility. Some persons (several thousand) with managed care plan type 01 have the PLAN ID field 9-filled from FY04 through FY06. MD explained that these are people who are part of health choice but not in a managed care plan. In Q3 FY04, MD began assigning its PACE plans to plan type 06. Prior to Q3 FY04, these plans were assigned plan type 01 (comprehensive). The affected plan ID's are: 510904300 and 511704600.

State	File Type	Record Type	Issue
MD	Eligibility	MASBOE	Q2-Q3 FY06. In April 2006, almost all enrollment in MASBOE 51-52 disappeared. This was due to the implementation of Part D, which replaced MD's Pharm Plus benefits for dually eligible aged and disabled. Presumably, the few remaining enrollees in MASBOE 51-52 are not Medicare eligible, and continue to receive pharmacy benefits through MD's Pharm Plus 1115 waiver. Those Pharm Plus aged and disabled who also were eligible to receive Medicare cost sharing are partial duals, and are reported to MASBOE 31-32 from Q3 FY06 forward. 1999-2005: In MD's MASBOE crosswalk for MSIS, individuals in state group X01(state only aliens) are not assigned to any MASBOE group, and, since the group is described as state only, we assumed individuals in the X01 group did not qualify for Medicaid matching. However, they were reported to MASBOE 44-45 from FY99 - FY05. Enrollees in X01P are pregnant women whose deliveries qualify for Mediciad matching funds (as emergency services). Enrollees in X01R (alien children) should not have been included in MSIS, as their full benefits are provided by the state, and do not receive federal funding. 2004: Prior to Q2 FY04, MD erroneously reported its Family Planning Only enrollees (State groups P10 and S12) to MAS/BOE 35. In Q3 FY04, MD began reporting Family Planning Only enrollees to MAS/BOE 55. 2003: In Q1 FY03, persons <65 in the state group S09 were incorrectly mapped to to MASBOE 51. This problem was fixed with correction records. 1999-2006: 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. 2000: During the second and third months of Q1 FY 2000, enrollment jumps by over 50,000 in MAS/BOE 22. The state reinstated these eligibles after improperly terminating their Medicaid benefits. They are mapped to an incorrect MAS/BOE group, however, and the state used correction/update records in Q4 FY 2000 to resolve the problem.

State	File Type	Record Type	Issue
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.
			From Q4 FY05 - Q2 FY06, MD decided to temporarily use the X01R state code for Katrina evacuees covered under the state's Katrina emergency waiver. These enrollees were reported to MAS '5' (1115 waiver), and restricted benefits code '1'. In Q3 FY06, MD used other state codes for its Katrina waiver.
			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.
		Private Health Insurance	Between Q2 and Q3 FY04, the number of enrollees with third party insurance rose 48 percent, from 24,625 to 36,575. The State conducted a TPL update/match at this time, which likely caused this increase. Retro/correction records smoothed this rate back to January 2003.
		Restricted Benefits Flag	Women who only get 1115 family planning benefits (P10 and F12) were assigned restricted benefits code 5 effective Q2 FY04. These women are assigned restricted benefits code 6 (family planning only) effective Q1 FY05. Correction records appear to have applied this change back to Q2 FY03.
			In Q1 and Q2 FY06, MD reported roughly 100 aged and disabled non-duals to RBF 3. The state corrected this issue in Q1 FY07.
			In addition, persons in the 1115 Pharmacy program were assigned RBF code 5 effective Q3 FY04. Some of these enrollees were partial duals, although the majority were working age adults who were not duals. Prior to this, many were assigned RBF code 1 by mistake, but MAX data suggest that correction records fixed this problem back to Q2 FY03. MD's 1115 Pharmacy program for duals ended in April 2006 while the program for non-duals continued through June 2006. In July 2006, the use of RBF 5 shifted so that it was assigned to the new expansion group of uninsured adults who received limited primary health care benefits under MD's 1115 waiver.

State	File Type	Record Type	Issue
MD	Eligibility	Restricted Benefits Flag	Beginning in 2008, MD is expected to begin implementation of 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. MPF enrollees will be assigned RBF code 8 in MSIS. From FY99 through Q3 FY05, 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 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). From FY99-Q3 FY05, 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. Thus, these children were incorrectly reported as Medicaid enrollees for purposes of MSIS. Both groups were assigned restricted benefits code 1. The X01P group should have been assigned RBF code 2. From Q4 FY05 through Q2 FY06, MD decided to temporarily use the X01R state code for Katrina evacuees covered under an emergency 1115 waiver. Beginning with Q3 FY06, MD relied on other state codes to handle Katrina enrollees until the waiver expired at the end of Q3 FY06. These enrollees correctly received restricted benefits code '1' (full benefits). During this time, MD continued to use state group X01P for pregnant aliens receiving emergency services.
		CHIP Code	Maryland reports its M-CHIP eligibles; however, until Q3 FY 2001 M-CHIP children in state groups P11 and P13 were not counted (state groups P12 and P14 were counted). This problem was fixed using correction/update records. In Q4 FY 2001 the state began to identify its S-CHIP children (in state groups DO1, DO2, DO3, and DO4). In Q4 FY06, MD's S-CHIP count in SEDS appears to be erroneous (inconsistent with Q3 FY06 and Q1 FY07 SEDS and MSIS). Q1 and Q2 FY07 SEDS and MSIS numbers compare well.

State	File Type	Record Type	Issue
MD	Eligibility	CHIP Code	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. CMS SEDS data reflect this change. MSIS data do not. We asked the state to review coding and confirm that it only has an M-CHIP program now.
			By mistake, MD S-CHIP children were reported to all the monthly fields instead of only being reported to state specific and CHIP fields. This problem was not discovered until Q2 FY04. It appears to have started in Q4 FY01. The state corrected this error in Q3 FY04.
			In September 2003 (Q1 FY04), MD switched children in state group P14 from M-CHIP to S-CHIP. However, MSIS reporting does not reflect this switch. From Q1 FY04 through Q3 FY04, children in P14 continue to be reported to CHIP code 2, instead of MASBOE 00 and CHIP code 3. Effective 7/1/04, children in state group P14 were switched back from S-CHIP to M-CHIP, and are reported correctly in MSIS from Q4 FY04 forward. MD submitted correction records to fix its Q1-Q3 FY04 M-CHIP and S-CHIP reporting problems. This problem was fixed in 2003 MAX data.
		SSN	More than 23,000 persons have the SSN field 9-filled (four to five percent of the population). In Q2 FY06, just less than 20,000 records have the SSN 9-filled (2-3%).
		TANF/1931	TANF figures are higher than reported by ACF due to the fact that individuals enrolled in TANF but who may not have received cash benefits are counted by MD. ACF counts only those who receive cash benefits. From Q1 FY06 forward, MD 9-filled its TANF flag.
		Waivers	MD did not report its Katrina waiver enrollees to waiver type A and waiver ID HS in MSIS for the first four months. However, these enrollees can be identified using state eligibility code X01R from September 2005 through December 2005. Beginning in January 2006, the Katrina reporting is correct in MSIS.
			MD continues to cover Family Planning - Only services as part of its 1115 waiver. In Q1 FY07, MD did not report family planning-only enrollees to Waiver Type F. In Q2 FY07, MD began reporting these enrollees to Waiver Type F. The state did not adjust this reporting in correction records.

State	File Type	Record Type	Issue
ME	Claims	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.
		All	Starting with 2005 Q2, ME has been unable to submit any usable MSIS claims files as they do not have a functioning MMIS. The system is supposed to be corrected in 2010 when they expect to be able to submit the MSIS claims.
		IP	Family Planning is not reported.
			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.
			There aren't any DRGs.
		LT	The state doesn't report leave days.
		OT	Maine discontinued its one HMO around the beginning of 2001.
			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.
			Some of the Service Code Indicators do not match the format of the Service Codes.
		RX	There are no adjustment claims on the file. Maine has indicated that this is OK, because drug claims are Point of Service.
	Eligibility	1115 Waivers	In Q2-3 FY 2008, Maine stopped new enrollment to the Childless Adult Waiver (state group 5C0000 and MASBOE 55) because of an expenditure cap.
			From June 2001 - December 2002, ME had a prescription drug 1115 waiver program for the aged and disabled. It was shut down as a result of a court ruling.
			In October 2002, ME implemented a 1115 waiver that extended Medicaid to childless adults with incomes under 100% FPL. These enrollees are reported to MASBOE 55.
		County Codes	In Q3 FY 2001, the number of enrollees with county code 999 increased to 13,000 (from 1,000 in Q2), presumably caused by enrollees in the new prescription drug program.

State	File Type	Record Type	Issue
ME	Eligibility	Date of Death	Dates of death are 8-filled for all eligibles.
		Dual Eligibility Codes	ME continued to report a small number of enrollees (roughly 50) to dual code 07 until Q4 FY05, even though the program ended on 12/31/02. These enrollees should not have been included in MSIS. In Q1 FY05, ME improved its dual reporting by moving about 6,000 SSI duals from dual code 08 (other) to dual code 02 (QMB plus). In Q3-Q4 FY05, ME informed us that some individuals were erroneously included in dual code 08. However, the state could not identify these individuals with a specific state group, or characterize the size of the problem. The state fixed this in FY06. Looking at Q1 FY06, it appears that the problem affected a very small number of individuals. Part A coverage: FY03 Q1. There is a persistant problem that a small percent of dual code 02's 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. In April, 2007 ME increased its income disregards for QMB-Only coverage. As a result, several thousand enrollees moved from dual codes 03 and 06 to dual code 01. As ME anticipated, the number of dual eligibles increased by about 15,000. ME explained that these individuals were members in ME's SPAP pharmacy program, and became eligible for Medicare Cost Sharing (partial duals) when ME changed its MSP income guidelines. In Q1 FY01, enrollment declined in QMB only (Code 1) and increased by about the same number in Qualified Individual (Code 6). When the 1115 prescription drug program started in Q3 FY01, many of the enrollees in the program were assigned dual code 00 and 08, in addition to 01, 03, 06 and 07. In Q1 FY03, all 1115 prescription drug enrollees were assigned dual code 02, 04 or 08, in compliance with new CMS MMA criteria. This caused enrollment in dual code 01, 03, 05 , 06, and 07 to decline. Many of the 1115 persons assigned 00 were probably duals.

State	File Type	Record Type	Issue
ME	Eligibility	Dual Eligibility Codes	Effective Q2 FY03, enrollment in dual codes 01, 03, 05 and 06 rebounded when the 1115 drug program ended in December 2002; however, overall dual enrollment dropped 43%.
			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.
		HIC Numbers	In, FY 1999 to FY 2000, 91 to 93 percent of dual eligibles had a valid HIC number. This proportion dropped to 69 percent with the implementation of the new prescription drug program in Q3 FY 2001 and continued to decline in FY 2002. From Q2 FY03 forward, the percent of duals with a valid HIC number improved, with 91% of duals having a valid HIC number in FY05 Q3.
		Managed Care	During FY2000, comprehensive managed care declined and PCCM enrollment increased. This shift happened as the state phased out its managed care contract with Aetna and increased its PCCM enrollment. By FY03 Q1, all enrollees were in a PCCM plan.
		MASBOE	2003: In Q1 FY03, ME corrected a long-standing programming error that had caused them to under-report foster care children. The children were still reported, but not to the appropriate category (MASBOE 48).
			2003: In FY03, ME began to report some disabled SSI recipients over age 65 to MASBOE 11, who were previously reported to MASBOE 12. In addition, groups 54000 and 62000 (nursing home enrollees who qualified for SSI) were moved to MASBOE 11-12 from MASBOE 41-42.
			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.
			2001 - 2002: In FY 2002, state group 53 (cost reimbursement boarding home enrollees) began to be reported in MSIS. They should have been reported to MSIS all along, but were ommitted from earlier data by mistake.
			2002: In October 2002, a new 1115 waiver extended Medicaid to childless adults under 100% FPL (MASBOE 55).

State	File Type	Record Type	Issue
ME	Eligibility	MASBOE	2004-2005: From month 3 Q2 FY04 through Q4 FY05, ME reported a small number of enrollees (<10) to MASBOE 52 each month. These enrollees should not have been reported in MSIS. The state stopped reported enrollees to MASBOE 52 in Q1 FY06. 1999 - 2000: Throughout FY1999 and FY2000, Maine had an age-sort problem in MAS/BOE 44 and 45. There were also age sort problems in MASBOE 24-25 in FY1999. Only persons older than age 20 should have been mapped to MAS/BOE 45 (or 25). Persons under age 21 should have been mapped to MAS/BOE 44 (or 24). 2002: Through FY02 Q1, ME's counts of SSI recipients in MASBOE 11-12 were somewhat higher than those reported in SSI administrative data. This probably occurs because Maine has a state-administered SSI supplement. 2005-2006: In Q3-Q4 FY05, roughly 4,000 enrollees shifted from MASBOE 55 to MASBOE 15. This happened when the state reevaluated the assignment of records to MASBOE 55. Enrollment in MASBOE 55 continued to decline in Q1and Q2 FY06. 2001 - 2002: During FY 2001, child enrollment shifted between MAS/BOE 34 and MAS/BOE 44 in January. Adult enrollment shifted between MAS/BOE 45 and MAS/BOE 15 in July, 2001 when ME expanded its Section 1931 Eligibility provisions to include parents with income to 150% FPL (SS group 4Y). 2000: In September 2000, the state implemented a new program to cover the parents of CHIP eligibles from 100-150% FPL. The state tried to get a waiver through to make these adults eligible for the higher CHIP matching rate, but were unsuccessful. 2000-2005: From Q2 FY00 through Q4 FY05, ME reported some enrollees to MASBOE 16-17. All enollees reported to MASBOE 16-17 should have been reported to MASBOE 14-15. From Q2 FY00 through Q2 FY03, over 1,000 enrollees were affected. From Q3 FY03 forward, much smaller numbers were reported to MASBOE 16-17. By FY05, less than 5 were reported each month. The state fixed this problem in Q1 FY06. 2000: In Q2 FY 2000, the state began to separate out the unemployed adults and their children. They had previously been enrolled in MAS/BOE 14 - 15, but are now reported separately into MAS/BOE 16 - 17.

State	File Type	Record Type	Issue
ME	Eligibility	MASBOE	2003: In Q1 FY03, enrollment in MASBOE 48 increased significantly as a result of a coding change. Prior to this point, foster care children were underreported.
			All years: The state provides full Medicaid benefits for the aged and disabled up to 100% FPL.
			2003: In FY03 Q1, ME reported 500 persons to MASBOE 54 (1115 children) who should have been reported to MASBOE 55. This problem was greatly reduced in Q2 FY03, but a small number (<100) continued indefinitely. These are persons <21 years qualifying under the childless adult group.
			2003: In FY03 Q2, MAS/BOE 51-52 should disappear, as the state's drug waiver program ended in 1/03. Most of the 100,000 are no longer eligible. Only enrollees who are SLMB only, QMB only, or QI's will continue to be enrolled in Medicaid. They will be reported to MASBOE 31-32.
			2001 - 2002: In June 2001, the state launched a Medicaid prescription drug program for the aged and disabled under an 1115 waiver. This program was shut down as a result of a court ruling in January 2003. In the six months prior to the waiver's start, about 1500 persons were mapped to MASBOE 51-52 due to programming complexities. They should have been mapped to MASBOE 31-32.
			1999 - 2000: Each month in FY1999 and FY2000, roughly 4-5 percent of the persons in BOE 1 are younger than 65. This is a higher-than-expected proportion. Additionally, in BOE 4 each month, roughly 7 percent of the enrollees are older than age 20. This, too, is a higher-than-expected proportion.
			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.
			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).
			2002: In July of 2002, enrollment in MAS/BOE 14/15 dropped due to a decline in welfare enrollment (state specific groups 04 and 05), while there was an increase in MASBOE 44/45 through TMA (state specific groups 15 and 16), as well as "eligible" for AFDC, but not receiving (group 67). Increases in these groups reported to MASBOE 44-45 continued in FY03 and FY04.

State	File Type	Record Type	Issue
ME	Eligibility	Private Health Insurance	FY02 Q3-4 data is inaccurate - 9,000 (33%) enrollees who should have been reported to private insurance were not. In Q1 FY03, private insurance patterns returned to normal.
		Restricted Benefits Flag	In some quarters prior to Q1 FY 2003, not all the persons assigned dual codes 01 and 03 were assigned restricted benefits flag 3. Aged and disabled persons enrolled in the 1115 prescription drug program (MAS/BOE 51 - 52) should have been assigned restricted benefits code 5, instead of restricted benefits code 1 (full benefits). The state correced this problem beginning in FY 2003; however, in January 2003 the program was shut down as a result of a court ruling.
		CHIP Code	Maine has both M-CHIP (state code 3P) and S-CHIP (state code 000000) programs, and both are reported into MSIS.
		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.
		TANF/1931	Prior to FY03, Maine's TANF numbers were consistently higher than ACF numbers. The state believes MSIS overcounted TANF enrollees, and may not be reliable. TANF was 9 filled beginning in FY03 Q1.
MI	All	MSIS ID	RX has a problem of with the linkage between RX encounter claims and the MSIS eligility files.
	Claims	All	The link between the quarterly encounter claims and EL files started deteriorating in 2002 and contined through 2004. This problem occurred primarily on RX claims. The state has now corrected the MSIS ID's.
		Capitation	There are no PCCM capitation claims as case management services are only paid when the service is rendered. The BHO capitation claims are reported as service tracking claims in the 1999 to 2002 OT files. The state started submitting them as individual claims starting with Q1 2003.
		IP	Large expenditures are reported on service tracking claims. More expenditures are reported on IP service tracking claims than on individual claims due to the method of hospital reimbursement. The number of claims decreased from Q1 to Q4 1999.

State	File Type	Record Type	Issue
MI	Claims	LT	The large number of service tracking claims are 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 of 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 2004 Q3. Normally the payments are monthly.
			Prior to Q2 2003, MI did not report covered days on most claims with a Type of Service of Mental Hospital for the Aged. This resulted in the average paid per covered day being very high in the MSIS validation tables.
		OT	Only about 80 percent of claims have a Service Code until 2007 Q2 when the state began reporting service codes on most outpatient hospital claims.
			Place of Service of ER is not reported until Q4 2001.
			Individual waiver claims are reported starting with the 2005 Q1 OT files.
			There was a sudden shift from state to HCPCS codes between Q3 and Q4 2001.
		TPL	Other Third Party Payment (or Third Party Liability/TPL) is missing on all claims.
	Eligibility	1115 Waivers	An 1115 Family Planning waiver was approved for MI on 3/1/06; however, MSIS reporting for this group did not begin until July 2006. FP enrollees are reported to state group L1Y, MASBOE 55, and restricted benefits code 6.
			MI implemented an 1115 HIFA waiver, effective 1/04 expanding eligibility to childless adults under 35 percent FPL. This population is also an M-CHIP group. Prior to Q2 FY04, this group was a state-only group that did not receive any matching funds. A freeze was implemented for this program effective 7/05, due to rapid enrollment growth. Enrollment in this group peaked in September 2005 and then declined gradually until May 2006, with an enrollment rebound in June 2006 (cause unknown). M-CHIP adult waiver enrollees only qualify for a limited benefit package that does not include inpatient hospital coverage. MI had to resubmit its Q2-Q4 FY04 MSIS files to include this group. However, MI did not resubmit its claims to include expenditures for this group. This affects FFS claims for roughly 26,000 1115 adults who were not enrolled in managed care. Capitation payments for about 50,000 1115 adults were included in MSIS claims. This issue was resolved in Q1 FY05.

State	File Type	Record Type	Issue
MI	Eligibility	Date of Death	All dates of death are "8-filled".
		Dual Eligibility Codes	The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL. In Q2 FY04, the distribution by dual code changed again. Most dual SSI recipients were correctly reported to dual code 02. In addition, there is a substantial increase in partial duals (cause unknown). As of Q4 FY06, the correction to dual code 02 had not appeared in the MMA file, accounting for a discrepancy between the two files. In Q1-Q4 FY05, MI began using the monthly dual code. It also appears that they erroneously stopped using the quartery dual code in their FY05 data. To generate the quarterly dual code for Q1-Q4 FY05, use the latest non-zero monthly dual code available for each quarter. For example, if an enrollee has dual code '01' in month 1 and 2 but dual code '02' in month 3, the quarterly dual code is '02'. If an enrollee has dual code '08' in month 1, but dual code '00' in months 2 and 3, the quarterly dual code is '08'. From Q1 FY06 forward MSIS relies solely on the monthly dual code. From Q1 FY03 through Q1 FY04, the distribution by dual code changed somewhat, although the total duals was about the same. In particular, enrollment shifted from dual code 02 to dual code 08. By mistake, almost all SSI duals in MASBOE 11-12 were switched to dual code 08, whereas they were previously reported (correctly) to dual code 02. A large proportion of Michigan's dual eligible population are reported with dual code 09 each quarter (dual code 08 effective Q1 FY03). Also, Michigan reports relatively few eligibles with dual code 01, since the state provides full Medicaid benefits to all aged/disabled up to 100 percent FPL.
		Managed Care	However, from Q2-Q4 FY04, MI mistakenly reported several counties as offering MI's "Delta Dental Managed Care" dental program. As a result, the number of enrollees reported to managed care plan type '2' (dental) increased by 40 percent from Q1 to Q2 FY04. Enrollees in the following counties should not have been reported to Plan Type 2 from Q2-Q4 FY04: 001, 007, 009, 013, 019, 039, 041, 071, 079, 085, 089, 097, 101, 103, 109, 113, 119, 129, 135, 137, 141, 153. These counties began offering dental managed care on May 1, 2006, and are included in Q3 FY06 MSIS.

State	File Type	Record Type	Issue
MI	Eligibility	Managed Care	In each quarter, a few Plan IDs are used that do not appear in the crosswalk. In addition, many Plan IDs are 10 bytes long, with three leading zeroes, while others are seven bytes long with no leading zeroes.
			Michigan underreported enrollees in its BHP managed care plans in FY 1999. This problem was corrected in FY 2000 files.
			In addition, MI failed to report 15 counties participating in the Delta Dental Managed Care plan in MSIS from Q1 FY01-Q4 FY04. All Medicaid enrollees under age 21 in the following counties should have been assigned to Plan Type '2' and Plan ID 0004181610: 005, 023, 029, 033, 035, 053, 057, 061, 083, 111, 131, 143, 149, 155, and 159. This error was fixed in Q1 FY05.
			Prior to Q2 FY04, MI reported its PACE program (Plan ID 0004070184) to Plan Type 1 (HMO) instead of Plan Type 6 (PACE).
			Michigan reports PCCM enrollment in Q1 to Q2 FY 1999, but enrollment phases out in Q3 FY 1999.
			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 Michigan.
		MASBOE	MI extends full Medicaid benefits to all aged and disabled to 100 percent FPL. However, by mistake, most of the individuals in this group (including some non-duals) were reported to MASBOE 41-42 until FY05. In Q1 FY05, about 65,000 aged/disabled shifted from MASBOE 41-42 to MASBOE 31-32 to correct this reporting error.
			2006: In Q1 FY06, MI began reporting all enrollees, 65+ to BOE 1, including all disabled aged enrollees previously reported to BOE 2. This caused enrollment shifts in MASBOE 11-12, 21-22, 31-32, and 41-42.
			From FY99 forward, MI reports a small number of individuals to MASBOE 99 (about 100-200 per month). From Q2 FY04-FY06, this problem was mostly resolved, and 0-2 were reported each month to MASBOE 99. These individuals should be reported to MASBOE 00.
			2006: See 1115 anomaly notes for discussion of 2006 adult M-CHIP and family planning enrollment patterns in MASBOE 55.

State	File Type	Record Type	Issue
MI	Eligibility	MASBOE	Until FY 2003, SLMB-only and QI-1and QI-2 eligibles older than 65 in state codes M2H and M2J were erroneously mapped to MAS/BOE 32. They should have been mapped to MAS/BOE 31. This problem was corrected in FY 2003. Another age sort correction for MASBOE 31-32 occurred in Q2 FY04. Until Q1 FY05, Michigan had a higher than expected number of enrollees younger than age 16 in BOE 5. This was likely tied to the fact that the state mapped its state-specific eligibility groups directly to MAS/BOE groups, rather than using any sort of age sort. This problem was largely corrected in Q1 FY05
		Race/Ethnicity	The number of eligibles with "unknown" race codes varies between two and six percent.
		Restricted Benefits Flag	Beginning in 2008, MI is expected to begin implementation of 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. MPF enrollees will be assigned RBF code 8 in MSIS. Prior to Q1 FY06, all 1115 enrollees should be reported to restricted benefits code '5' since their benefit package is limited and does not include inpatient hospital coverage. However, in Q2-Q4 FY04, MI erroneously assigned 25,000 in its adult 1115 waiver program (implemented 1/04), restricted benefits code '1'. These enrollees should be assigned restricted benefits code '5'. These M-CHIP adults qualify for a limited benefit package that excludes inpatient hospital coverage. In Q4 FY06, MI began reporting enrollment in its 1115 Family Planning waiver. These enrollees are reported to MASBOE 55 and restricted benefit code 6.
		CHIP Code	MI has both M-CHIP and S-CHIP programs. Beginning in 1998, M-CHIP covered all Medicaid children ages 15-18 to 150 percent FPL, while S-CHIP covered children from 150-200 percent FPL. Then, in 2003, MI expanded its S-CHIP program to cover unborn children of noncitizen mothers from 133-185 percent FPL (called MOMS). Finally, MI implemented an 1115/HIFA waiver in January, 2004 to add M-CHIP coverage for childless adults to 35 percent FPL. These individuals are reported to MASBOE 55. (The state CHIP plan does not mention this adult coverage group, but CHIP funding is noted in the waiver documentation).

State	File Type	Record Type	Issue
MI	Eligibility	CHIP Code	Problems with M-CHIP child coding (program is called "Healthy Kids") began to occur in Q2 FY02, when children who appear to have aged out of M-CHIP coverage continued to be assigned M-CHIP codes. MI's M-CHIP data began to be reliable from this point forward. SEDS data suggest M-CHIP enrollment of about 20,000 children/month during this period. MI stopped reporting M-CHIP children all together in Q2 FY04 - Q4 FY05. Some M-CHIP children reporting resumed in Q1 FY06 but M-CHIP children appear to have been greatly undercounted for all of FY06 and FY07.
			Adult M-CHIP coding begins in January 2004 and appeared to be reliable. It is consistent with SEDS data.
			MI's large state-only child health program is called "MIChild." Of the roughly 250,000 enrollees in MIChild, approximately 7,000 also qualify for Medicaid as M-CHIP enrollees (according to the state). Prior to Q1 FY06, MI had not been able to report these children as M-CHIP enrollees, but intended to include this group when it improves its M-CHIP coding starting in FY06. However, M-CHIP reporting was still incomparable to SEDS in FY06 and FY07.
			In FY 2007 MCHIP child counts did not compare well with SEDS counts of MCHIP children. The state identified errors with its SEDS reporting. They are unsure when the SEDS reporting will be corrected.
		TANF/1931	Michigan 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.
		Waivers	MI submitted waiver data for FY04, but is not reliable. The FY04 files were submitted before MI's waiver crosswalk was approved. The FY05 waiver data is reliable.
	Encounter	All	Most encounter claims have the regular encrypted Medicaid ID for the MSIS ID, but Judy Moran thought that some claims were coming in with the SSN. However, she believes that these SSNs are being crosswalked to the MSIS ID. Need to check when we start receiving encounter data.
			They are 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.
		IP	The procedure code is missing on 95 percent of the claims.

State	File Type	Record Type	Issue
MI	Encounter	LT	75 percent of the claims have only one covered day.
			The only Type of Service is NF.
		OT	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."
			The state can't distinguish between FQHC and RHC claims in their managed care data.
			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.
MN	Claims	IP	Service tracking claims have been reported with Type of Claim 5 (Supplemental Payment) from Q1 1999 to Q4 2005. These are mostly adjustment claims.
			There aren't any family planning claims. The state said none meet the definition. The professional component is billed in the OT file.
		IP/LT	Starting in Q3 2001 Minnesota moved their chemical dependency claims from IP to LT.
		LT	The diagnosis code is "00000" on most claims from Q1 1999 through 2004 and on some claims after that.
			The percent of ICF/MR claims is greater than expected, but consistant across years.
			The ICF/MR days are missing on many ICF/MR claims.
		OT	Specialty Code is missing on most claims.
			The distribution of OT claims paid each month is uneven.
			The percent of lab claims is lower than expected in 1999.
		RX	Date Prescribed is always missing.
			The distribution of RX claims paid each month is uneven.
			The NDC is not reported on credti & debit adustment claims, but there are very few of those types of adjustments.

State	File Type	Record Type	Issue
MN	Eligibility	1115 Waivers	In Q4 FY06, MN implemented a family planning only-waiver. These enrollees are reported to MAS '5' and Restricted Benefits Code '6'. Each month, the count of RBF '6' and Waiver type F differ by a few hundred people. MN explained this is because some FP-only enrollees become eligible for Medicaid retroactively. RBF changes to reflect Medicaid eligibility.
			MN had a Katrina waiver approved on 3/20/06.
			MN's 1115 CHIP waiver (approved in 2001) secured enhanced matching funds for some adults enrolled in the state's PMAP+ 1115 waiver. Basically, these are parents of CHIP and Medicaid children with family income up to 200 percent FPL.
			MN operates an 1115 waiver demonstration called the "MN Prepaid Medical Assistance Project Plus (PMAP+) (originally approved in 1995). The program provides services through prepaid managed care plans to "MinnesotaCare" enrollees, including children, adult caretakers, pregnant women, with income to 275 percent FPL.
		Dual Eligibility Codes	MN's MSIS dual reporting and MMA monthly dual distribution are not consistent. In January 2006, the updated MMA reporting shows 3,000 (30 percent) more partial duals than MSIS, and 6,000 (six percent) 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. This pattern continued through Q2 FY08. In Q1 and Q2 FY07, reporting of full and partial duals came within roughly 3,000 individuals each of MMA counts (3-4% and 17%, respectively).
			In Q1 FY06, MN began using the monthly dual flag. From Q1 FY06 - Q1 FY07, MN reported roughly 100 partial duals to restricted benefits code '1' (full benefits) each month. These enrollees were QI-1 eligibles who were found to be retroactively eligible for full Medicaid. They should have been assigned dual code 08. The state corrected this problem in its Q2 FY07 data.
		Managed Care	Until 2005, MN reported enrollment in a Tribal Dependancy Treatment Plan as managed care to the CMS June survey. However, this was a mistake, since this is a FFS plan.
		MASBOE	MN's FY05 and FY06 data consistently show a small seam effect, with enrollment higher in month 1 of each quarter. This seam effect disappeared in Q4 FY06.

State	File Type	Record Type	Issue
MN	Eligibility	MASBOE	MN's FY05 and FY06 data consistently show a small seam effect, with enrollment higher in month 1 of each quarter. This seam effect disappeared in Q4 FY06. The seam effect reappears in Q1-2 FY08. 2003: In Q4 FY03 MSIS data, MN expanded its S-CHIP program to include certain groups of unborn children. These are reported to state group PC9900 and MASBOE 00. Q1 FY01-Q1 FY06: MN mistakenly mapped most persons in state group UN2854 to MASBOE 45. However, most are >65 and should be reported to MASBOE 41. This error was not fixed until Q2 FY06, when MN shifted to using UN2814 for aged in this group. Enrollees in this state group (UN28) only receive "access" services. 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. In early 2007, the 125,000 MN residents who purchased Long Term Care insurance will become eligible for Medicaid before spending down. The partnership affects only asset eligibility (and not income eligibility). The state has confirmed this policy change, which has not been fully implemented as of November, 2007. The state expects to see its first recipients eligible under the partnership in State FY (starts in July), when they project 20 eligibles. The state does not project that the count will reach 100 eligibles until State FY 2013. 1999-2000: In FY99 and FY00, the assignment of enrollees to MAS 2, 3, and 4 was not reliable in Minnesota, except to the extent that individuals were identified as aged, disabled, children, or adults. As an example, "children" at a general level were appropriately identified, but the sorting of children by medically needy, poverty-related, or other status had many errors. Only the MASBOE 11-15, 48, and 54-55 designations are reliable. Until FY01, the state had an MSIS coding mistake related to income -- and income is a critical variable to the assignment of individuals across MAS 2, 3, and 4. 2001: Effective FY 2001, Minnesota reported almost all of its poverty-related children and adults into MAS/BOE 54 and 55 as a part of its MinnesotaCare 1115 Waiver Program. About 24,000 adults transferred out of MAS/BOE 55 to the S-CHIP parent program in Q401.

State	File Type	Record Type	Issue
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. In addition, disabled SSI enrollees age 65 and older appear to be reported to MAS/BOE 11.
			2001-2003: From FY01 through Q3 FY03, MN reported many children and adults to MAS 2,3 and 4 who should have been reported to MAS 1 as a result of the state's expanded 1931 criteria. This problem was corrected in Q4 FY03.
			2001: In July 2001, MN exercised the OBRA 86 option, extending full Medicaid benefits to the aged and disabled to 95% FPL. However, these individuals were not assigned a special eligibility code and were not identified in MSIS data until Q4 FY03. They were probably reported to MASBOE 21-22. In addition, in FY01, MN began extending "access" services to aged persons whose eligbility was not yet finally established.
		Private Health Insurance	The number of enrollees with state-purchased health insurance declined from 8,000 in Q4 FY 2000 to 5,600 in Q1 FY 2001. The drop was the result of Minnesota's deletion of a number of records that had been found to be erroneous.
		Restricted Benefits Flag	Each month, MN reports a few hundred more enrollees in Waiver Type F than in RBF 6. The state contact explained that this is because of overlapping FP and Medicaid eligibility. An FP enrollee can become eligible under MA retroactively, and his/her RBF, MASBOE, Waiver, etc will change to reflect MA eligibility. See 8/12/2008 correspondence.
			Persons assigned restricted benefits code 5 only qualify for "access" services, since their eligibility has not yet been fully established. Most appear to be in state group UN2854 and UN2814.
			From Q4 FY06 - Q3 FY07, several hundred enrollees in MASBOE groups other than 54-55 were assigned restricted benefits code '6' (Family Planning Only). These are individuals who were retroactively found eligible for a wider range of benefits, and should have been assigned restricted benefits code '1' (full benefits). MN corrected this beginning in Q4 FY07.
		CHIP Code	MN ran out of S-CHIP funds effective September 2006, and this continued through October 2006. As a result, no S-CHIP enrollment was reported for these two months. S-CHIP reporting resumed in November 2006. This shortage did not occur in September-October 2007.

State	File Type	Record Type	Issue
MN	Eligibility	CHIP Code	The state did not have an S-CHIP program until Q4 FY 2001, when it transferred adults from its 1115 waiver to S-CHIP (state groups A429 and M429). These S-CHIP enrollees are included in MSIS under MAS/BOE 00. A further expansion occurred in Q4 FY03, when MN added unborn children to its S-CHIP program (state group PC9900). They are also reported to MASBOE 00. SEDS-MSIS comparisons are poor for this group because individuals in the unborn S-CHIP groups are reported as children in SEDS, but have their parents date of birth in MSIS. SEDS data in FY 2002 are not reliable. SEDS data is reliable for FY03 forward. Minnesota has a very small M-CHIP program reported to MASBOE 34 that covers only infants with income from 275 to 280 percent FPL. In Q2 FY07, MN reported 13 percent more S-CHIP enrollees in MSIS than were reported in CMS administrative data (SEDS). The state contributed this to time lags between running the SEDS and MSIS data, and are monitoring the situation to see if it requires a change in their data processing. In Q3 and Q4 FY07, this discrepancy was reduced to less than 10%. In Q1-3 FY08, the two sources were consistent. However, in Q4 FY08, MSIS includes 18 percent fewer S-CHIP adult enrollees than SEDS does.
		TANF/1931	Eligibles reported as TANF recipients in Minnesota's data are actually recipients of the Minnesota Family Income Program. For their Medicaid population, this is nearly equivalent of the TANF code and is of greater interest to the state (from a data feedback perspective). In FY 1999 and FY 2000, 99 percent of children and adults in MAS/BOE 14 - 15 are TANF recipients. In Q1 FY 2001, the TANF numbers in MSIS were 15 percent higher than the ACF administrative data. MSIS TANF counts remains inconsistent with ACF data through FY06. The state blames this on state workers having to manually enter TANF data into the state's MMIS. The state has been unable to improve its TANF reporting, and from Q4 FY07 forward, 9-filled its TANF flag in MSIS.
		Waivers	In FY05, MN reported about 25,000 individuals each month to waiver ID 'B2'. These people are S-CHIP enrollees and not regular Medicaid enrollees and the state should not have included this waiver in its reporting. Supposedly, the state removed this group through correction records.

State	File Type	Record Type	Issue
MO	Claims	IP	The IP Procedure Code Indicator was not correctly reported until Q1 2005. Previously ICD-9 Procedure Codes were reported with a CPT-4 Indicator.
			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.
			There is a higher than expected percent of records with a Patient Status of 30 (Still a Patient).
			DRG is not on the file
			The state does not report DRG's.
		LT	The Admission Date is missing.
		OT	Outpatient hospital claims have Service Codes rather than UB-92 revenue codes.
			33 percent of claims have Type of Service 19 (Other Services). Missouri says these are mostly claims for homemaker chores
			The Servicing ID is mostly missing
			There aren't any claims with a type of service of sterilization or abortion.
			Missouri proposed a state plan change in November 2006 that would "change the reimbursement methodology for personal care services and transfer responsibility for that service to another agency." CMS regional office was going to review this proposal, so we don't know if the changes will take place or any specifics of what is involved.
		RX	New Refill Indicator is always missing.
			All compound drugs are coded as "COMPOUND" in the NDC field.
			Date Prescribed is always missing.

State	File Type	Record Type	Issue
MO	Eligibility	1115 Waivers	MO's 1115 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 remained in the 1115 in FY06. MO's 1115 waiver expired in October 2007 and the postpartum women transitioned into a separate, stand-alone 1115 family planning demonstration. When the 1115 expired, some M-CHIP children should have shifted to MASBOE 34 while others should have been shifted to the new S-CHIP coverage, but this change did not occur in Q1-4 FY08 MSIS data.
		County Codes	MO also reports some enrollees to county code "186" and the state has been asked to clarify who is reported to this code.
			Missouri reports eligibles with County Code = 510. These are residents of the city of St. Louis. While this FIPS code is technically correct, documentation for the Area Resource File suggests that researchers might want to recode these persons into county "191."
			Through FY02, MO used improper FIPS code 193 for Ste. Genevieve county. They should have used code 186. The state corrected this problem for most (but not all) enrollees beginning in Q1 FY03.
		Date of Birth	MO's Q1 FY05 file had the date of birth data field missing for about 3,000 individuals. This information was corrected through correction records submitted in Q2 FY05.
		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.
			Another problem is that in FY07 and Q1 FY08 MO had about 60 partial duals reported to MASBOE 11-12 and 200 to MASBOE 41-42.
			By mistake, some persons in MASBOE 31 - 32 are assigned dual codes 2, 4, or 8 and RBF 3 each month. This problem was first noted in FY03 and MO said it was caused by some bad data. It was fixed in FY05. However, minor problems of inconsistency occurred again in FY06 forward.

State	File Type	Record Type	Issue
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 were different. In FY07 and FY08, the full dual counts were close, but MSIS data showed only about half as many partial duals. The state has been asked to clarify why these sources are different.
			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 did not get a response.
			According to the state, these are eligibles that might qualify under QMB or SLMB rules, but pay for a 209(b) own Part B premiums as a part of their spend down. The state also indicated that dual eligibles have to apply for QMB/SLMB coverage.
		Managed Care	In June 2006, CMS Medicaid managed care administrative data reported 473,017 Medicaid beneficiaries in MO as being enrolled in in the Non-Emergency Medical Transportation (NMET) plan, a prepaid ambulatory health plan. The state did not explain why this enrollment is not captured in MSIS. However, NMET coverage was not reported in June 2007 CMS data.
			Missouri was under-counting managed care enrollment in FY 1999. This problem was corrected in FY 2000.
			No PACE reporting was included in MSIS until Q1 FY06. During 2003 - 2005, CMS data showed PACE enrollment of about 175 per month.
		MASBOE	2005: In Q1 FY05, all enrollees in state-specific group "AALN00" were mapped to MASBOE 31 instead of some going to MASBOE 32 as well. In this quarter, the date of birth was missing for these enrollees causing them all to be mapped to 31; however, correction records were submitted in Q2 FY05 fixing this assignment in Q1.

State	File Type	Record Type	Issue
MO	Eligibility	MASBOE	2002: In Q3 to Q4 FY 2002, approximately 2,000 enrollees in state-specific eligibility group 11M (Medical Assistance -- Old Age assistance) were falsely reported to MAS/BOE 41 rather than MAS/BOE 11 and about 4,500 enrollees of group 13M (Medical Assistance-Old Age assistance) were falsely reported to MAS/BOE 41 rather than MAS/BOE 11 and about 4,500 enrollees of group 13M (Medical Assistance --Aid to Disabled) were falsely reported to MAS/BOE 42 rather than MAS/BOE 12. This error was resolved by FY03 Q1 and FY02 Q3-4 were fixed through correction records. 2002: Effective Q2 FY 2002, Missouri increased its 1931 income threshold to 100 percent FPL, causing many children to transfer from MAS/BOE 34 to 14 and many adults to transfer from MAS/BOE 55 to 15. Effective Q4 FY 2002, the 1931 threshold was lowered to 77 percent FPL, causing many adults to disenroll and some children to transfer from MAS/BOE 14 to MAS/BOE 34. Also, in Q4 FY 2002, Missouri cut back eligibility for 1115 enrollees in MAS/BOE 55, reducing TMA coverage for state groups 76C from 24 months to 12 months. Family planning only enrollees (80R) were also reduced. 2003: Towards the end of Q1 FY03, MO added 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. 2004: BCCPTA coverage was added for Q1 FY04. All Years: TMA enrollees are included in the 1931 group mapped to MASBOE 14-15. 1999: Effective Q2 FY 1999, Missouri extended full Medicaid benefits to adults in its 1115 program (MAS/BOE 55). In addition, some adults in MAS/BOE 55 only qualify for family planning benefits. Children were already covered. 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. All Years: Missouri does not provide medically needy coverage.

State	File Type	Record Type	Issue
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. 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. 2002: Through Q3 FY02, Missouri reports a larger than expected number of persons younger than age 65 in BOE 1. Eligibles in state-specific eligibility groups AALN00, BBLN00, and CCLN00 are mapped only to MAS/BOE 31. Eligibles in these groups that are younger than 65 should be mapped to MAS/BOE 32. The state corrected this in Q3 FY 2002. 2003: In July 2003 there was a noticeable increase in enrollment in MASBOE 34 and 55 when some families transferred out of MASBOE 14-15 when they hit the standard 12 month TMA time limit. 2005 - 2006: MO's total Medicaid enrollment dropped 6 percent from during FY05 as a result of legislation passed reducing eligibility for the elderly and disabled to 85% FPL and reducing eligibility for low-income parents to 22% FPL. Beginning in Q4 FY05, MO no longer reported any 1115 adults with full benefits (state code 76C) to MASBOE 55. Only adults with family planning only coverage remained. In addition, the lowering of the FPL requirements also caused some shifts by MASBOE group during the year (e.g., some children moved from MASBOE 14 to 34 and some disabled moved from 12 to 42--mostly state-specific eligibility groups "11M 00" and "13M 00). The declining enrollment for adults and kids and shift from MASBOE 14 to 34 continued in FY06. 2008: In Q1 FY08, MO continued to have M-CHIP children reported to MASBOE 54 even thought the 1115 waiver had expired. They should have been reported to MASBOE 34, and the new S-CHIP group should have been reported to MASBOE 00, or not included in MSIS data. 2007: In Q1 FY07, MO had a noticeable enrollment shift from MASBOE 11-12 to 41-42. Since MO is a 209b state, the cause of the shift was not pursued.

State	File Type	Record Type	Issue
MO	Eligibility	MASBOE	2002: For the April-September period of 2002, MO did not have reliable SSI information. As a result, reporting to MASBOE 11-12 and 41-42 was not reliable during this period. This problem was corrected in October 2002. In October 2002, enrollment increased in several MASBOE groups, while a few had declines. This likely coccurred because these data were updated several times as a result of the MMA effort.
			2000: Enrollment in MAS/BOE 14 - 15 jumps by roughly 40,000 persons in July 2000. This shift is caused by the reinstatement of persons who lost Medicaid because their welfare benefits were terminated. This special initiative ended in March 2001.
		Private Health Insurance	The number of enrollees reported to Health Insurance flag "2" (receiving 3rd party insurance) increased 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. The count then decreased back to about 44,000 enrollees per month in Q2 FY08. The state was asked to clarify if there is a reason for this pattern.
			In Missouri's Q1 FY 1999 file, roughly 5,000 persons who were ineligible for Medicaid during the month (i.e., those in MAS/BOE 00) received HEALTH INSURANCE flags, indicating that they were eligible for Medicaid during the month. This problem was corrected in Q2.
		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 know 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.
			Beginning in Q2 FY2008, MO began implementation of a Money Follows the Person (MFP) program and started reporting 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.
			In Q1 FY03, some persons in MASBOE 31-32 were incorrectly assigned restricted benefit flag 1. This was corrected in Q2 FY03 forward.
			In addition, adults in state code 80R000 (mapped to MAS/BOE 55) only qualify for family planning benefits and were assigned restricted benefits code 5 starting in Q1 FY03. The state started assigning RBF 6 in Q1 FY06.

State	File Type	Record Type	Issue
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). In Q1-2 FY07 and Q1 FY08, some adults in state group 80 (reported to 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. Will need to fix in MAX. 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'.
		Retroactive/Correction Records	In the Q1 FY06 file, MO submitted over 200,000 correction records for each of the Q2, Q3, and Q4 FY05 files (replacing about 20% of these files). While most of these records do not seem to change any key data variables, they do impact the dual counts. It appears they increase full dual enrollment (dual codes 02, 04, & 08) by about 5,000 people and decrease partial dual enrollment (dual codes 01, 03, & 06) by about 4,000. In Q2-4, the number of correction records decreased, but still raised at a higher than expected level number of records that apply to earlier quarters of data. The state indicated that they did not intend to include such a large number of correction records and they should be disregared.
		CHIP Code	Missouri is reporting M-CHIP eligibles into MSIS. The data differs from SEDS in some quarters thought FY06, but the state insists their MSIS data are correct. Beginning in October 2007, MO implemented an S-CHIP program, in addition to the M-CHIP program. 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 this change, the M-CHIP program covered all children to 300% FPL. The shift to a combination program caused M-CHIP enrollment to decline in Q1 FY08 SEDS data but not MSIS. MSIS data appear to be incorrect and we've asked the state to confirm.
		TANF/1931	From January 2005 to June 2005 (Q2-3 FY05), MO virtually stopped reporting TANF enrollment in MSIS. The state is uncertain of the cause. Reporting was restored by the end of FY05, but the comparison to ACF counts in December 2005 showed a 12 percent difference (cause unknown). TANF reporting in FY07 forward look more consistent.

State	File Type	Record Type	Issue
MO	Encounter	IP	In 2002, only 30 percent of the claims had UB-92 Revenue Codes for ancillary services, and 13 percent have procedures.
			In 2003 about three percent of the IP encounter claims have an invalid Type of Service.
MS	Claims	All	Mississippi will start including $0 paid claims (previously not included) with 2005 Q1. These claims sometimes have TPL amounts.
			Mississippi will start including claims with invalid IDs, but with payment amounts, in Q1 2005. They realize these could fail an edit check (the numbers are usually 0s or 9s), but feel their inclusion provides a truer portrayal of claims activity.
			In 2001 Q1 MS submitted lots of service tracking claims. These are lump sum payments to providers to compensate for higher than normal denial rates, slow claim adjudication, systems problems, communication issues related to the implementation of HIPAA.
		Capitation	The HMO capitation void claims in Q1 to Q3 1999 appear to be lump sum adjustments.
			The Mississippi HMO program ended 10/99, however, there are some lagged capitation claims and around 8,000 HMO enrollees listed in the Q1 and Q2 2000 EL files.
		IP	Family Planning is not reported.
			The IP file has a large percentage of adjustment claims in Q1 1999. Mississippi has confirmed that this is accurate.
			Mississippi does not report DRGs.
		IP/LT/OT	MS went to a new claims system starting with Q1 2004. Because they knew there would be a delay in paying claims at first, they made large advance lump sum payments to providers. As the providers submit claims, those amounts are deducted from their financial system. However, the claims will show up with $0 until the advance payments are exhausted. This continued on throughout FFY 2004 but tapered off during the year.
		LT	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.
		OT	The state has put revenue codes into the Service Code field on about 25,000 original non-crossover claims in Q1 1999.

State	File Type	Record Type	Issue
MS	Claims	OT	There are no PCCM claims in the 1999 files and the PCCM program was discontinued in 2002.
			The capitation claims for desease 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.
		OT TOS	Mississippi incorrectly included lab and xray claims from outpatient hospitals in TOS 11 from an unknown date through Q3 2004. Starting in Q4 2004, these services are reported correctly in TOS 15.
		Pharmacy Counseling	1999 program note: When HCFA approved an amendment to Mississippi's Medicaid plan last year, the state became the first -- and thus far, the only -- to pay for pharmacists' services to Medicaid patients. Pharmacists can evaluate patients, assess compliance, review drug therapy, and educate those patients in physician-supervised disease management programs for asthma, coagulation, diabetes, and hyperlipidemia. These are coming in to MSIS as capitation payments
		RX	Starting with FFY 2005 Q2 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.
			Quantity of Service is not reported on most drug claims from Q3 2000 to Q4 2003. It appears again starting with the 2004 files.
	Eligibility	1115 Waivers	Although it was not reported to MAS 5 in MSIS, MS implemented an 1115 Medicaid expansion in October 2004 to cover aged and disabled individuals whose Medicaid eligibility would otherwise have been discontinued. Two groups were included in the waiver: 1) aged and disabled non duals with income <135% FPL (state code 45) and 2) aged and disabled duals with income <135% FPL and certain medical conditions, ESRD, cancer, transplant patients and patients with mental illness receiving anti-psychotic drugs (state codes 46-49). Persons in the second group only received 1115 coverage through December 2005. However, in FY07 and FY08, MS reported no enrollment to MASBOE 51-52. We asked the state to clarify their reporting.
			MS had an 1115 FP waiver approved for implementation in July 2002. MSIS reporting began in until Q1 FY04.

State	File Type	Record Type	Issue
MS	Eligibility	1115 Waivers	MS had a Katrina 1115 waiver approved on 9/22/05. Katrina enrollees were reported to State group 092, MASBOE 51-55 from Q4 FY05 through Q1 FY07. MS reported to this waiver again in FY08. We asked the state to correct this reporting.
		County Codes	MS assigns county code 00 to roughly 2,500 enrollees each month. Nearly all of these individuals are infants under the age of 1.
		Date System Change	MS switched from EDS to ACS as its MMIS contractor effective Q1 FY04.
		Dual Eligibility Codes	Starting in Q3 FY06, MS reports no enrollees to dual code 04 (SLMB+).
			In Q4 FY 2000, the state began to disregard income between 100 to 135 percent FPL, in effect providing full benefits to 135 percent FPL. As a result of this change, the number of SLMB-only dual eligibles dropped from more than 8,000 in Q3 to around 1,000 in Q4. Through FY 2003, Mississippi assigned dual code 02 to all full benefit duals, rather than distinguishing between QMB plus (02s), SLMB plus (04s) and other full duals (08s). This occurs because the state disregards income between 100-135 percent FPL.
			In January 2006, MS made major cutbacks in its Medicaid eligibility criteria for aged and disabled persons, in addition to other changes. This caused about 65,000 duals to switch from full to partial dual status. In addition, some declines in the aged and disabled eligible population occurred in FY06 and FY07.
			From Q1-Q4 FY05, a few individuals (<150) were assigned monthly dual codes, but not quarterly dual codes.
			From Q2 FY04- Q4 FY04, MS revised its dual coding in MSIS to conform with its MMA dual coding, assigning many persons previously reported to dual code 02 to dual codes 04 and 08, including most dual eligibles in MASBOE 11-12. This change was not considered by MPR to be appropriate. MS fixed this problem in Q1 FY05; MMA reporting was corrected in April 2006.
		Foster Care	Mississippi reports a smaller proportion of children in foster care than we generally expect, but this number is correct (see documentation in notebook).

State	File Type	Record Type	Issue
MS	Eligibility	Managed Care	Beginning in November 1999, Mississippi stopped reporting any eligibles with comprehensive managed care. However, in the June 2004 CMS managed care report, MS reported 75,445 enrollees with PAHP (prepaid ambulatory health plan) coverage. These managed care enrollees are all covered by the McKesson disease management plan. MS began reporting this plan and its enrollees to plan type 08 in MSIS in FY05 Q1 (Plan ID 000000000001). The Q3 FY05 MSIS managed care data reported 18 percent fewer enrollees than the June 2005 CMS managed care report report. The state explained that MSIS only counts managed care enrollment when the recipient is completely set up and actively participating in the program. Unlike CMS, the MSIS managed care count excludes enrollees in state group 028 (DMIE project). The McKesson plan ended in October 2006.
			The PCCM program was discontinued April 2002.
			In Q1-Q3 FY06, MS reported about 1,500-2,000 partial duals to the McKesson Disease Management Plan (ID 000000000001). These enrollees are partial duals, and were erroneously reported to managed care. This problem persisted until October 2006, when the program ended.
		MASBOE	2001: Beginning June 2001, Mississippi changed its reporting system as part of the welfare delinking process so that now state group 85 includes 1931 eligibles AND TMA enrollees. As a result, TMA enrollees were no longer separately identifiable and no longer reported to MAS/BOE 44 - 45. They are now mapped to MAS/BOE 14 - 15. Only a small group of hospice recipients remain in MAS/BOE 45 in FY 2001. No one is assigned to MAS/BOE 45 in FY 2002.
			2000: Through Q3 FY 2000, the state provided full Medicaid benefits for the aged and disabled up to 100 percent FPL. In Q4 FY 2000, the state began to disregard income between 100 to 135 percent FPL, in effect providing full benefits to 135 percent FPL. This continued until October 2004. Then, in Q1 FY05, the state cut back its expanded coverage for non dual aged and disabled enrollees with income from 100 - 135% FPL shifting them to 1115 coverage instead. A subset of the dual group with income 100 - 135% FPL were also transferred to 1115 coverage, but only through December 2005 (see 1115 discussion).

State	File Type	Record Type	Issue
MS	Eligibility	MASBOE	2004: In Q1 FY04, aged enrollment increased substantially. Most, but not all, of this increase resulted when some shifts were made in the age sort for aged and disabled. However, some persons 65+ continue to be reported to BOE 2. Overall SSI enrollment also increased noticeably and may have resulted from more up to date SSI information.
			2001-2003: State groups 10 and 21 (300 percent nursing home, and illegal aliens) were mistakenly mapped to MASBOE 32 from Q1 FY01 to Q4 FY03; they should have been mapped to MASBOE 41 or 42. State groups 12 and 22 (same groups) were mistakenly mapped to MASBOE 34 from Q1 FY01 to Q4 FY03; they should have been mapped to MASBOE 42.
			2005-2008: From Q3 FY05 through FY07, enrollment in MASBOE 14-15 gradually declined. The state conducted an extensive review of enrollees during this time period, removing those who no longer qualified. Modest declines also occurred in aged/disabled enrollment in FY06 and FY07 as a result of cuts to Medicaid. In FY08, enrollment in MASBOE 14-15 increased.
			2004: In Q1 FY04, MS began reporting enrollment to its FP waiver in MASBOE 55. The waiver had been approved for implementation in 2002.
			2005: In Q4 FY05, Katrina waiver enrollees began to be reported in MSIS.
			1999-Present: MS routinely reports a small number of individuals to MASBOE 99. These are disenrolled individuals, who should be assigned MASBOE 00. This problem has been gradually improving, and MS expects it to disappear within the next year or so.
			2006: In January 2006, MS implemented long planned cutbacks in Medicaid eligibility for the aged and disabled. The main impact was to move about 65,000 duals from full to partial coverage status.
		Private Health Insurance	In April 2003, Mississippi reported a surge in private health insurance of about 4,000 (16 percent). The state believes they had been under-reporting private health insurance enrollment prior to this time.
		Restricted Benefits Flag	In Q1-3 FY08, Mississippi reported about 160 non-dual eligibles to restricted benefits code 3. In each quarter this group included about 60 aged non-duals and about 100 disabled non-duals. We asked the state to address this issue.

State	File Type	Record Type	Issue
MS	Eligibility	Restricted Benefits Flag	Starting in Q1 FY04, MS also used restricted benefits code 5 for its FP-only waiver enrollees. The state switched to RBF code 6 (FP-only) in Q1 FY06.
			In Q1-Q4 FY05, MS erroneously assigned a small number of enrollees in state code 020 restricted benefits flag '2' (alien emergency services). These enrollees are deemed SSI recipients who have an emergency need for expedited eligibility. They should have received restricted benefits flag '1' (full benefits). Enrollees in state group 021 (alien) should receive restricted benefits code '2', the state started assigning restricted benefits code '2' to these enrollees in Q1 FY06, but fewer than <100 enrollees were reported (not all enrollees in State group 021 received RBF 2 in FY06). The state investigated the completeness of its reporting of aliens receiving emergency services, and found systems limitations that prevent children and adults from being reported as aliens. They are working toward improving their system. This problem persists through Q3 FY08.
			In Q1 FY04, approximately 15,000 children in MASBOE 34 are assigned restricted benefits code 5. MS assigns this code to infants under the age of 1 whose family income is below 185% of poverty. They are restricted from receiving dental services and eyeglasses.
		CHIP Code	Until October 2002, Mississippi's state-specific eligibility group "91" encompassed M-CHIP children, non-CHIP poverty-related children and poverty-related pregnant women. The state could not accurately determine which individuals in state group "91" were M-CHIP children, however. Thus, Mississippi elected to assign CHIP code "9" (CHIP status unknown) to all individuals under age 19 in "91." The state erroneously continued this practice in Q1 to Q3 FY 2003 after the M-CHIP program had been discontinued. These individuals should have been assigned CHIP code 1 ("eligible and no CHIP") after the program ended.
			Effective 1998, Mississippi had an M-CHIP program. Beginning in January 2000, it had an S-CHIP program as well. The M-CHIP program phased out in FY 2002. The S-CHIP program is not reported in MSIS.
		SSI	In December 2004, MSIS reported 11 percent more SSI enrollees than SSA administrative data. The main discrepancy occurred for the aged. The number of disabled enrollees was much more comparable. This problem occurred again in December 2007, when MSIS reported 42 percent more SSI aged enrollees than SSA. We asked the state for more information about this discrepancy.

State	File Type	Record Type	Issue
MS	Eligibility	SSN	MS reports roughly 1,500-2,000 SSNs with duplicate records through FY06.
			Roughly 5 percent of Mississippi's eligibles do not have SSNs. Many of these eligibles have been identified as "K Babies" (state-specific eligibility group "KK"). These eligibles are newborns who have yet to receive SSNs.
		State-Specific Eligibility	In Q1 FY04, MS changed its state specific eligibility codes, going from 2 bytes to five bytes.
		TANF/1931	In Q1 FY 2002, the number of TANF recipients was about 20 percent less than the number reported in ACF administrative data. Data from the two sources began to converge in Q2 and the discrepancy was within the expected range by Q3; however, in FY 2003 discrepancies reappeared.
			In Q2 FY04, MS began 9-filling its TANF indicator. Prior TANF data is not reliable.
MT	Claims	IP	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.
			The DRGs appear to be CMS DRGs, but they are reported as state-specific.
			There weren't any claims paid in Month 3, Q3 FY 2000, but there wasn't a drop in the claim count for the quarter, so it doesn't appear that the state failed to submit a month's worth of claims.
		LT	The TPL amount is mostly combined with the Patient Liability field due to system reporting.
			1999 to 2001 files: Montana reports that mental health services are entirely state-funded and therefore not included in MSIS.
			There are no crossover claims on the file. Montana does not process long term facility claims as crossovers.
			1999 to 2005 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).
		OT	There are some debit adjustment claims with a negative Medicaid Amount Paid

State	File Type	Record Type	Issue
MT	Claims	OT	Q4 2004 - the percent of claims with a Type of Service 19 (Other Services) is increasing over time. By Q4 2004 it is up to 42%.
			Some original, non-crossover FFS claims have a negative Medicaid Amount Paid. This is correct because Montana needed to create dummy bills in cases where they had summary bills. On the summary bills, the state assigned the allowed amount on each line item into the Medicaid Amount Paid field, and then created a dummy claim which had cost-sharing. The cost-sharing (e.g., copayments, TPL) was included as a negative Medicaid Amount Paid on the dummy record.
			The percent of lab claims is lower than expected in 1999.
			MT has a lowers than expected percentage of lab claims, but the lab service codes are properly mapped.
	Eligibility	1115 Waivers	MT had a Katrina Waiver Approved on 3/20/06.
			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. No eligibility expansion occurred with this waiver.
		Dual Eligibility Codes	Starting in FY1999, due to an error in programming, MT underreported the number of dual eligibles to code 01 and overreported the number to code 02. MT believes these issues were worked out over the years.
			Also, starting with the new monthly dual code reporting in Q1 FY06, 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. We've asked the state to review its dual code reporting so that individuals not enrolled in Medicaid for a given month are not assigned a dual code for that same month. This problem continued in Q1 FY08.
			The comparison of MSIS counts to MMA counts shows that the count 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 is currenting reviewing these sources to clarify how the reporting methodologies are different and hopefully make them more consistent.

State	File Type	Record Type	Issue
MT	Eligibility	Dual Eligibility Codes	Starting in 1999, MT did not include dual eligibility groups 05 (QDWI), 06 (QI1), and 07 (QI2) in its MSIS files. QI1s were added to the MSIS file starting in Q1 FY05. Also, in Q1-4 FY06, MT started reporting about 500-600 individuals with 9-filled dual codes each month. It appears that these might not be duals as most of these individuals are also assigned to MASBOE 00. These individuals should have had the dual code 0-filled for those months. This was fixed starting in Q1 FY07. In June 2003, MT stopped reporting dual code 03 by mistake (not included in MSIS), and persons who should have been reported to dual code 04 were converted to dual code 08. Starting in Q1 FY05, MT fixed these problems causing a slight increase in the total number of duals and a shift from 08 to 04.
		Managed Care	MT reports the majority of its enrollees with PCCM enrollment to Plan Type 1. However, a smaller number of enrollees in MT's 1115 Basic Medicaid waiver are reported with PCCM enrollment in Plan Type 2. The state indicated this smaller group have Plan Type 1 8-filled and are not double counted for PCCM enrollment. MSIS and CMS data are generally consistent on managed care enrollment in PCCMs (HMO enrollement ceased effective Q4 FY00). However, the June 1999 CMS data show 70,000 persons in PHPs. According to state officials, this was an error. No PHP enrollment is shown in MSIS.
		MASBOE	1999 - 2002: Montana had an age calculation problem until Q3 FY 2002. In Q1 to Q2 FY 2002, three to four percent of enrollees in BOE 4 were over age 20. All Years: MT appears to report many of disabled SSI age 65 and older to MASBOE 11. 1999 - 2003: Until Q1 FY03, MT reported a small group of enrollees to MASBOE 99 each month. Most appear to be children in the "M1" state group who would ordinarily be mapped to MASBOE 34.
		MMIS	MT plans to implement a new MMIS system (CHIMES) in July 2009.

State	File Type	Record Type	Issue
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 identifer 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.
		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 idenfity whether any persons who only qualify for emergency Medicaid services are currently included in the state's MSIS data to assign RBF 2. 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. MT also assigned restricted benefits code 5 to its BCCPTA enrollees. 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. Montana has a PRTF grant. As of Q1 FY08, the state reports no one to RBF A. We asked the state about the implementation timeline.
		CHIP Code	There was a considerable discrepancy between SEDS and MSIS S-CHIP counts in FY2002 Q3. According to the state, the SEDS numbers are incorrect. Subsequent SEDS data is comparable to MSIS data. Montana has a S-CHIP program and began reporting its S-CHIP data in FY 2000. It appears that 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.

State	File Type	Record Type	Issue
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 identifer. 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 both MSIS and MAX CY2000 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") in July 2009 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.
		TANF/1931	Montana cannot identify TANF recipients. All eligibles are coded with TANF = 9, indicating that TANF status is unknown.
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.
		Data System Change	new MMIS implementation which now looks to be delayed until Aug 2007 (contract signed April 2004 and supposed to be up July 2006) sort of indicates to you that we are in chaos. So much with the Legacy MMIS was put on delay anticipating July 2006 and now we are having to reorient to what can't wait and parallel participate in the new implementation. For example, Legacy is now going to have to implement National Provider Number as the deadline is May 2007.
		IP	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.

State	File Type	Record Type	Issue
NC	Claims	IP	Some claims have procedure dates after the date of the file because this field is not validated by the state MMIS system.
		LT	A slightly higher than expected percent of claims are for ICF/MR services which the state has confirmed is correct.
		OT	The Place of Service is missing or has invalid codes on most claims in 1999. The percent with valid codes has increased somewhat over time. About 60 percent of the OT claims have valid codes in the 2002 files.
			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.
			There are a few adjustment claims with the incorrect sign.
			PCS sometimes reported as Other Services and sometimes as PCS.
			The Service Code Indicator was not set correctly on some claims prior to Q2 2004.
		RX	The prescribing physician ID is missing.
			The state reported the fill date in both the Fill Date and Prescribed Date fields until 2005 Q3. After that the Fill Date is reported as missing.
			The file contains non-standard NDC codes that start with "0A" in 1999.
	Eligibility	1115 Waivers	NC had a Katrina waiver approved on 2/17/06. Enrollees (waiver codes AL, LA, MS) were reported in MSIS starting in Q4 FY05 and continued through Q2 FY08 even though the waiver expired in Q3 FY06. The small number of enrollees that were reported as Katrina enrollees past Q3 FY06 should not have been reported with this enrollment.
		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.
			The state assigns dual code 99 to aged and disabled persons who appear to be duals but for whom the state is not yet showing a buy-in.

State	File Type	Record Type	Issue
NC	Eligibility	Dual Eligibility Codes	About 11 percent of persons age 65 and older are not reported to be dually eligible for Medicare in Q1 FY 1999 a somewhat higher proportion than expected. This issue was corrected in subsequent quarters.
		Managed Care	In October 2001, the Wellness Plan of North Carolina was terminated, causing a noticeable drop in HMO enrollment. In December 2002, United Health Care was terminated, also causing an enrollment drop.
			The number of enrollees in a comprehensive health plan (Southern Coventry Health Care of the Carolinas, Inc.) spiked in January 04 (Q2, month 1 FY 2004) and returned to an expected level by September 2004. This is likely due to a managed care reporting error.
			North Carolina was reporting its 1915b health plan (CALTERN) as a comprehensive managed care plan (Plan Type 01), while it was reported as a PHP in the CMS managed care system. Enrollment in the plan expired at the end of June 1999.
			In Q3 FY08, NC started reporting enrollment in a PACE plan (plan id: 6700850). We asked the state to confirm a new PACE plan and for more information about it.
			NC stopped reporting any HMO enrollment in Q4 FY06 when the state terminated its only HMO plan (Southcare/Coventry Health Care of the Carolinas) in June 2006.
			NC implemented the Piedmont Behavioral Health Care waiver in April 2005 which provided enrollees mental health, developmental disability, and substance abuse services to all age groups in five counties. The state started reporting BHP enrollment in May 2005.
		MASBOE	2000: Effective 11/1/99, North Carolina expanded their 1931 eligibility rules to cover eligibility for 12 months after termination of TANF benefits. These enrollees would otherwise have received transitional Medicaid (MAS/BOE 44 - 45). As a result, enrollment increased in MAS/BOE 14 - 15 in FY 2000, while it fell in MAS/BOE 44 - 45.
			1999-2000: Roughly 2,000 eligibles were mapped to MAS/BOE 46 and 47 each month in Q1 FY 1999. These persons should have been mapped to MAS/BOE 44 and 45. In the remaining quarters of FY 1999, this number was down to a few hundred per month. By the end of Q1 FY 2000, this problem disappeared.

State	File Type	Record Type	Issue
NC	Eligibility	MASBOE	2006: NC implemented a Family Planning waiver (state eligibility group MAFDN) in October 2005 (Q1 FY06) and started reporting these enrollees to MASBOE 55.
			2005: There were increases across several MASBOE groups in April 2005. Any changes to FPL rules or COLAs in NC are determined in February of each year, and become effective in April of the same year. This can cause some changes in MASBOE reported. In 2005, NC reported increased from March to April in several MASBOE groups, including 22, 24, 25, and 31-35.
			2006: In January 2006, there was an increase in reporting to MASBOE 34 when NC shifted about 35,000 children from S-CHIP to M-CHIP.
			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.
			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.
			2008: NC will be implementing a Ticket to Work program for individuals below 150% FPL on November 1, 2008 (Q1 FY09). These individuals will be reported to MASBOE 42 and RBF 1.
			2000: Effective 11/1/99, North Carolina eliminated their UP Policy. After that date, no eligibles are reported into MAS/BOE 16 or 17.
			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.
			2001: Beginning in Q1 FY 2001, North Carolina reinstated a large group of former AFDC welfare enrollees in to MAS/BOE 14 - 15. These enrollees may have been inappropriately terminated from Medicaid as a result of welfare reform. At the peak in April 2001, this reinstated group more than 70,000 persons. By October 2001, it had dropped to about 10,500, according to the data provided by the state. This policy accounts for the increase in MAS/BOE enrollment in FY 2001.

State	File Type	Record Type	Issue
NC	Eligibility	MASBOE	1999: About 700 refugees were mapped to MAS/BOE "**" each month in Q1 FY 1999. 2003: Prior to 9/1/03, enrollees losing TANF coverage were provided an additional 12 months of Medicaid coverage before they were moved to traditional transitional Medicaid coverage. After 9/1/03, this 12-month extended coverage was ended by the state resulting in a portion of state group MAFCN being moved into traditional transitional coverage (state group AAFCN). Hence, there was a transfer of enrollees from MASBOE 14-15 to MASBOE 44-45 in September 2003.
		Restricted Benefits Flag	NC implemented a Family Planning waiver in October 2005 (Q1 FY06). These enrollees (state eligibility group MAFDN) are assigned restricted benefits flag 6. Beginning in 2008, NC is expected to begin implementation of 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 has been asked to assign RBF 8 to MPF enrollees. Persons with restricted benefits code 5 (other) are generally medically needy enrollees; however, starting September 1, 2008 (Q4 FY08), NC will also assign RBF 5 to individuals under a new coverage that continues Medicaid in a limited capacity for incarcerated individuals 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 from incarceration before the Medicaid certification period ends. 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.
		Retroactive/Correction Records	NC almost completely replaced its Q3 FY04 and Q2 FY04 files with correction records in Q4 FY04; most did not involve actual changes. NC submitted a large number of correction records in its Q3 FY05 file that incorrectly added Piedmont waiver and BHP enrollment data to Q1-Q2 FY05. This waiver was effective April 2005 (Q3 FY05); therefore retro/correction records in the Q3 FY05 file for enrollees in waiver IDs P1 and P2 should not be used.

State	File Type	Record Type	Issue
NC	Eligibility	Retroactive/Correction Records	Analysis of North Carolina correction records in the Q1 FY 2003 file for Q4 FY 2002 indicated that 60 percent of the records did not change any key data elements. The records with changes seemed appropriate. NC submits a higher than expected number of correction records (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.
		CHIP Code	NC implemented a new M-CHIP program in January 2006. Reporting of M-CHIP enrollees (state eligibility group M1C1N) began in MSIS in January 2006 (Q2 FY06) when roughly 35,000 children ages 0-5 shifted from S-CHIP to M-CHIP. This reduced monthly S-CHIP enrollment by just over 20 percent. In Q1 FY06, a small number (<20) of enrollees were reported to CHIP code '2' (M-CHIP). NC implemented an M-CHIP program in Q2 FY06; and it appears that these enrollees should have been reported to MASBOE 00 and CHIP code '3' in Q1 FY06 (all other monthly fields should be 0-filled). It is also possible these were retro records. North Carolina has opted to report its S-CHIP enrollees.
		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 become 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 MSIS TANF count in 12/07 were 14 percent higher.
		Waivers	In Q1-2 FY08, it appears that NC swapped the waiver type reporting for two waivers: Piedmont Innovations is being reported as a type 2, and Piedmont Cardinal Health Plan is being reported as a type 4. The NC MSIS waiver crosswalk indicates that NC's Piedmont Innovations waiver (ID P2) is a 1915(b)(c) waiver, and thus a type 4. It also says the Piedmont Cardinal Health Plan waiver (ID P1) is a 1915(b) (type 2). External sources seem to indicate the crosswalk is correct. In Q3 FY08, NC reported Piedmont Innovations as waiver type 4 and Piedmont Cardinal Health Plan as Waiver Type 2.

State	File Type	Record Type	Issue
NC	Eligibility	Waivers	Through Q2 FY08, NC continued reporting 4 enrollees in their Louisiana Hurricane Katrina Relief waiver even though these waivers expired prior to FY08. We assume this enrollment should no longer be included in NC's MSIS files and have asked the state to review for future submissions.
			In FY07 Q2-Q4, NC shows no enrollment in its AIDS waiver, type "3", waiver ID "AI" as this waiver was terminated.
			The Piedmont Pilot waivers P1 (1915b&c Waiver) and P2 (1915b 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.
			NC implemented a Family Planning waiver (ID# "FP") in October 2005 (Q1 FY06) and started reporting these enrollees to MASBOE 55 and restricted benefits flag 6.
ND	Claims	Capitation	There are very few HMO capitation claims until Q1 2000.
		IP	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 he LT file.
		LT	Nearly all of the claims do not have diagnosis codes.
			There are almost no crossover claims in the LT files.
			Two thirds of the original claims have an admission year prior to 1997. This percentage is higher than expected.
		OT	TOS not reported correctly on claims until 2005.
			The provider ID servicing number is missing on some claims.
			North Dakota has state specific Service Codes that are a single letter (e.g., 'M', 'L', or 'E'). The state has been asked for the definitions, but so far they have not been provided.
			Over 40% of the claims have a TOS of 19.
			The percent of claims with Other Third Party Payment (or Third Party Liability/TPL) is higher than expected

State	File Type	Record Type	Issue
ND	Eligibility	Dual Eligibility Codes	Most dual eligibles receive the dual flag 09 (code 08 effective 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.
			Also in Q1 FY06, ND assigned blank dual codes to roughly 40-60 individuals per month. These individuals are reported to MASBOE 00 (not eligible), so they should also have the dual code field 0-filled. The state fixed this reporting in Q2 FY06.
			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 is reviewing these inconsistencies for future file submissions.
			In Q2 FY04, total dual enrollment fell by about 3%. In addition, there was a shift by dual status code with partial duals more than doubling and full duals dropping by about 8%. This occurred because ND stopped reporting as Medicaid enrollees some individuals who had not spent-down yet.
		Managed Care	The provider ID of the state's only HMO (Altru Health Plan) changed from "0006900" to "MCO" in FY 2002.
		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. Finally, ND has a state-administered SSI supplement.
			2004 - 2006: Starting in FY04, ND reported a couple individuals to MASBOE 30 and one individual to MASBOE 40 during some months. These are invalid MASBOE codes and the state will fix starting in Q1 FY07.

State	File Type	Record Type	Issue
ND	Eligibility	MASBOE	2003: In January 03, there was a decline in MAS/BOE 16 - 17 (SS code 37 and 38) and a commensurate increase in MAS/BOE 44 - 45 (SS code 09 27 and 28). This resulted from a more stringent definition of underemployment accounting for income and the number of hours per month worked, instead of only accounting for income. For those who did not qualify for transitional coverage, the children were able to qualify under the poverty-related provisions, while the adults became ineligible for Medicaid. 2003: In September 2003, ND reduced the earned income disregards used for Section 1931 enrollees. As a result, enrollment declined in MASBOE 14, 15, 16, and 17. At the same time, child enrollment increased in MASBOE 34, while adult enrollment increased in MASBOE 25 and 35. 2001: In Q4 FY 2001, ND made changes to its 1931 policies that resulted in increased enrollment in MAS/BOE 14 - 17, with declines in other child/adult groups. In FY 2002 increases occurred in MASOBE 44 - 45 as a result of growth in TMA (state-specific groups 26 and 27). 2006: ND reports only 1-2 people in MASBOE 41 during FY06, which seems unusual to have so few enrollees in this MASBOE code; however, the state confirmed that it is correct. 2004: In Q2 FY04, enrollment decreased in several MASBOE groups. Medically needy enrollment declined somewhat when ND stopped reporting persons who had not satisfied their spend-down liabilities. As a result, medically needy enrollment was probably somewhat overcounted in the past. In addition, enrollment decreases might have been a result of the state changing the criteria to determine "underemployment". Eligibles who no longer met the new guidelines were not considered eligible starting in January 2004. 2004: In Q3 FY04, enrollment began to be reported in MASBOE 42, when the state began to report enrollment in its working disabled group (state code 052). 2008: In April 2008 (Q3 FY08), ND is implementing a new program under the Family Opportunity Act as part of DRA 2005 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 (need to discuss with state once they get approved through FY07).

State	File Type	Record Type	Issue
ND	Eligibility	Private Health Insurance	ND's reporting to Health Insurance code 2 (private health insurance) increased from about 10,000 enrollees at the end of Q1 FY06 to about 18,000 enrollees in Q2 FY06. The state found an error in the data reported to this field, which caused an overcount from Q2-4 FY06. The count to HI code 2 should have been just under 10,000 enrollees each month. ND will make the fix to its data starting in Q1 FY07.
			North Dakota reports that about 17 percent of its eligibles have private insurance, a higher than expected proportion.
		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.
			In Q2 FY04, about 500 partial duals in MASBOE 31-32 were assigned restricted benefits code '1' (full benefits). This was a mistake as these duals should have been assigned restricted benefits flag '3'. Supposedly, ND fixed this assignment through correction records included in the Q3 FY04 file.
		Retroactive/Correction Records	The number of correction records increased in Q2 FY 2001 due to changes in the state's reporting system. There was also a high volume of correction records in Q3, as the state changed the way that it reported the "days of eligibility" data element in order to comply with CMS standards. This change did not effect the value of any data elements, just the way that it is reported.
			Until Q2 FY 2002, a sizable proportion of retroactive and correction records were for 6+ months ago, a somewhat unusual pattern. From Q2 FY 2002 forward, the state only submits correction and retroactive records for the prior three quarters. The state discovered a problem with its system of correction and retroactive records that particularly impacted dual coding and appeared to date back to FY 1999. The state fixed the programming for Q1 FY 2002 forward.
		CHIP Code	North Dakota reports its M-CHIP children. The state has an S-CHIP program, but did not start reporting those children in the file until 10-99.

State	File Type	Record Type	Issue
ND	Eligibility	CHIP Code	From Q4 FY05 to Q1 FY06, ND data show an increase of over 30 percent in S-CHIP enrollment. While this increase is fairly gradual and moderate, the CMS administrative data on CHIP enrollment (SEDS) indicates that S-CHIP enrollment in ND actually decreased from 6,981 personmonths in Q4 FY05 to 5,720 personmonths in Q1 FY06. This discrepancy causes ND's S-CHIP count in MSIS to be inconsistent with that in SEDS. Through the rest of FY06, MSIS counts continued to increase, while SEDS decreased. The state reviewed its CHIP reporting in both sources and found an error in the data reported to SEDS. The state is confident that MSIS counts are reliable. Corrections to the SEDS logic was implemented in April 2008, so the counts should become consistent again at that time.
			In Q2 to Q4 FY 2002, there is a discrepancy between MSIS and SEDS data. The state believes the MSIS data are more accurate. The two sources compare well FY 2003 forward.
			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.
		SSN	In FY05, 18 percent of the eligibility records in ND used SSN as MSIS ID. The state contact suggested that ND is using SSN as the ID number for QMB duals (we are not sure if this is QMB-only, QMB-plus, or both). We asked the state to stop using SSNs in the MSIS ID field.
			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 (use 8-filled for SSN state) 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 is confident in their SSN numbers.

State	File Type	Record Type	Issue
ND	Eligibility	SSNs	In the Q4 FY05 data, ND submitted more than one MSIS record for 450 SSNs. In previous quarters, the number of SSNs with duplicate records was less than 150. The data for Medicaid enrollees and the data for S-CHIP enrollees comes from different areas of their data system. Individuals enrolled in both Medicaid and S-CHIP at different points in time during the same quarter are not completely reconciled to be reported as one record. This results in some duplicate SSNs. The state does not have the resources to correct this reconciliation process now, but expects to work to improve this reporting once they get more current with their MSIS submissions.
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. A cross reference file will be sent by the state for use with the MAX files.
	Claims	OT	In the 1999 and 2000 files, Nebraska will include a lump sum claim in each quarter for their waiver, transportation, 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.
			The BHO case management capitation claims are reported as individual claims through Q1 2002. From Q2 2002 through Q3 2003 they were not included in the file in any form. Starting in Q4 2003 they are reported as service tracking claims with a Type of Service of PCCM because they are only for BHO case management.
		RX	The following data elements are not available: Days Supply, Date Prescribed, and New Refill Indicator.
		Waivers	The 1999 to 2004 OT files include some of the waiver services as individual claims and some as service tracking. The percent varies across quarters with a drop in Q1 2003. Nebraska is working on changing their system so they can report all waiver services as individual claims.
	Eligibility	Date of Birth	See Unborn Child note.
		Dual Eligibility Codes	Through FY04, about 80 percent of eligibles in MAS/BOE 11 (Aged-cash) are reported as dually eligible. This is lower than generally expected, but the overall dual rate for BOE 1 is 95 percent.

State	File Type	Record Type	Issue
NE	Eligibility	Dual Eligibility Codes	The MSIS distribution of full benefit duals between dual code 02 and 08 is not consistent with MMA data. About 9,000 duals are reported as 02 in MSIS, but as 08s in MMA. The state indicated that the error is in the MMA reporting and they have submitted a request to make the data correction in the MMA processing. The discrepancy continues through Q3 FY08.
			Through Q1 FY04, Nebraska assigned dual flag 09 to 100 to 200 enrollees per quarter.
			NE does not use dual code 04 or code 07. Through Q4 FY05, QI (code 06) enrollees were included with the dual code 03 group. The state started separately reporting dual flag 06 in its Q1 FY06 file.
			In Q1 FY 2002, SLMB-only dual eligibles were mistakenly excluded from MSIS. This resulted in a dip in MAS/BOE 31 - 32 that rebounded in Q2. This oversight appears to have been fixed with correction records.
			Nebraska does not report any eligibles with the dual code 01, since the state extends full Medicaid to all aged/disabled <100 percent FPL.
		Managed Care	There was no behavioral managed care reported in MSIS in Q4 FY 2002. The state failed to report this enrollment as Nebraska moved from the Value Options BHP plan to the Magellan plan. BHP reporting was returned to the data in Q1 FY 2003 and the state fixed Q4 FY 2002 through correction records.
			From Q3 FY05 to Q4 FY05, behavioral health enrollment grew from about 147,000 enrollees per month to about 168,000 enrollees per month. This resulted after NE implemented mandatory behavioral health care for all subsidized adoption recipients and full benefit dual eligibles in July 2005.

State	File Type	Record Type	Issue
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. 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. All Years: See note about unborn children, which complicates reporting into MAS/BOE 35. 2000: In Q4 FY 2000, Nebraska begins to correctly re-map eligibles who had been mapped to MAS/BOE 99 in previous quarters. At the same time, the state is refining its state-specific eligibility code. These changes result in uneven enrollment patterns, but the state insists they are correct and they seem to smooth out over time. 2000 - Q3 FY08: 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. 2004: In the fall of 2003 (Q1 FY04), NE settled a lawsuit restoring Medicaid eligibility for 6-12 months for a group of enrollees whose eligibility had been terminated as a result of a new state law (LB8). This caused an enrollment increase in MASBOE 44-45 in October 2003. Enrollment in MASBOE 45 then declined 6 months later. (April 2004) and MASBOE 44-45 declined 12 months later (October 2004).

State	File Type	Record Type	Issue
NE	Eligibility	MASBOE	2003: In FY 2003, Nebraska imposed cuts in eligibility for working families, causing major declines in child and adult enrollment.
		Private Health Insurance	In FY05, NE was unable to submit the Health Insurance flag since MEDSTAT, its new Decision Support System contractor effective 2005, forgot to include this information in their system. The State corrected this error in Q3 FY06. In addition, some records had the insurance code 9 filled in 2004.
			Nebraska had a significant drop in the number of people with private health insurance from Q4 1999 to Q1 2000. In addition, NE 9-filled the insurance field for about 2000 enrollees each month through FY04.
		Restricted Benefits Flag	In 2008, NE is expected to begin implementation of 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. In month 3 of Q3 FY08, NE reported 1 person to RBF 8 (benefits restricted to MFP coverage).
			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 our 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 (expected in 2011). They do not have an estimate for when the restricted benefits code 2 will start being set correctly.
		Retroactive/Correction Records	The health insurance data contained in the retro/corr records included in the Q1 FY05 MSIS file should not override any information in the original record as it will set the data to 9-filled. However, if there is no original record to correct, then keep the 9-fill information since nothing else is available. All other data in the retro/corr records is reliable and should be used.

State	File Type	Record Type	Issue
NE	Eligibility	CHIP Code	Nebraskas MSIS data include their M-CHIP enrollees (the state does not have an S-CHIP program).
		Sex	See Unborn Child note.
		TANF/1931	Nebraska is not reporting any 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.
			Over time, TANF enrollment in MSIS is about 15 - 25 percent higher than ACF data. The state believes this is because there is a separate TANF plan that is not reported to ACF.
		Unborn Children	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 Unknown. The DOB is 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.
		xREVIEW NOTE	If MASBOE trends continue, maybe ask state to confirm that still correct.
NH	Claims	LT	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.
			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.
			There is a large shortfall of LT claims in Q2 1999 due to a mass adjustment that was done to most claims. Since these files were created more than a year after the time of the file and quarter, the state just dropped the original/void pairs, keeping the resubmissions as originals, but recording them in the subsequent quarter (Q3 1999).
			The Admission Date is missing on most claims as that information is not collected on the New Hampshire claim form.
		RX	Credit adjustment claims are reported as original claims from 2003 Q4-s004 Q1.
			Credit claims are reported as originals from 2003 Q4-2004 Q1.

State	File Type	Record Type	Issue
NH	Eligibility	Data System Change	NH will be implementing HEIGHTS, a new MMIS (scheduled for 1/09), that will allow the state to start identifying enrollees that: (1) are part of NH's disease management program, and (2) should be assigned restricted benefits code 2 (individual is eligible for Medicaid but only entitled to restricted benefits based on alien status). In addition, the new system will use 4 byte NHTS codes, replacing the current 2 byte aid category codes.
		Dual Eligibility Codes	New Hampshire did not report dual eligibles in the SLMB only, QI-1, QI-2, and QDWI groups in its MSIS data until Q1 FY03. In addition, NH reported all full benefit duals to code 02 until Q1 FY03.
			New Hampshire incorrectly reported in Q1 to Q2 FY 1999 that all dual eligibles in MAS/BOE 31 and 32 were QMBs with full Medicaid (dual flag = 02). In subsequent quarters this problem was corrected, and the vast majority of dual eligibles in MAS/BOE 31 and 32 were reported as QMB onlies (dual flag = 01).
			From Q1 to Q2 FY2006, NH made an adjustment to its dual code reporting to make it more accurate. This caused an increase of about 400 enrollees (7 percent) assigned to dual code 02 (QMB plus). This increase was also reflected in the number of enrollees reported to MASBOE 31-32 (mostly in state group 69). This change in dual code reporting caused NH's dual reporting in MSIS to become more consistent with NH's reporting in its monthly MMA file.
		Managed Care	New Hampshire is reporting comprehensive managed care (Plan Type 01) enrollment of 2,172 in its June 1999 MSIS data. The CMS data for the same time period indicate that enrollment was more than double that -- 5,872. The state explored this issue, but was unable to find an explanation. They guessed it could have resulted from the fact that MSIS data contained only the managed care enrollment of case heads. The gap between the two counts converged by June 2001.
			NH reported about 400-500 individuals per month with dental managed care enrollment from Q1 FY03 through Q4 FY04. This was incorrect as NH does not have a dental MC program and should not have been reporting any dental care enrollment.
			In July 2003 (Q4 FY03) NH terminated its only HMO managed care program.

State	File Type	Record Type	Issue
NH	Eligibility	Managed Care	CMS managed care data for NH show 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 is currently unable to identify these individuals in MSIS. However, with the implementation of its new MMIS (scheduled for 1/09), NH expects to begin reporting this group in MSIS.
			In February 2002, NH switched from Matthrew Thornton HMO to Anthem/BCBS.
		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 their 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 the new MMIS is implemented, thus, we will probably continue to see an undercount in MASBOE 11-12 until 2009.
		Private Health Insurance	From Q1 - Q3 FY03, about 10,000 were reported to the state-purchased private insurance code (3) by mistake. This error was corrected in Q4 FY03.
		Restricted Benefits Flag	NH'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. MPF enrollees will be assigned RBF code 8 in MSIS.
			NH will be implementing a new MMIS (scheduled for 1/09) 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).
			In Q1 to Q2 FY 1999, all persons in MAS/BOE 31 and 32 are correctly reported to have restricted benefits related to dual status, even though they are incorrectly reported under dual code 02.

State	File Type	Record Type	Issue
NH	Eligibility	CHIP Code	In Q4 FY 2002, there is a 13 percent discrepancy between MSIS and SEDS M-CHIP counts. The state says that this occurred because the state submitted its MSIS files before all of the CHIP data had been received. The state has been asked to delay submission in the future. The SEDS and MSIS M-CHIP and S-CHIP data were comparable in Q1 FY03.
			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.
		State-Specific Eligibility	NH's new MMIS (scheduled for 2009) will use 4 byte NHTS codes, replacing the current 2 byte aid category codes. A few aid category codes are defined differently in this new crosswalk. For example, the S-CHIP code is reported as aid category 61 in the new crosswalk (8/07), while the current NH xwalk shows it as 26. Apparently, NH decided to switch S-CHIP to a new aid category at some point, so the state might start reporting S-CHIP with aid category 61, instead of 26 in future data. Another example of a difference is that the aid category definitions don't always match. For example, the current NH xwalk defines aid category 20 as "TANF/categorically needy", while the new xwalk defines aid category 20 as "4-mo. extended MA," with both mapped to MASBOE 44-45. Val explained that there is not always an exact link between the old aid category codes and the new NHTS program codes. Apparently, the definitions in this new xwalk primarily relate to the new HEIGHTS program codes, not the old aid category codes.
		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.
		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.
NJ	All	MSIS ID	The state does not provide many records with a Temp ID/MSIS ID linkage. We used a state provided cross reference file to correct the MSIS ID's in the MAX 2005 processing.

State	File Type	Record Type	Issue
NJ	Claims	Adjustments	Because of reimbursement system, there are a few original and resubmittals claims with negative amount pd, particularly in the LT file.
		Capitation	The state submitted payments to pharmacies for dispencing fees for LT residents as PHP capitation fees instead of Service Tracking claims through 2007 Q4. They plan to correct this starting with 2008 Q1.
			In 2007 Q1 the state started to report supplemental payments to HMO's for maternal care with a Type of Service of HMO capitation and Type of Claim of Supplemental instead of Type of Claim of Capitation.
		Crossovers	There was a drop in the percent of crossovers from 9.1 percent in Q1 1999 to two to three percent in subsequent quarters. This is due to the processing cycle. In Q1 1999 they were catching up from the 2 previous quarters when there was a shortfall.
		LT	The claims from five or six inpatient psych hospitals were inadvertently left out of the files prior to FY 2002. This was fixed starting with Q1 2003. New Jersey doesn't know how long those claims were omitted.
			A small percentage of the adjustment claims have the wrong sign on the amount paid field.
			Through 2006 Q2 NJ submitted supplemental managed care capitation payments with a Type of Service of HMO capitation and a Type of Claim = supplemental instead of Type of Claim = capitation.
		OT	The Service Code Flag is not always correct in Q1 1999.
			There aren't any claims with a Type of Service of 34 [Physical Therapy (PT), Occupational Therapy, Speech Pathology and Language Therapy].
		RX	All compound drugs are coded as "COMPOUND" in the NDC field.
			Date Prescribed is always missing.

State	File Type	Record Type	Issue
NJ	Eligibility	0-filling	NJ's FY05 files show some records (<100) with data elements that were blank-filled every month. These data elements include the state-specific eligibility code, CHIP flag, MASBOE, and Plan IDs 1-4. Other data elements for these individuals were 0-filled, including the TANF flag, the restricted benefits flag, Plan Types 1-4, and Waiver Types 1-3, and Waiver IDs. The state is checking to confirm that the blank-filled data elements should have been 0-filled as well. (There were some blanks in some retro/correction records for FY04 included in the Q1 FY05 files as well). In Q1 FY06, the state no longer reported any individuals with blank-filled data elements.
		1115 Waivers	Starting in 2001, NJ implemented an 1115 demonstration waiver ("NJ FamilyCare") that covers: (1) custodial parents and caretakers of Medicaid and CHIP children with incomes up to 133% FPL as M-CHIP enrollees, (2) custodial parents and caretakers of Medicaid and CHIP 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. 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 and FY07.
		Dual Eligibility Codes	Starting in Q1 FY06 (with the switch to monthly dual 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.
			Between Q2 and Q3 FY05, full dual enrollment increased. The number of enrollees reported to dual code 02 increased by 8,000 (six percent) and the number of enrollees reported to dual code 08 rose by 1,000 (ten percent). The state was not able to determine a reason for this increase.

State	File Type	Record Type	Issue
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.
			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.
			NJ reported approximately 60 individuals to dual code 99 each quarter in Q1-3 FY05. These individuals were mostly reported to MASBOE 31-32 and had the state-specific code 9-filled. Other data elements appear to be populated with valid codes (e.g., CHIP, TANF, Plan Type, etc.). The state was uncertain who was included in this group, but believes the dual code should be 0-filled. NJ has not completely resolved this issue and from Q4 FY05 forward a small number (<5) individuals are reported to dual code 99 each month. State will address this issue once it gets caught up with submissions.
			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.
		Managed Care	Through Q2 FY06, NJ's MSIS files reported about 30,000 persons with Plan Type 08 (Other) enrollment in the first month of each quarter. These persons were residents of long term care facilities, and were receiving capitated payments for the costs associated with dispensing prescription drugs. The actual drugs were paid FFS. Due to a reporting lag (individuals have to be verified as NF residents each month of enrollment), no one received this flag in months two and three of any quarter. Data for the second and third months of the quarters were supposed to be reported in subsequent quarters as correction/update records. However, this correction proved to be problematic. Related to this issue, we do not have Plan IDs for these capitated pharmaceutical plans since the payments were made to pharmacies, not nursing home providors. In addition, Q2 data for this plan were problematic in FY 1999 - FY 2001. Finally, this plan type 08 enrollment was not reported in the CMS June managed care each year. NJ was asked to start 8-filling enrollment for this plan type as CMS would prefer that this type of plan not be considered managed care since it bears no risk. The state made this change effective Q3 FY06.
			Sometime in 2008, NJ is implementing a new initiative that will result in new PACE enrollment (no additional details at this time). The state will report these enrollees to Play Type 06 and will provide an updated managed care ID list once it is available.

State	File Type	Record Type	Issue
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 note) causing increases in reporting to MASBOE 55 during FY06 and FY07. 2006: NJ reported a large increase in reporting to MASBOE 34 from the end of Q1 FY06 to the start of Q2 FY06. The state believes this is related to the state hiring a new vendor to accept eligibility as well as a media blitz to get kids enrolled in the program. 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. All Years: New Jersey provides full Medicaid benefits for the aged and disabled up to 100 percent FPL. 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. All Years: NJ has an 1115/HIFA waiver for CHIP parents. 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 CHIP 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. 1999-2001: Until FY 2002, some aged and disabled waiver enrollees were mistakenly mapped to MAS/BOE 45, instead of MAS/BOE 41 and 42. The state believes that the 2001 mapping problem was fixed through correction records. 2006: In Q4 FY06, one person was reported to MASBOE 4A each month. The state indicated that this enrollee should have been mapped to MASBOE 3A.

State	File Type	Record Type	Issue
NJ	Eligibility	Race/Ethnicity	Between Q1 and Q4 FY 2002 there was a considerable change in the distribution of enrollees by race, especially for whites and Hispanics/Latinos. In Q1, 31 percent of enrollees were coded as white and 25 percent were coded as Hispanic/Latino, whereas, in Q4, 36 percent were coded as white and 20 percent were coded as Hispanic/Latino. The state was unable to explain this shift.
			New Jersey reports about 10-12 percent of its eligibles with an unknown race.
		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.
			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. It is expected that MFP enrollees will be reported in MSIS starting in Q4 FY08. These enrollees should be assigned RBF code 8 in MSIS.
		CHIP Code	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.
			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 CHIP code 1 (they should have been assigned 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 CHIP for state group 380 (M-CHIP parents); so some of the reporting problems for M-CHIP parents may have been corrected for MAX.) 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 CHIP code 3.

State	File Type	Record Type	Issue
NJ	Eligibility	CHIP Code	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 CHIP flag 2. These enrollees in MAS 14-15 are TANF-eligible individuals and not CHIP. They should not have been assigned CHIP enrollment. Then, in Q1 FY07, NJ corrected the assignment of the M-CHIP flag (CHIP-=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 Medicaid enrollees (CHIP = 1). This is what we generally expect to see. (NOTE: about 10 enrollees in group 380 are also reported to MASBOE 44-45.)
		SSN	NJ is an SSN state, however, in a special analysis, it was determined that 12 percent of NJ Medicaid enrollees in 2002 were never assigned SSNs. This dropped to 5 percent in FY05, a big improvement. The state indicated that, in most cases, its system does not allow for the SSN and Temp ID to be reported together in MSIS for any given quarter to allow for the link to be established between these numbers once an SSN has been assigned. CMS and NJ are continuing conversations to resolve this problem in MSIS. However, NJ provided a cross-reference file to CMS that will provide this link.
		TANF/1931	Some persons in MAS/BOE 44 receive TANF. This is not an error. 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). In December 2001, MSIS data report 20 percent more TANF enrollees than data from the Administration for Children and Families. The state was unable to explain this discrepancy.
		xREVIEW NOTE	Look for PACE in FY08. Remind NJ to make MASBOE 40 and dual code 99 reporting fixes once state is caught up with submissions.
NM	All	MSIS ID	There is a MSIS ID linkage problem between the claims and eligibility files partly due to the fact that NM does not submit many records with the Temp ID/SSN link when the person is issued an SSN. The state has provided a cross reference file to correct this problem that was used with the MAX files.

State	File Type	Record Type	Issue
NM	Claims	All	Service tracking expenditures are only reported in Q4 files.
		IP	Approximately one quarter of the claims do not have DRGs. These include Indian Health Service (IHS) inpatient per-diem claims.
			50 percent of Q1 1999 claims are adjustment claims, due to a DRG reprocessing for Grouper 12 recovery conducted during the quarter.
			Approximately one quarter of the original, non-crossover claims do not have UB-92 Revenue Codes for ancillary services. These include Indian Health Service (IHS) inpatient per-diem claims.
			There are more crossover claims than expected. This is probably due to the enrollment of mostly non-duals in managed care.
			There are no family planning claims until Q1 2003.
		LT	The diagnosis code is missing on nearly all claims.
			There are not any claims with a Type of Service of Mental Hospital for the Aged. KFF says NM covers this group but not IP Psych <22. However there are many IP Psych < 22 claims in the LT file.
		OT	New Mexico does not currently have a separate Place of Service code for ER. For a UB-92 invoice, any line item with a rev code of 450, 451, or 452 is reported as an emergency room Place of Service. The State does not have the information needed to capture ER Place of Service on their physician/clinic claims. Therefore ER is under reported.
			Adjustment claims that are resubmittals are reported as original claims.
			The percent of clinic claims fluctuates considerably across quarters, probably reflecting billing cycles.
			About 25 percent of the claims had CPT Service Codes in Q1 to Q3 1999. This jumped to 45 percent in Q4 99. There was an similar drop in local Service Codes in Q4 99.
			An increase in the number of Indian Health Service and waiver claims in the Q4 2000 file impacted the Type of Service distribution.

State	File Type	Record Type	Issue
NM	Claims	OT	Approximately one third of the Q1 to Q3 FY 1999 original, non-crossover claims had a Type of Service of 12 (Clinic); this is higher than expected, but New Mexico verified this was correct. However, the percent dropped to 11 percent in Q4 1999 and then back up to 32 percent in Q1 2000. In Q4 2001, there was a big increase in the average amount paid for all OT services. New Mexico has no explanation.
		RX	Drugs provided by the I.H.S. are not flagged with that program type, but are included in the 1999 Q1 - 2003 Q1 and 2004 Q2-4 files.
	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. In Q4 FY05, New Mexico implemented an 1115 HIFA waiver to cover uninsured parents of Medicaid and CHIP children, as well as childless adults (state codes 62-64), in a partnership with employers in the State. Those eligible for coverage include uninsured parents of Medicaid and CHIP children, who are themselves ineligible for Medicaid under the State's current rules, with incomes up to 200% FPL. Adults without dependent children, who are otherwise ineligible for Medicaid, are also eligible with incomes up to 200% FPL. These are all reported as M-CHIP adults. In March 1999, New Mexico implemented an 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.
		County Codes	NM has two even-numbered county codes (06 and 28) that are legitimate FIPS codes.
		Dual Eligibility Codes	New Mexico does not report persons in dual flags 03 and 06 because these enrollees are not part of the MMIS. The state hopes to start including these codes in MSIS in 2009. 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 should probably be mapped to MASBOE 42, but we have not asked the state since it is such a small group.

State	File Type	Record Type	Issue
NM	Eligibility	Dual Eligibility Codes	Through April 2007, NM's distribution of duals assigned to dual codes 02 and 08 is different in MSIS compared to MMA. NM has basically been doing their dual coding correctly for SSI recipients in MSIS (reporting them to dual code 02), but decided not to use this approach for MMA reporting (where all SSI duals are reported to dual code 08). NM fixed its MMA dual reporting effective May 2007 (with retro records), making this reporting more consistent with the state's MSIS reporting (except for reporting to dual codes 03 and 06 that are included in MMA but not in MSIS).
		Managed Care	In Q1 FY07, the Plan Type 1-3 data fields and the Plan ID 1-3 data fields were either filled with a single "0" or left blank for a small number of individuals each month. These individuals were also assigned to valid MASBOE codes for those months indicating that they were Medicaid enrollees. Therefore the Plan Type and ID fields should have been populated with a valid code or 8-filled. 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. NM implemented an ASO arrangement in December 2004 for prescription drug administration. This plan is not included in MSIS managed care reporting. NM does not report any PACE enrollment in its MSIS data; however, the CMS June data show about 200 enrollees in a PACE plan called "Total Community Care." NM is working to include this plan in its MSIS reporting and hopes to have the change made by the end of 2008.
		MASBOE	2005: In Q4 FY05, NM started reporting about 1,400 enrollees (state groups 062, 063, and 064) to MASBOE 55. These individuals are enrollees in the state's HIFA waiver covering parents and other adults with income to 200%FPL and are considered M-CHIP adults. Enrollment rose to over 5,000 by Q1 FY07. 2004: In Q1 FY04 there is an enrollment shift from state specific eligibility code 036 to 032 because the state altered the definition of code 036. Previously, the code included children 0-185% FPL for some ages. Effective Q1 FY04, 036 only included children from 133-185% FPL.

State	File Type	Record Type	Issue
NM	Eligibility	MASBOE	2005 - 2007: Through FY04, enrollees in the family planning only demonstration (state group 29) were mapped to MASBOE 44-45. Starting in Q1 FY05, these enrollees were shifted to MASBOE 54-55 and RBF 6. In Q1-4 FY06, NM erroneously reported these enrollees back to MASBOE 44/45 and restricted benefits code '5'. The state fixed this error starting in Q1 FY07 causing a shift from MASBOE 44-45 back to MASBOE 54-55.
			2004: There was a shift in enrollment from July to August 2004 (Q4 FY04). In August, MASBOE 14-15 declined by about 16,000 enrollees (state group 072), while MASBOE 44-45 increased by about 14,000 (state group 028). The state indicated that they recertified a large number of enrollees in July as a result of new auto closure and recertification processes causing a shift in transitional Medicaid (state group 028).
			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.
			2002: In Q2 to Q4 FY 2002, between 200 and 400 persons age 19 or older each month in state groups 032 (133 percent FPL kids) and 036 (185 percent FPL kids) were mapped to MAS/BOE 99, because they had aged out of coverage.
			2002: 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.
			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 (CHIP children are also reported to this state group, but their enrollment stayed consistent).
		Restricted Benefits Flag	Restricted benefits code '5' is used for state groups 62, 63, and 64 - NM's HIFA waiver enrollees/CHIP adults, since they have some limits to their benefits coverage.

State	File Type	Record Type	Issue
NM	Eligibility	Restricted Benefits Flag	Through FY04, enrollees receiving family planning benefits only (state group 29) were assigned restricted benefits code 5; however, starting in Q1 FY05, these enrollees were assigned RBF 6. In Q1 FY06, the State reverted to reporting FP only enrollees to RBF '5'. This was corrected back to RBF 6 starting in Q1 FY07.
		CHIP Code	In Q4 FY05, NM started reporting enrollment under the state's HIFA waiver covering uninsured adults using Title XXI funds. (These adults are reported as adult CHIP enrollees in the CMS SEDs system.) These CHIP adults are reported in state groups 062, 063 and 064, but were assigned CHIP flag 1 in MSIS each month. They should have been assigned CHIP code 2. The state fixed this mapping starting in Q1 FY07.
			Enrollment in New Mexico's M-CHIP program is first reported in Q2, month 3 FY 1999. Enrollment from Q2 FY 1999 to Q3 FY 2000 are somewhat inconsistent with SEDS, but the state assures us that the data are correct. By Q4 FY 2000, the data in the two systems are comparable. The state does not have an S-CHIP program. M-CHIP children are mapped to MAS/BOE 54.
			M-CHIP enrollment in MSIS significantly dropped in Q4 FY06 and then increased in Q1 FY07 (cause unknown). The MSIS and SEDS counts are about 25-30% different in both Q3-4 FY06 before becoming consistent again in Q1 FY07.
		SSN	For persons with temporary MSIS IDs, through Q3 FY07, NM (an SSN state) failed to submit any MSIS record that included both a temporary MSIS ID and an SSN. The state provided a crossreference file to CMS that provides SSNs for any persons ever assigned a temporary ID in MSIS records from 2004 to 2006 for use in MAX processing. This reporting was fixed in MSIS starting in Q1 FY07.
		TANF/1931	Beginning in FY01, the state reported that systems problems led to discrepancies between MSIS and ACF TANF counts in some months. The discrepancy was particularly pronounced in December 2001, when the MSIS count dropped close to 0. It was determined that NM's TANF data are not reliable and in the state began 9-filling the TANF flag in Q1 FY03.

State	File Type	Record Type	Issue
NV	Claims	All	NV is a SSN state, but has not been providing the link between the Temp ID and SSN when a SSN is assigned to an enrollee. The main impact is in the IP file for newborns. The claims are submitted with the Temp ID, but often, by the time the EL file is submitted a SSN has been assigned and the record does not include the Temp ID. NV has agreed to fix this beginning with Q2 2004.
		IP	There were no UB-92 Revenue Codes on the IP file until 2004 Q1 because Nevada's system did not capture the revenue codes.
			Nevada had state-defined codes in the IP procedure code field from Q1 1999-S4 2003; these codes are quite general, and report the type of hospital stay, such as medical/surgical one- to five- days' stay. They switched to standard procedure codes in 2004 Q1.
			The DRG code is always missing as they don't use DRGs for hospital reimbursement.
			Diagnosis Code fields 2 to 9 were blank until 2004 Q1, because Nevada did not collect this information in its existing system.
		IP/LT	There are some FFS adjustments that are probably really service tracking claims since the Medicaid Amount Paid on them is very large.
		IP/LT/OT	In 1999 the diagnosis codes are padded with zeros or reported as missing. As a result, all diagnosis codes are five-digit codes. This was fixed, for the most part, starting with Q1 2000.
		LT	The files do not include leave days.
			In Q1 1999 on original claims, the admission year is 1997, 1998, or 1999. These dates are the beginning date of service in most cases, so the field should be 9-filled instead. In Q4 1999, the field is mostly 9-filled. ??and now??
			Medicaid IP Covered Days are missing (Type of Service of Aged MH and IP Psych < 21.
			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).
		OT	14 percent of the original claims with a Type of Service of 08 (Physician), 11 (Outpatient hospital department), 12 (Clinic), 36 (Nurse Midwife), or 37 (Nurse Practitioner) are missing diagnosis codes.

State	File Type	Record Type	Issue
NV	Claims	OT	Nevada has had a transportation managed care waiver since October 2003. The have not been reporting either the capitation claims, service tracking claims with the expenditures or enrollment.
			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 five-digit numeric codes, with a Service Code Flag of 10. Since they therefore look just like CPT-4 codes, it is important to use the flag before determining each code's meaning
			Starting with FFY 2004, NV will submit individual transportation capitation claims. There will be a mix of service tracking and capitation claims in Q1.
			There isn't any PHP enrollment, but there are a few PHP capitation claims in the file with unexpected payments in Q1 to Q3 2000.
			Place of service is missing, or invalid on about 20 percent of the original claims.
			Provider ID Servicing Number is missing.
			Only four percent of the original claims are physician claims (Type of Service of 08); this is a low percentage.
			Nevada sent only five-digit numeric service/procedure codes until Q1 of 2004 when it began submitting codes with a HCPCS format. Procedure code listings from the state suggest that they were using HCPCS codes during the earlier years, but had not submitted them. We have asked NV to explain what they sent.
			There are no UB-92 Revenue Codes on outpatient hospital department claims, but the claims do have Service Codes.
			Specialty codes are missing.
			About 40 percent of the original claims are for Type of Service of 15 (Lab/X-ray Services); this is a high percentage.
			In the 2000 Q1 file the most frequent diagnosis is '42' which is not a valid code.
		RX	Date Prescribed is always missing.
			New Refill Indicator is always missing (so CMS reset the error tolerance at 100 percent for this field).
			All compound drugs are coded as "COMPOUND" in the NDC field.

State	File Type	Record Type	Issue
NV	Eligibility	1115 Waivers	NV had a Katrina Waiver approved on 11/23/05.
		County Codes	Effective FY04, NV added new FIPS county codes. County code 03 (Clark) is now reported as 703 (Urban Clark) and 803 (Rural Clark). County code 31 (Washoe) is now reported as 731 (Urban Washoe) and 831 (Rural Washoe).
			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 researchers might want to recode these persons into county "025."
		Dual Eligibility Codes	NV's improvements in how the state assigned dual codes also resulted in an increase in the number of reported duals in Q1 and Q2 FY04.
			In FY02, about five percent of enrollees reported as QMB+ (dual code 02) are not receiving Medicare Part A coverage. This is due to a lag in the payment of Part A premiums for these enrollees by the state. The state assures us that these persons are eventually provided with Part A coverage once the state has fully processed the eligibility information.
			Until FY04, Nevada reported all its full benefit dual eligibles as full benefit QMBs (dual code 02). In addition, QI-1 and QI-2 enrollees (dual codes 06-07) were reported as SLMB onlies (dual code 03). The state began to report to dual codes 04 through 08 in Q1 FY 2004.
			In FY05, NV updated its dual coding and discovered that persons in all state groups with "5" in the last byte had over 100% FPL. This caused a shift from Q4 FY04 to Q1 FY05, of about 3,600 enrollees from dual code 02 to dual code 08.
		HIC Numbers	In FY01, between 74 to 76 percent of NV's dual eligibles had HIC numbers. We generally expect that at least 95 percent of dual eligibles will have valid HIC numbers. This was corrected in FY02.
		Managed Care	In the three months of FY99 Q1, there are 2,841, 1,304, and 47 persons who are mapped to MAS/BOE 00 and incorrectly receive Plan Type 88 and Plan ID 88888888. This problem was corrected in FY99 Q2.
			In June 2001, MSIS showed 24 percent fewer HMO enrollees compared to the CMS managed care count. The discrepancy may be partially explained by unusually low reporting for total enrollment in Q3 FY 2001. In July 2001, the difference was reduced to 13%.

State	File Type	Record Type	Issue
NV	Eligibility	Managed Care	In June 2002 managed care reporting in MSIS was 12% lower than CMS data. However, in July 2002, HMO enrollment in MSIS increased considerably, bringing MSIS data much closer to CMS reporting. The state did not provide an explanation for this change. Until Q3 FY 2003, Nevada incorrectly identified about 30 Hospice care enrollees as receiving comprehensive managed care. Beginning in Q4 FY 2003, their plan type code was 8-filled. In 10/03 (Q1 FY04), a non-emergency transportation waiver went into effect in NV. Enrollees are reported to plan type code 08 in MSIS. However, enrollment in this waiver was not reported in the CMS June managed care counts until 2005. A comparison of the CMS and MSIS data in June 2005 shows a 20% difference in counts (CMS reported enrollment of 175,043 and MSIS reported 142,369 enrollees). NV indicated that the MSIS counts are lower because they did not include Nevada Check-Up enrollees (S-CHIP) or "retro eligibles" (pending with probably future eligibility). If you disregard these groups from the CMS count, the two sources compare well. Starting in 2006, the June CMS report uses the same method and the two counts are consistent. Also, effective Q1 FY04, NV switched to a new managed care plan ID system. Mandatory HMO enrollment in the northern region became effective 2/1/04, with an increase in managed care enrollment in Q2 FY04. Through FY 2000, Nevada reported all HMO enrollees into one managed care Plan ID in MSIS. CMS managed care data show three managed care plans in Nevada. The state MSIS staff has now identified distinct plans and assigned each a distinct plan ID. This fix was implemented in the FY 2001 files.
		MASBOE	1999 - 2001: In FY99-FY01, roughly 27-28 percent of eligibles in BOE 5 are younger than 21. 2002 - 2004: Nevada began a BCCPTA program in July 2002. They began reporting these individuals to MASBOE 3A in October 2004. 2004: In addition, NV moved to a new crosswalk effective Q1 FY04 when the state moved to a new system and changed the eligibility codes assigned to state groups. In addition, NV corrected some errors in past reporting.

State	File Type	Record Type	Issue
NV	Eligibility	MASBOE	1999 - 2004: It was also determined that NV had been inappropriately mapping all the other state groups with '48' and '49' in bytes 1-2 since MSIS began. Persons with '48' and '49' in bytes 1-2 should be mapped to MASBOE 14-15, dependent on age. This problem was fixed in FY03 forward for '48' and contributed to the enrollment increase in FY03. The problem was fixed from FY04 forward for '49' (although eligibility codes changed in FY04--see below). This caused MASBOE shifts in Q1 FY04. As a result of these reporting errors, NV was undercounting enrollment in MASBOE 14-15 and overcounting enrollment in MASBOE 44-45 through FY03. 2002 - 2003: In FY02, NV underreported persons in state group '48 105' (approximately 15,000 persons). Some, but not all, of these persons were included in MSIS reporting, but mapped to MASBOE 04-05. Persons in '48 105' should have been mapped to MASBOE 14-15, dependent on age, through FY02. The state corrected the mapping starting in FY03. This caused much of the enrollment increase from FY02 to FY03. 2005: In Q1-Q4 FY05, enrollment in foster care rose steadily from 5,628 in October 2004 to 6,807 in September 2005 (21% increase). NV indicated that they had a system glitch that prevented cases which were closed from registering as such in the system. The state expects to correct this in Q2 FY06. 1999 - 2004: A recurring problem in Nevada until FY04 was that there are persons each month with invalid MASBOE combinations. In FY01, the problem was small (<30 per month), but in FY02, the number of records with this problem was several thousand each month. These records should have been coded as MASBOE 00. In FY03, this problem was greatly reduced, but a few individuals (<10) were assigned MAS 4 but a BOE of 6 or 7. 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. 2001: During FY 2001, total enrollment drops from Q2 to Q3 by about 4,000 and then it increases by about 10,000 from Q3 to Q4. There is an especially dramatic drop in the number of infants: 5,000 in Q3 compared to 9,000 in both Q2 and Q4. There appears to have been a reporting problem in Q3 FY 2001.

State	File Type	Record Type	Issue
NV	Eligibility	MSIS ID	NV is a SSN state, but has not been providing the link between the Temp ID and SSN when a SSN is assigned to an enrollee. NV suposedly agreed to fix this beginning in Q2 FY04. Later information emerged, indicating NV has been using "dummy" SSNs for undocumented observed newborns until FY05.
		Race/Ethnicity	In Q1 FY04, NV began reporting to race code 07 (Hispanic/Latino & more than one race) and code 08 (not Hispanic/Latino and more than one race).
		CHIP Code	Nevada does not report its S-CHIP enrollment. The state does not have an M-CHIP program.
		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. NV will work to 8-fill the SSN field and provide temp ID links in its FY06 files.
		TANF/1931	In FY02 and FY03, NV's TANF enrollment data in MSIS are overreported. In FY04, the state corrected its TANF reporting in MSIS which brought the data consistent with ACF data. In FY05, 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.
		Waivers	NV listed waivers AL (Assisted Living Waiver), ES (HIFA: Employer Subsidy Insurance Program), and PR (HIFA: Pregnant Women Initiative) in the state's waiver crosswalk, but these waivers do not show enrollment in FY05. The ES and PR waivers have not been implemented. AL was implemented in 7/06, so enrollment is expected in the FY06 files. In addition, NV listed the TR (non-emergency transportation) waiver in its crosswalk, but no enrollment was reported in the state's FY05 MSIS files even though this waiver was implemented in 2004. The state will work to fix this reporting in the FY06 files. (TR enrollees can be identified by using the managed care enrollment reporting in MSIS. All TR enrollees are also captured as enrollees in NV's non-emergency transportation plan, Plan Type 08 & Plan ID 100500601).

State	File Type	Record Type	Issue
NV	Eligibility	xREVIEW NOTE	SEDS data show an adult CHIP program in NV, beginning in Q1 FY07. Enrollment is about 500 personmonths of enrollment in Q4 Fy07. Add to anoms whenever we get NV's FY06 data and perhaps ask them about it before they submit FY07. Check if NV plans to report adult CHIP program in MSIS & update state characteristics table.
NY	Claims	All	NY expects to only be able to provide NPI's on about 6% of the claims by 2007. They are behind in doing the conversions.
		IP	New York uses a DRG reimbursement methodology except for certain psychiatric and rehabilitation services that NY pays using per diem.
			There are a large number of service tracking claims in the 1999 IP files. These are probably the Lombardi program payments. 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 identified with a Type of Claim of 9 and an Adjustment Indicator of 5 (Gross Adjustment). NY switched to reporting these claims as supplemental claims in 2004.
			40 percent of the claims do not have an Amount Charged in 1999. New York notes that this is correct: "Our claims processing and payment system often utilizes our Procedure File fee schedules and Provider Rate File amounts to determine payments and not the "Amount Charged" entered by provider. For our rate-based service categories, i.e. Clinics, we simply pay the rate amount on our files and do not necessarily validate the "Amount Charged" amount, if any, is entered."
			The percent of claims with a Patient Status is around 10% which is higher than expected. NY does not have an explanation.

State	File Type	Record Type	Issue
NY	Claims	IP/LT/OT	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."
		IP/OT	The New York State Medicaid program does not utilize the UB-92 Claim Form for Hospital Inpatient services nor the HCFA-1500 Claim Form for Hospital Outpatient services. Instead the state uses the EMC Version 4.0 or 5.0. The state has its own rate codes (definitions for the rate codes are in the MSIS documentation). Therefore, there are no UB-92 Revenue Codes on the IP or on Outpatient Hospital Department claims on the OT file.
		LT	The reimbursement for LTC crossover claims is greater than for non-crossover claims, but there are very few crossover claims.
			Some LT claims properly do not have covered days as they are claims for non-bundled services.
			The New York bundled nursing home rate includes maintenance drugs. Therefore claims for those drugs do not appear separately in any file.
			Most supplemental claims are for non-bundled services starting with 2001. In prior quarters these supplemental claims are reported as service tracking claims.
			Some the 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. This situation was corrected using adjustment claims. It does mean that special rules are needed to be developed to properly adjust LT.
			The admission year is not available on these claims.
			Starting in 1999 there is only a small percent of LT claims have a diagnosis code, but it is increasing over time. By 2005 it is at 95%.

State	File Type	Record Type	Issue
NY	Claims	LT	The percent of claims with Patient Liability is much lower than expected.
		OT	NY reports services provided under their OMB MCBS and LTCHHC waivers as service tracking claims. They will be able to submit individual claims starting in 2008.
			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.
			From 2001 to 2006 Q3, NY submitted more PHP capitation claims than person months of enrollment in a PHP plan. NY has no explanation. The ratio of PHP capitation claims to PHP person months of enrollment has been increasing over time. Starting in 2006 Q4, NY only reports HMO capitation claims, even though there are a small number of HMO enrollees shown in the EL file.
			Over 80% percent of the claims have local codes. Most of these are state-specific rate codes.
			AIDS case management expenditures were reported as PCCM capitation claims in 1999. The average payments is quite high as it includes some AID services. In 2000 there claims were reported as PHP capitation claims, having the impact of higher expenditures starting with 2000.
			New York only reports a small percentage of FQHC claims in the 1999 to 2003 files.
			In Q1-3 2006 NY reported some HMO capitation claims as PHP capitation. This was corrected in Q4 2006. They also appear to be using provider identification numbers instead of plan numbers in the PLAN ID field.
		RX	In Q2 to Q3 1999, the NDC field has leading zeros when it contains a HCPCS code.
	Eligibility	County Codes	Until Q2 FY02, enrollment in county code 007 (Broome County) was incorrectly reported as enrollment in county code 005 (Bronx). Therefore, researchers may want to recode.
			New York did not use FIPS for the County Code in Q2 FY 1999. This problem was corrected in Q3 FY 1999. The state also provided us with a crosswalk, which included information on the state codes that were in use in Q2, as well as the corresponding FIPS Codes. Additionally, from Q3 FY 1999 forward, all New York Cities are mapped to one state county code "61." This includes persons residing in 005 (Bronx), 047 (Kings), 081 (Queens), and 085 (Richmond).

State	File Type	Record Type	Issue
NY	Eligibility	Date of Birth	New York usually reports 60,000-100,000 enrollees with no date of birth. Most, but not all, of these enrollees are reported into child eligibility groups. The state believes that most of the enrollees who do not have dates of birth are unborn children. The state assigns ID numbers to unborn children to make sure that they are eligible for services at birth.
		Dual Eligibility Codes	In April 2008, NY eliminated the asset test for QMBs and SLMBs causing an increase in the counts of dual codes 01 and 03 during Q4 FY08. During this time, there was also a decrease in reporting to dual code 06. The state believes this may be due to a delay in the mailing of recertification letters, resulting in some cases not getting processes in time. In addition, as part of the information sent to districts about the elimination of the assets tests, NY reminded districts to assess for the correct dual classification based on income, which may have caused some better reporting. NY's dual reporting in MSIS differs from the state's reporting in the monthly MMA files to CMS. Over time, the count of total duals became more consistent (within 1% in FY08), but the counts of partial duals (codes 01, 03, and 06) remain lower in MSIS compared to MMA through September 2008. Starting in Q1 FY09, the state will be making some changes to its dual code reporting in MSIS that should make these two sources more consistent. These changes include adding in the partial duals that are trying to spendown as well as duals receiving emergency services only. It is expected that these changes will minimize differences between the two sources.
			Until Q1 FY02, New York coded over 60 percent of its dual eligible population with dual flag = 09 (individual is entitled to Medicare, but reason for Medicare eligibility is unknown). This was switched to 08 in Q2 FY02. In addition, NY increased its identification of duals in Q2 and added other dual codes, including dual codes 03, 06, and 07. Nevertheless, New York continued to have relatively small QMB-only, SLMB-only, and QI-1 populations until Q2 FY05 when there was a large increase in the number of enrollees reported to dual codes 03 and 06 (about 7,000 and 20,000 enrollees, respectively) from December 2004 to January 2005.
			In FY05, dual enrollment increased across several dual codes 01, 03, 04, 06, and 08. Presumably, much of this related to NY's efforts to prepare for Part D implementation in 2006. In addition, there was a large increase (about 20,000) in partial duals (primarily codes 03 and 06) in Q2 FY05 when the state identified additional duals.

State	File Type	Record Type	Issue
NY	Eligibility	Dual Eligibility Codes	From month 1 to month 2 during Q3 FY07 (May to June 2007) there was a large increase in the reporting to dual codes 01 and 03. Code 01 increased from about 5,000 to about 16,000 and code 03 increased from about 11,000 to over 14,000. The state indicated there was a systems correction made to correct the coding for Buy-in enrollees resulting in a spike in the number of 01 and 03 dual counts.
			NY discovered that they do not include partial duals that are trying to spenddown in their MSIS reporting. This has caused an undercount in the reporting of dual codes 01, 03, and 06 through FY08. The state expects to make this fix in its Q1 FY09 file submission.
		HIC Numbers	Until Q3 FY02, New York was unable to report HIC numbers for its dual eligibles.
		Managed Care	While New York's comprehensive managed care enrollment compares favorably with CMS data, there was a problem with PCCM and PHP enrollment in FY 1999 and FY 2000. The state assured us that the MSIS data are correct and seemed to think that the CMS data flip-flopped PCCM and PHP enrollment.
			New York's Senior Care Plan is reported as "other" in CMS data, but as "comprehensive" in MSIS.
			Reporting of Behavioral Health Plan enrollment essentially stopped in July 2007 (Q4 FY07). Enrollment dropped from about 6,500 enrollees each month during Q3 FY07 to about 3 enrollees each month in Q4 FY07 when "NY ended BHP enrollment and these claims are now being processed as clinic claims."
			NY reports a small number of partial duals to each of its managed care plans. The state has indicated that this is just some "noise" in the data and doesn't feel it can be improved.
			During FY99, there were major shifts in the number of eligibles with comprehensive managed care plans and PCCMs.
		MASBOE	2002: In addition, many corrections to the MASBOE crosswalk were made in Q2 FY02, moving some children and adults from MASBOE 24-25 to MASBOE 14-15. These changes included state groups 17, 18, 19, 21, and 32. In addition, adults in state groups 68 and 69 were switched from MASBOE 25 to MASBOE 55. And, persons in state group 62 were moved from MASBOE 22 to MASBOE 42. Finally, the elderly in several state groups (17, 18, 19, 21, and 80) were remapped from MASBOE 21 to MASBOE 41.

State	File Type	Record Type	Issue
NY	Eligibility	MASBOE	1999 - 2002: Until Q2 FY02, the number of poverty-related children mapped to MASBOE 34 was lower than expected. Similarly, the number of eligibles in MASBOE 24 and 25 was higher than expected. Finally, until Q2 FY02 no one was reported to MASBOE 31-32 or MASBOE 45. 2002: Also, beginning in January 2002 (Q2 FY02), new state groups 78-79 were added (mapped to MASBOE 14-15), accounting for another surge in child and adult enrollment. These were persons no longer on TANF who continued to qualify for Medicaid through Section 1931 criteria. All Years: NY only reports a small group to MASBOE 35 (poverty-related adults or pregnant women). The reason for this is not clear. Starting in Q2 FY02, some children and adults in MASBOE 44-45 had restricted benefits related to pregnancy. 2005: In March 2005 (Q2 FY05), there was a large increase in the number of enrollees reported to MASBOE 31-32 when NY added over 20,000 new partial duals. 2006-2007: NY experienced an overall decline in Medicaid enrollees during FY06 - FY07. Declines were especially noticeable in MASBOE 14, MASBOE 34, MASBOE 44, and MASBOE 54. 2008: Starting in 2008, NY became extremely current with its submission of MSIS files which seems to have caused a seam effect pattern each quarter. Enrollment in several of the MASBOE groups shows enrollment highest in month 1 of the quarter, and lowest in month 3, but increasing again in month 1 of the next quarter. This may be smoothed out over time by retroactive and correction records. 1999 - Current: NY has an extensive 1115 demonstration extending Medicaid benefits to many low-income individuals. This 1115 coverage began with adults in the state's Home Relief (Safety Net) population in 1997 (including state groups 17, 18, 19, 21, and 39). In October 2001, another group of low-income uninsured adults were added under the Family Health Plus program (state groups 68-69), although this population qualify for a more restricted set of benefits (not LTC, for example). Finally, in October 2002, NY's 1115 was expanded to cover family planning only coverage (state group 56).

State	File Type	Record Type	Issue
NY	Eligibility	MASBOE	2002: In Q1 FY02, major increases in child and adult enrollment (MASBOE 24-25) occurred as a result of the September 11 terrorist attack. These persons were reported to new state code 36. Then, in January 2002, new state group 80 (Disaster Relief) also began to be used for September 11 coverage. (The use of state group 36 was generally phased out by May 2002.) In addition, MASBOE mapping changes effective January 2002 meant that children and adults in both state groups 36 and 80 began to be mapped to MASBOE 44-45, accounting for a major increase in enrollment in these MASBOE groups.
		Private Health Insurance	NY moved to a new data system in FY05 that provided better data for reporting private insurance. This resulted in a 33% increase from Q4 FY04 to Q1 FY05 in the number of individuals reported with private insurance. The state was likely underreporting the number of enrollees with private insurance prior to FY05.
		Race/Ethnicity	More than 20 percent of eligibles in New York have an unknown race code. This increased to almost 30 percent during FY 2002 as a result of increases in enrollment due to the September 11 terrorist attack. In Q1 FY05, NY switched to the expanded race/ethnicity codes. About 7-9% of enrollees have unknown race each quarter.
		Restricted Benefits Flag	Effective Q1 FY05, NY started assigning restricted benefits flag 6 to the Family Planning only enrollees (state group 56). Most of these enrollees are mapped to MASBOE 54-55; however, a very small number are mapped to several other MASBOE groups.
			Effective Q3 FY02, 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). In addition, persons in state group 56 (family planning only) mapped to MASBOE 54-55 were also assigned RBF 5. When NY moved to a new data system in Q1 FY05, 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 and FP enrollees, enrollees receiving other capitated services receive RBF 5.

State	File Type	Record Type	Issue
NY	Eligibility	Restricted Benefits Flag	NY reports some inconsistent mapping of restricted benefits codes and dual codes. In FY06 & 07, some full duals each month are reported with a restricted benefits flag 3 indicating they only qualify for Medicare cost-sharing. In addition, some partial duals are mapped to restricted benefits code 1 indicating that they receive full benefits. The state indicated that there will be some "noise" in NY's reporting due to the size of the Medicaid program, but the state will work to improve this reporting as time permits. In May 2008, NY'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. The state started enrolling individuals in this demonstration starting December 2008 and it is expected that these enrollees will be included in MSIS reporting starting with the Q2 FY09 file submission. These enrollees will be assigned RBF code 8 in MSIS. In FY07, NY generally reported about 2,500 enrollees with RBF 2 each month. This dropped to about 1700 in FY08. We would expect NY to be reporting a higher number of these enrollees unless NY has a state-funded program or some other way of providing coverage for these individuals outside the Medicaid program. The state is reviewing its reporting for RBF 2. Until Q3 FY02, New York had a large group of enrollees (over 40,000 each month in Q4 FY 2001) incorrectly assigned restricted benefits flag 5. They should have been assigned RBF code 1. This error was corrected effective Q3 FY02.
		CHIP Code	However, as this subgroup of M-CHIP coverage was phasing out, NY added another M-CHIP group -- children ages 6-18 with family income of 100-133% FPL. This group had been previously part of the state's S-CHIP program, but they were changed to M-CHIP in 2002 (with retroactive coverage to 2001). These children are reported in state groups 71 and 81 in MSIS data. However, by mistake, they were not coded as M-CHIP children in the MSIS data until FY05. They were also not reported to SEDS in FY01 through FY03, but SEDS reporting for this group began in FY04. Although coverage in state groups 71 and 81 continues, these children were no longer considered to be M-CHIP enrollees after April 2005. Effective May 2005 (Q3 FY05), NY only has an S-CHIP program.

State	File Type	Record Type	Issue
NY	Eligibility	CHIP Code	From 1999 through 2002, NY had a very limited piece of the M-CHIP program that accelerated Medicaid coverage for older children (born before October 1, 1982) with family income to 100% FPL. These older children were reported to state groups 39 and 41, and were correctly identified as M-CHIP children in MSIS data. (They were only a small subset of the children reported to state groups 39 and 41). This M-CHIP subgroup phased out in the fall of 2002, as these older children became a mandatory traditional Medicaid coverage group.
			New York's M-CHIP data in MSIS differ from SEDS numbers through Q1 FY 2001. After that, they are generally consistent in FY01. In FY02, M-CHIP coverage was underreported in MSIS and not reported at all in SEDS. In FY03 and FY04, no M-CHIP enrollment was reported in MSIS (it was also not reported in SEDS for FY03), but the state confirmed that the M-CHIP program was still in operation unitl is phased out in FY05. (M-CHIP enrollment was reported in SEDS again in FY06, but not in MSIS. This SEDS reporting was a mistake as no M-CHIP program in operation during this time.)
			NY does not report its S-CHIP program in MSIS, and it only reported M-CHIP coverage in FY1999-2002 and Q1-2 FY2005. (M-CHIP enrollment was mistakenly not reported in FY2003-2004; however, researchers can identify M-CHIP enrollees by using state eligibility codes 71 and 81.) In Q3 FY2005, NY stopped reporting M-CHIP enrollment when the the program was phased out.
		Sex	Each year a large group of eligibles (more than 50,000) are reported with an "unknown" sex code. These are probably in the unborn group.
		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.
		SSN	In Q2 FY 2002, the proportion of enrollees with SSNs dropped to 81 percent as a result of increases in enrollment due to the September 11 attack. By FY07, NY was reporting over 90 percent of enrollees with SSNs.
			New York assigned over 25,000 SSNs in FY 2001 through FY 2003 to more than one MSIS record. The number continued to rise and reached 49,000 in FY04. By the end of FY07, the number had dropped to about 30,000.

State	File Type	Record Type	Issue
NY	Eligibility	Waivers	No enrollment is reported for NY's SED Children waiver (waiver ID '03', waiver type '3') in FY 2005, 2006, 2007 and 2008 because the state does not have any way of identifying waiver enrollees in its MSIS data. The state indicated the client exception codes were not completed to identify these individuals in the MSIS data. NY initiated a systems project that should permit them to properly identify and report enrollment in this waiver. The state expects to begin identifying these enrollees in MSIS in Q2 or Q3 FY 2009 data.
			NY began to report enrollment in its LTHHCP waiver waiver (waiver ID '09', waiver type '3') in Q4 FY 2006. No enrollment is reported for this waiver in FY 2005, and Q1, Q2 and Q3 FY 2006 because the state does not have any way of identifying waiver enrollees in its MSIS data. The state indicated the client exception codes were not completed to identify these individuals in the MSIS data. NY initiated a systems project that permitted them to properly identify and report enrollment in this waiver.
OH	Claims	IP	IP covered days are incorrectly reported in Q1 2005 and should be ignored.
			Almost all claims have a procedure code from 2004 Q3 - 2005 Q4.
		LT	In 2006 Covered Days are not reported for ICF/MR
			Admission date is missing.
			Diagnosis codes are missing until 2005 Q4.
			Leave days are missing on most claims until 2005 Q4, when they are incorrecty over reported. Starting in Q1 2006 the number of leave days is reasonable.
			Patient status is missing on most claims.
		OT	Physcian specialty codes are missing on all claims.
			The Provider ID Number Servicing fields are not filled in.
		RX	The century is reported as '19' instead of '20' on many date prescribed claims - 1999-2004.
			Other Third Party Payment (or Third Party Liability/TPL) is missing.
			New Refill Indicator is missing.
			Days supply is missing in the 1999-2008 files.

State	File Type	Record Type	Issue
OH	Eligibility	1115 Waivers	OH had a Katrina waiver approved on 12/7/05, but did not report any enrollment in this waiver in MSIS.
		2007 program change	Ohio's Medicaid program, in a statewide expansion initiative, will mandatorily enroll its SSI-eligible population (excluding dual eligibles) into its managed care program by the end of 2007. The state plans to use a regional roll-out strategy for its managed care expansion.
		County Codes	Ohio incorrectly used state-specific county codes in their FY 1999 to FY 2002 files. The state has supplied MPR with a crosswalk, linking together their state county codes with FIPS county codes. This problem was corrected in FY 2003 when OH started using FIPS codes in MSIS.
		Data System Change	Ohio will be implementing a new MMIS system that will be implemented towards the end of 2009. Several corrections and changes (mentioned throughout the anomalies) are planned to be made as part of this implementation.
		Date of Birth	In Q1 1999 1,675 eligibles have birth dates claiming that the person was born in 1999.
		Dual Eligibility Codes	Until FY03, Ohio was only able to code 2 values for dual eligibles; 01 (QMB-only) and 09 (eligible is entitled to Medicare, but reason for Medicaid eligibility is unknown). SLMB only, QI-1, and QI-2 were not included in MSIS uintil Q1 FY03. About half of the increase in duals in Q1 FY03 was caused by the addition of these groups. It appears that some dual code changes were implemented when OH moved to the monthly dual code reporting in Q1 FY06 causing causing shifts from Q4 FY05 (we've asked the state to confirm that 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). There are still differences in the MSIS and MMA comparision, but the state made changes to the MMA reporting and expects the two sources will be more consistent once MSIS time period becomes more current. 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.

State	File Type	Record Type	Issue
OH	Eligibility	Dual Eligibility Codes	OH had some problems with its dual code reporting in FY05. Starting in Q1 FY05, it appears that almost all of the individuals reported to dual code 01 in past MSIS files (about 23,000) may have shifted to dual code 02. However, the count of code 02 increased by about 32,000 individuals total, so it appears that about 10,000 new duals may have been added to code 02 in the Q1 FY05 file as well (other dual counts remained generally consistent). These changes are also reflected in the large increase in the count of total full duals and the large decrease in the count of total partial dual counts for Q1 FY05
			From FY03 through FY04, OH reported about 3,000 - 4,000 partial duals to MASBOE 11-12 and 41-42. Those reported to MASBOE 11-12 are assigned RBF 3, but those reported to MASBOE 41-42 are assigned RBF1. Generally, all partial duals should be reported to MASBOE 31-32. The dual code assignment appears to be corrected starting in Q1 FY05 so that very few partial duals were reported to MASBOE 11-12 and 41-42; however it is unclear whether this change was correct as OH had other issues with their dual code reporting in FY05 (see below). In addition, OH continued to assign RBF 3 to about 2,500 duals in MASBOE 11-12. (This was reduced to about 1,500 duals in Q1 FY06 which the state believes is related to its 209(b) coverage.)
		Federal Fiscal Year/Quarter	OH's Q2-4 FY04 and Q2 FY05 files submitted about 13,000 records as current quarter records (type of record = 1) but with an incorrect FFYQ (see Report 4). In other words, the 13,000 "current" records submitted in Q2-4 FY04 were all labeled as Q1 FY04. In addition, the 13,000 "current" records submitted in Q2 FY05 were labeled as Q1 FY05. The state informed us that the "type of record" field is correctly populated, but the FFYQ field is incorrect. The FFYQ field should be labeled consistent with the quarter in which they were submitted. The state fixed this reporting in FY06.

State	File Type	Record Type	Issue
OH	Eligibility	Managed Care	Reporting to plan type 01 (HMO) increased during Q1 FY06 when OH added new managed care plans. Large increases in enrollment occurred again in Q1 FY07 when there were several changes in reporting to Plan IDs -- some plans terminated enrollment during the quarter, while other plans experienced significant growth resulting in a net increase in HMO enrollment. OH indicated that the state expanded managed care coverage for children and families during this time. In addition, OH passed another statewide initiative to mandatorily enroll the state's SSI-eligible population. Enrollment for this group began in Janary 2007, so it is expected there will be another increase in HMO enrollment in Q2 FY07.
			PACE enrollees have been reported in CMS MC data since FY03, but not identified in MSIS managed care enrollment reporting (Plan Type); however, OH started flaggin PACE enrollees with a "Z" in the Waiver ID field even though PACE is not a waiver. Therefore, all enrollees with 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. We've asked OH to work towards correctly this enrollment reporting in MSIS when the state implements its new MMIS system.
		MASBOE	2003 - 2006: Starting in FY03, OH reported about 7,000 enrollees age 65 plus to MASBOE 32 and about 1,500 age 65 plus to MASBOE 42. This reporting was fixed in Q1 FY07 and the enrollees were reported to MASBOE 31 and 41.
			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.
			All Years: Ohio is a 209 (b) state, using more restrictive rules for Medicaid eligibility than SSI. As such, the number of SSI eligibles reported into MAS/BOE 11 and 12 is lower than the number reported by the Social Security Administration. In addition, most SSI disabled over 65 appear to be mapped to MASBOE 12.
			1999-2001: Through Q3 FY 2001, a higher-than-expected proportion of Ohio's foster care children are over age 21. The percentage reaches as high as seven percent in FY 2001, but is within the expected range of less than one percent by Q4 FY 2001.

State	File Type	Record Type	Issue
OH	Eligibility	MASBOE	2001 - 2003: In FY02 (and FY01 to some extent) enrollment seems to decline for the aged and disabled month one to month three of each quarter and then increases noticeably in month one of the following quarter. Through Q1 FY03, there also seems to be a surge in enrollment in month one of each quarter for adults and in month two for children. This is most noticeable in MASBOE 14-15. The state determined they were using a different age sort for month one compared to months 2 and 3. This problem is fixed in Q2 FY03.
			OH's MASBOE reporting in Q4 FY06 had one unusual pattern. Total aged and disabled enrollment stayed consistent from Q3 FY06 to Q4 FY06, but it appears that there was a large shift of enrollment from MASBOE 11-12 to MASBOE 41-42). These changes occurred across several state-specific eligibility groups. The state indicated it had an error with its SSI indicator in Q4 FY06 and this shift is expected to be fixed in Q1 FY07.
			2003 - 2004: In FY03 and FY04, flucuations in enrollment between 12 and 42 may relate to inconsistencies in identifying SSI disabled recipients.
			2003: From Q4 FY02 to Q1 FY03, there is a noticeable increase in enrollment across all MASBOE groups, probably related to the last submission of this data for purposes of the MMA. In addition, OH added two new groups of duals to its MSIS reporting in Q1 FY03, contributing to this increase in enrollment.
			2001: In January, 2001, child and adult enrollment increased by about 163,000 for an overall gain of 20 percent. About 133,000 recipients were added through a Medicaid Reinstatement project (in response to problems with Medicaid disenrollment related to welfare reform) that ran from January 2001 through March 2001. As a result, MSIS data show a dramatic increase in enrollment in January 2001 and a dramatic decrease in April 2001.
		Private Health Insurance	The number of enrollees reported to Health Insurance flag "2" (receiving 3rd party private health insurance) increased from about 52,000 enrollees per month at the end of Q4 FY05 to about 142,000 enrollees per month at the beginning of Q1 FY06 when the state improved its identification of third party insurance, including the addition of retroactive spans.

State	File Type	Record Type	Issue
OH	Eligibility	Restricted Benefits Flag	In Q1-4 FY05, over 20,000 enrollees in MASBOE 31 and 32 were reported as full duals (an increase from 1,500 in Q4 FY04). We suspect that many of these duals in MASBOE 31-32 should have remained coded as partial duals and this change is related to the shift from dual code 01 to 02 discussed under Dual Eligibility Codes. Also related, over 22,000 aged and disabled full duals were assigned restricted benefits code 3 throughout FY05. Considering the absence of dual code 01 raised earlier, it is very possible that many of these enrollees are partial duals, and should have been reported to dual code 01 instead of 02 or 08. However, the error could also be that these enrollees are full duals who should have been assigned restricted benefits code '1' (full benefits). The dual coding, MASBOE, and RBF assignments look much more consistent in month 1 of Q1 FY06 (but, contain similar errors in months 2-3 as found in FY05).
			Ohio has a sizeable group of eligibles (about 8000 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, but the state was asked to further review this problem in 7/08.
			Beginning in 2008, OH is expected to begin implementation of 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. MPF enrollees will be assigned RBF code 8 in MSIS.
			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.
		CHIP Code	Ohio has an M-CHIP program, but no S-CHIP program. Ohio is somewhat unusual in that some M-CHIP children are reported into MAS/BOE 12. Since Ohio is a 209(b) state, some disabled children do not quality for Medicaid through the SSI-related provisions. However they are able to quality for CHIP coverage.

State	File Type	Record Type	Issue
OH	Eligibility	SSN	OH has several thousand foster care children with two MSIS IDs, but the same SSN. This increased to over 7,000 duplicate SSNs in Q1 FY05. The state is including this fix as part of the new MMIS system that will be implemented towards the end of 2009. Researchers might want to combine these records. 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 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.
		State-Specific Eligibility	Through FY02, a handful of eligibles are missing state-specific eligibility codes in each quarter.
		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. In Q1-2 FY05, OH did not report any TANF enrollment. All enrollees were assigned TANF code 1 (no TANF). This was corrected in Q3-4 FY05 when enrollment was reported at about 190,000 individuals each month. However, from Q1-4 FY06, OH stopped reporting TANF enrollment again and all enrollees were assigned TANF code 1. This was fixed in Q1 FY07 when TANF enrollment was reported again.
		Waivers	OH has been reporting new 1915(c) waivers which are not in the state's approved crosswalk. These include the following waiver IDs: H, U, V, W, X, Y, Z, 1, 3, 6. We've asked the state to update their crosswalk to include these waivers. In the last crosswalk update (in February), OH noted the Residential Facility waiver, type 3 and ID D, ended 6/30/05, yet OH has about 300 enrollees reported to this waiver in each month of Q1 of FY06. The crosswalk also noted that Disability Waiver IV, waiver type 3 and ID 7, and Ventilator Dependent Waiver V, waiver type 3 and ID 8, folded into the Ohio Home Care Waiver in 1998. Yet OH's DQ reports show steady enrollment in both of these waivers in Q1 FY06. We've asked the state to explain this discrepancy.

State	File Type	Record Type	Issue
OH	Eligibility	Waivers	OH's Q4 FY06 waiver enrollment reporting is inconsistent with prior quarters of FY06. The number of enrollees within waivers is very different in this quarter and we've asked the state to explain these changes. [ADD MORE DETAIL TO THIS NOTE ABOUT WHY REPORTING WAS INCONSISTENT.]
		xREVIEW NOTES	From Q1 FY07 review (12/30/09), Marilyn thought the enrollees in "L1" 6-byte codes should maybe be reported to dual code 04 since they are reported to MASBOE 31-32....our MMA comparison shows we have many more dual code 04 enrollees in MSIS than expected and fewer reported to dual code 03. Maybe we can tackle this in FY08.
OK	All	MSIS ID	Starting with Q3 2003, Oklahoma reported that they began using new MSIS IDs. Oklahoma has been asked to convert the "old" MSIS IDs to the new ones, starting with Q1 2003. Prior to that, the MSIS files will contain the old MSIS IDs. The state has submitted a cross-reference file of old and new MSIS IDs. However, there are some 'new' MSIS ID's in the 1999-2002 files. So the crosswalk may be needed.
	Claims	All	The date of payment on voids is the date of payment of the original claim, not the date is was adjusted. This means that many of the void claims have payment dates prior to the quarter.
		Capitation	The state terminated their HMO contracts in December 2003, but there were some outstanding capitation payments that occur in the next quarter. Also they continue to pay HMO's for some deliveries that occur after that time.
		IP	A higher than expected percent of claims do not have UB-92 Revenue Codes. This is because claims from the Indian Health Service and residential treatment centers are not billed on a UB-92. However, the Program Type of Indian Health Service appears to be under-reported in the IP file. The residential treatment center claims should be reported in the OT file.
			Program Type of 5 (Indian Health Service) appears to be under-reported in the IP file.
			There aren't any DRGs as Oklahoma does not use them for reimbursement.
		IP/LT	There are no adjustment claims in the IP and LT files in 2006 - 2007 Q3. The state is checking.

State	File Type	Record Type	Issue
OK	Claims	IP/LT	The dates of payment on voids are often prior to the quarter as they contain the Date of Payment/Adjudication/Adjudication of the original claim, rather than the date of adjustment.
		LT	Most claims do not have a diagnosis code until Q2 2003.
			Patient Status is missing on most claims until Q1 2003.
		OT	Some of the diagnosis codes may have an extra zero or two because this field is not edited by the state. MPR checks only the 50 most frequent diagnosis codes, and these appeared to be correct.
			About 25 to 30 percent of claims have a Type of Service of 19 (Other Services).
			The date of payment on voids is the original date of payment, not the date of the adjustment in Q2/3 2008. This state is going to correct this.
			In Q1 to Q2 2003 there is a significant decrease in the average paid for HCBS claims.
			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.
			PCCM is covered under PHP plans for most people, so what appears to be a shortfall of PCCM capitation claims in some quarters is reasonable.
		RX	The file only has three claims with a Program Type of Family Planning
	Eligibility	1115 Waivers	Then, 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.

State	File Type	Record Type	Issue
OK	Eligibility	1115 Waivers	In 1995, OK had its SoonerCare 1115 waiver approved by CMS. This waiver basically set up a statewide managed care infrastructure. No eligibility expansion was added until until 2005 when the state added family planning only coverage (state group 29FP reported to MASBOE 55).
		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.
			In Q1 FY05, OK's total dual count increased by about 6,000 duals (8%). This was the result of a large increase in the number of duals reported to 02. The state indicated that this increase was the result of a time lag since the FY05 files are being submitted much later than the FY04 files, allowing for more current dual information.
			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 are still some differences in reporting to dual code 04, but this continued to improve over time. The total counts remain consistent.
			Effective 11/99, OK covered all aged and disabled for full Medicaid benefits up to 100% FPL.
		Managed Care	OK implemented PACE in about August 2008, so we expect to see enrollees assigned to Plan Type 06 start about Q4 FY08.
			The second plan reported to Plan Type 08 is a non-emergency transportation (NET) waiver that the state added in January 2003 (Q2 FY03) with Metropolitan Tulsa Transit as the provider. The state switched to another provider, Logisticare, in 8/1/03; however, Logisticare (Plan ID 200010600A) was not reported to the CMS data system until 6/05. However, it was not included in the June 2007 CMS data. Many clients are enrolled in both the hybrid PCCM and the transportation plan, so they have two Plan Type 08s.
			In Q2 FY04 HMO enrollment ceased (185,000 persons in Q1 FY 04), accompanied by a major increase in NET (plan 08) and the hybrid PCCM (plan type 08) in Q2 and Q3 FY04.

State	File Type	Record Type	Issue
OK	Eligibility	Managed Care	In Q4 FY 2001, OK began a more traditional PCCM program for Native Americans. By Q4 FY 2002, enrollment had reached about 2,000 per month and continued to grow. Enrollees of this plan are reported into plan type 07 (PCCM).
			Oklahoma reports a significant number of eligibles with Plan Type = 08 (other) which is used for two different types of managed care plans. The first one is a hybrid managed care program that combines capitated and case management services. Under the plan, physicians are capitated for a limited number of common office procedures and lab work. Additional services are provided on a FFS basis. Physicians also provide a case manager role by referring eligibles to specialists, as needed. These individuals are reported under PCCM in the CMS managed care report for 2003 and under PAHP in 2004 and forward.
			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 is expected to continue growing 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.)
			From June to July 2002, managed care enrollment (HMOs and PCCMs) declined about 10%--cause unknown. By December 2002, managed care enrollment had returned to the June 2002 level.
		MASBOE	2005: From September 2004 (Q4 FY04) to October 2004 (Q1 FY05), enrollment in MASBOE 14 dropped by about 10,000 and enrollment in MASBOE 34 increased by about 14,000. It is believed that is shift is related to the increase in M-CHIP reporting that occurred at the same time when OK made a correction to its assignment of the CHIP indicator.

State	File Type	Record Type	Issue
OK	Eligibility	MASBOE	All Years: Oklahoma is a 209(b) state, using more restrictive rules for Medicaid than SSI. This makes the comparision 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. 1999 - 2003: Until Q1 FY03 some 1931 eligibles are mapped to groups other than MAS/BOE 14 and 15, explaining why enrollment in MAS/BOE 14 - 15 is lower than TANF. All 1931s were not mapped to MAS/BOE 14 and 15 until Q1 FY03. 2004 - 2007: Starting in FY04, OK had some age sort problems. About 250 individuals <65 years in age were reported to MASBOE 31 and about 3,000 individuals age 65 or older were reported to MASBOE 32. The state did some clean-up starting in the Q1 FY06 file that fixed this age sort and caused some MASBOE shifts. About 3,000 individuals in state group "22A4" were shifted from MASBOE 32 to MASBOE 31 and then about 3,000 individuals in state group "24X" were shifted from MASBOE 31 to 41. These shifts in and out of 31 caused total reporting to this group to remain consistent, but reporting to MASBOE 32 dropped by about 3,000 and reporting to MASBOE 41 increased by about 4,000. However, this created a new age sort issue where about 1,400 enrollees under age 65 were reported to MASBOE 41. This greatly improved starting in Q3 FY07. 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. 2005: In Q2 FY05, OK started reporting enrollees to MASBOE 3A under the BCCPTA provisions (state group "BC" in bytes 3-4). 2005: OK reported large increases in MASBOE 44-45 from December 2004 (Q1 FY05) to January 2005 (Q2 FY05). This is mostly due to increased reporting to state groups with "T7" in bytes 3-4 (transitional medical, TANF). The state believes this increase was related to a policy change that occurred during this time. 2003: OK phased out its medically needy program in FY03.

State	File Type	Record Type	Issue
OK	Eligibility	MASBOE	2003: In Q1 FY03, some significant corrections were made to OK's MASBOE crosswalk. These changes resulted in shifts by MASBOE from FY 2002. In particular, many enrollees were moved from MASBOE 34 and 45 to MASBOE 14-15 and 48.
			All Years: Effective 11/99, OK provides full Medicaid benefits to 100% FPL for aged and disabled.
			2003: There were also some changes in enrollment by MASBOE group from Q1 to Q2 FY03 when the state transitioned to a new reporting system. The state believes they were underreporting enrollment in MASBOE 12 prior to this change.
			2003: Oklahoma cannot identify Title IV-E foster care children for MASBOE 48. In addition, until Q1 FY03, non-Title IV-E foster care children were undercounted. Finally, there was a system problem in MASBOE 48 counts in October 2002, causing an overcount for that month. Researchers should probably only use foster care data with caution.
			1999 - 2000: Oklahoma's MAS/BOE 14 - 15 and 44 - 45 enrollment fluctuated greatly during Q4 FY 1999 and Q1 FY 2000. We suspect this was caused by difficulties with TANF delinking.
			2004 - 2005: 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
			1999 - 2002: From FY 1999 through FY 2002, individuals in state-specific eligibility groups CB__00 and KB__00 were incorrectly assigned to MAS/BOE 11 and 12 when they should have been assigned to MAS/BOE 31 and 32. These are persons newly covered under the OBRA 86 provisions allowing coverage for full Medicaid benefits to 100 percent FPL. The state began covering this group in November, 1999. The state fixed this problem in its FY 2003 files.
		Restricted Benefits Flag	Restricted benefits code 5 (other) was generally assigned to medically needy enrollees, which ended in FY03 when the program was terminated.
			Beginning in FY05, FP only enrollees are assigned restricted benefits flag 6.

State	File Type	Record Type	Issue
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. 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. MPF enrollees will be assigned RBF code 8 in MSIS.
		CHIP Code	OK's enrollment for M-CHIP children increased substantially from Q4 FY04 to Q1 FY05 (mostly state group 01A8). The state believes this increase was the result of a correction made by the OK Dept. of Human Services to the assignment of the CHIP indicator for many clients. Previous to Q1 FY05, the state had trouble assigning the indicator, which means there was a possible undercounting of M-CHIP enrollment in MSIS prior to this correction. In addition, throughout Q3 FY03 - Q3 FY05, OK continued to show a large discrepancy between SEDS and MSIS M-CHIP counts. (M-CHIP counts in MSIS are about one-third lower than M-CHIP counts in the CMS SEDS system.) The state believes there is still an error in the SEDS reporting system and maintains that the MSIS counts are correct. Starting in Q4 FY05, the SEDS count appears to make a large correction bringing it more consistent with the MSIS count. In FY 2003, OK had problems with its M-CHIP coding in MSIS, making this data unreliable. M-CHIP reporting fluctuated month-to-month, with unusual drops in enrollment from March through July and then again in December. Starting in March 2003, some persons in state groups 14A8, 15A8, and 17A8 were inadvertently switched to another state specific code, dropped as M-CHIP enrollees, and mapped to MASBOE 14. They should have been mapped to MASBOE 34 and given a CHIP flag = 2. Enrollment reporting increased again by August before declining again in December. From Q2 FY 2001 through Q1 FY 2002, there was a considerable discrepancy between SEDS and MSIS M-CHIP counts. The state believes there was a problem with the SEDS numbers.

State	File Type	Record Type	Issue
OK	Eligibility	CHIP Code	Oklahoma reports its M-CHIP children (codes A7 and A8 in bytes 3-4 of the state specific code) in MSIS. The state does not have an S-CHIP program.
		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 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. (see 3/25/05 email)
		State-Specific Eligibility	In Q1 FY05, there was some shifting of state code assignments when OK changed its state-specific eligibilty coding system to stop using "17" in bytes 1-2.
			In October 2002, OK changed its state specific eligibility coding system.
		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 believes that the MSIS counts are more accurate; however, the difference between the two counts increased to almost 50% in FY07. The state reviewed these counts again, but they are received from a different agency and they are not able to double-check who is being included (see 6/13/08 email). Check the next Q1 file submission and then maybe ask state to start 9-filling.
		Waivers	In FY07 Q1-2, 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. Instead, OK entered the waiver enrollment information for these individuals in the waiver type 2 and 3 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 should be fixed in 2008.

State	File Type	Record Type	Issue
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 will be fixed starting in Q4 FY07.
OR	Claims	All	Because so many people are enrolled in managed care, the distribution of FFS services is sometimes unusual.
		IP	There are nine state-specific DRGs that aren't flagged as state codes.
			There aren't any claims with a Patient Status of 30 (Still a Patient).
		LT	There are no crossover claims.
			The Patient Liability field contains both TPL and Patient Liability. This can't be corrected until the whole system is revised
			In Q1 FY 1999 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.
		OT	There aren't any FFS claims with Program Type of 4 (FQHC) although Oregon has an FQHC program.
			About one third of the claims have a Type of Service of 26 (Transportation).
			Specialty Code is missing on about half the claims on which it is expected to be reported.
			There is a low percentage of dental claims as most people are enrolled in dental managed care.
		RX	There are only original and credit adjustments in the file. The credits are used to void originals. Resubmitted claims are coded as originals.
			The Fill Date and Prescribed Date fields both contain the Fill Date. The state will '9' fill the Prescribed Date field in future submission as it is not available.
	Eligibility	0-filling	Throughout FY05, two individuals were reported each month with blanks in the MASBOE, TANF, state specific, waiver ID, and waiver type data fields. These individuals were not Medicaid enrollees and should have been dropped from the file.

State	File Type	Record Type	Issue
OR	Eligibility	1115 Waivers	OR has had an 1115 family planning waiver since 1999; however, these enrollees are not included in the MSIS data as they are processed outside the state's current MMIS. OR is implementing a new MMIS in 9/07 and is working to include these enrollees at that time.
			OR had a Katrina waiver approved on 3/6/06.
			OR's 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 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 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 implemented a small eligibility expansion for pregnant women and children with incomes between 170-185% FPL, but due to budget cutbacks, the larger expansion for parents and other adults with income between 100-185% FPL has been delayed indefinitely.
			OHP enrollees are divided into two different types of coverage: (1) "OHP Plus" which serves most previous Medicaid enrollees eligible through more traditional categories, as well as expanded coverage to children and pregnant women with incomes between 170-185% FPL; and (2) "OHP Standard" services some previously eligible parents and other adults with incomes below poverty, and possible expanded enrollment (when the 1115 expansion discussed above is implemented) 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.
		County Codes	Prior to FY03, OR's county code data were not reliable.
			The state does not have the FIPS codes for about 6,000 - 9,000 persons and reports them to county code '0' each quarter. In FY05, this improved significantly and the state reported less than 10 persons to county codes '0' and '000' each quarter, and was completely resolved by FY08.

State	File Type	Record Type	Issue
OR	Eligibility	Dual Eligibility Codes	In Q2 FY 2000, Oregon reviewed the dual eligibility status of their eligibles. They discovered that many were coded incorrectly. As a result, we observed a shift from dual flag = 02 to dual flag = 09. Most dual code 09 individuals were shifted to dual code 08 in 2003. In Q2 FY01, enrollment in dual codes 03, 06, and 07 increased substantially. Until Q1 FY03, many persons with dual codes 03, 06, and 07 were assigned restricted benefits code 1 or 5 and reported to MASBOE groups 21-22 and 41-42. It is not clear whether these persons were assigned an incorrect dual code, or they were incorrectly reported to MASBOE 21-22 and 41-42, or incorrectly assigned restricted benefits code 1 or 5. As a result, partial benefit dual coding for SLMB-only and QIs may not be reliable until Q1 FY03 In FY03 and FY04, it appears that SLMB-only and QI-1 eligibles have blank-filled state specific codes, but they are correctly mapped to MASBOE 31-32. This was changed to state code '00' in FY05. 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.
		HIC Numbers	In Q1 FY 1999, Oregon 0-filled the HIC code for about 12,000 persons who were eligible for Medicaid, but not Medicare. This problem was resolved in Q2 to Q4 FY 1999, when the field was correctly 8-filled for these eligibles. In FY 2001, several thousand dual eligibles were added. Many of these had only 9-digit HIC numbers, resulting in an increase in the percentage of dual eligibles with invalid HICs.
		Managed Care	Managed care enrollment declined in FY03 due to a decline in eligibility (medically needy program ended 1/03) and reductions in services (e.g., mental health and dental services).

State	File Type	Record Type	Issue
OR	Eligibility	Managed Care	A large disparity exists between the June 1999 CMS and MSIS PCCM enrollment. It appears as if there was an error in the data reported to CMS. The MSIS numbers are consistent with data from the state's website in FY 1999. Additionally, the MSIS, CMS, and state data are consistent in FY 2000 and FY 2001. However, there may be a slight overcount in managed care enrollment for Q1 FY 2001 due to reporting problems.
			In FY07 Q1-2, OR data showed a drop in reporting to managed care plan type 08 (PCCM) of over 1,000 enrollees. In addition, reporting to managed care plan type 02 (dental) decreased by roughly 13,000 enrollees over the same period. The state confirmed these decreases but did not provide a reason.
			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) program 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.
			In August 2004, restrictions to the managed care auto enrollment process were removed which allowed a large number of recipients to be enrolled in managed care. The result is large increases in comprehensive, dental, and behavioral managed care plans.
			In month 2 of Q3 FY05, OR started reporting about 2,000 individuals each month to managed care plan type 08 (other). These individuals are enrolled in the Kaiser Permanente OR Plus program, which began serving Medicaid enrollees in May 2005. This is a medical PCO (physician care organization) plan that provides physical services only. These enrollees should have been reported to Plan Type 01. This was fixed in the Q1 FY06 file.
			In Q1 FY05, dental plan enrollment increased significantly from month 1 to month 2 and then declined in month 3. These changes appear to be due primarily to fluctuations in plan enrollments. The state confirmed that these numbers look correct. Fluctuations in dental plan enrollment also occurred in later quarters of FY05; however, over the long-term, enrollment remained fairly constant

State	File Type	Record Type	Issue
OR	Eligibility	MASBOE	2003: Oregon's Medically Needy Program ended 1/31/2003. At that time some recipients were determined eligible for other programs and shifted to MASBOE 31-32 (poverty-related aged and disabled) and some to MASBOE 42 (other disabled). All Years: Since 1994, OR has had an 1115 program--the Oregon Health Plan--that expanded eligibility, prioritized health benefits, and relied heavily on managed care. This 1115 waiver eliminated the spend-down component of the state's medically needy program and it also eliminated retroactive coverage, but it expanded coverage to all low-income individuals, including childless adults and eventually college students. Expansion enrollees are reported to MASBOE 55. 2004-2005: Budget cuts caused OR to postpone eligibility expansions in its 1115 waiver. Instead, there was a dramatic decline in the 1115 adult population (MASBOE 55) in FY 2004-2005 due to reduced benefits and new premiums. 2003: In Q1 FY03, enrollment in MASBOE 31-32 increased substantially when OR corrected MASBOE reporting for SLMB only and QI duals. 1999 - 2007: Through Q3 FY07, OR reported about 200 individuals under age 19 to MASBOE 55. The state fixed this age reporting in Q4 FY07. 1999 - current: Beginning in 1999, OR had a family planning only waiver (called FPEP by state); however, these individuals will not be reported to MSIS (through FY07). Their enrollment and claims are handled in a separate system operated by OR's public health department. OR hopes to include them in its new MMIS to be implemented 9/07. 2003 - 2004: In OR's FY03 and FY04 data, OR has entries other than "0" in the monthly fields for many individuals in MASBOE 00. 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 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 in some (but not all) months.

State	File Type	Record Type	Issue
OR	Eligibility	MASBOE	2003: In November 2003, some reprogramming by the state caused a shift in enrollment from MASBOE 16-17 to MASBOE 14-15.
			All Years: Oregon maps most SSI disabled age 65 and older to MASBOE 11.
		Private Health Insurance	OR had a glitch in its processing code that resulted in an undercount of about 5,000 individuals reported with third party/state health insurance (Health Insurance = 4) throughout FY05. The state fixed this glitch starting in Q1 FY06 showing a rebound in the number of individuals reported with third party/state health insurance.
			Each month, a couple of thousand people ineligible for Medcaid received a Health Insurance Flag of "1" or "4". All persons who are ineligible each month should have a health insurance code value of "0". In addition, some persons who are current enrollees have the health insurance field 0-filled starting with Q1 FY01. These problems improved in FY03 and appear to be fixed in FY05.
		Race/Ethnicity	OR made some changes to its MMIS causing some reporting changes in its race/ethnicity data from FY05 Q4 to FY06 Q1. The Hispanic/Latino code was eliminated causing approximately 70,000 individuals to shift from code 5 (Hispanic or Latino) to code 9 (unknown) in the combined race/ethnicity data field. However, the state also started reporting about 20,000 individuals to code 1 (Hispanic/Latino) in the separate Ethnicity code (previously, everyone was reported as "unknown"); however, the count started dropping several thousand each quarter until Q3 FY08 there were only about 130 enrollees reported as Hispanic/Latino. The state indicated that the new MMIS implemented in December 2008 should not fix this reporting to an appropriate level in the next file submission.
		Restricted Benefits Flag	In the first two months of each quarter of FY05, OR reported about 8,000 individuals in MASBOE 31-32 to restricted benefits flag 9 (unknown). In the third month, these individuals were assigned to RBF 3. These individuals should have been reported to RBF 3 in all three months. This was corrected starting in Q1 FY06.

State	File Type	Record Type	Issue
OR	Eligibility	Restricted Benefits Flag	In June 2008, NY'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. It is expected that MFP enrollees will be reported in MSIS starting in Q4 FY08. These enrollees will be assigned RBF code 8 in MSIS.
			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.
			Through 1/03, persons with restricted benefits code 5 (other) were generally medically needy enrollees. Beginning with 2/03 data (after medically needy program ended), restricted benefits code 5 was used for 1115 expansion adults in MASBOE 55.
			OR had had an 1115 family planning waiver since 1999; however, these enrollees are not included in the MSIS data as they are processed outside the state's current MMIS. OR is implementing a new MMIS in 9/07 and is working to include these enrollees at that time.
			Until Q1 FY03, some full benefit duals may have been incorrectly assigned partial benefit dual codes and restricted benefits code 3.
			There was a decline in full benefit dual eligibles after 1/31/03 when the medically needy program for aged and disabled ended.
			In Q1 FY 1999 about 3,000 people in MAS/BOE 21 and 22 received a restricted benefit flag of 3. This error was resolved in Q2 to Q4 FY 1999 when these eligibles were correctly assigned the restricted benefit flag of 5.
		CHIP Code	OR began using state specific codes Z1-Z8 in October 2004 (Q1 FY05) to identify S-CHIP children. Prior to this, the state specific code field was 0-filled for S-CHIP enrollees.
			Oregon reports its child S-CHIP data in MSIS. Its adult S-CHIP program, which began in 2/03 is not being reported to MSIS. The adult coverage is not mentioned in the Title XXI plan (2007). The state does not have an M-CHIP program.

State	File Type	Record Type	Issue
OR	Eligibility	CHIP Code	About 60 persons in FY03 through FY04 who were reported to a valid MASBOE group were assigned CHIP code 0, indicating they were not enrolled that month. They should have been assigned CHIP code 1. In addition, about 216 persons assigned to MASBOE 00 starting in October 2003 were assigned CHIP code 1. We assume they should have been assigned CHIP code 0. The state corrected this problem in Q1 FY05.
		SSN	Each quarter, several hundred SSNs are assigned to more than one record.
		State-Specific Eligibility	Effective Q1 FY03, the state reports about 5,000 - 8,000 persons to a blank state specific eligibility code each quarter. This is a group of SLMB-only's and QI's that are extracted from a file that does not contain eligibility group information. Starting in Q1 FY05, these individuals were assigned to state eligibility code '00'. Beginning in Q1 FY2006, OR dropped the 'SS' suffix to state codes A1, B3, D4, 3, and 4, as they were deemed unnecessary.
		TANF/1931	Oregon's TANF data are overreported from July 2001 through October 2003.
		Waivers	Through Q3 FY07, OR's files showed a small number of enrollees (about 7 each month) in the state's Katrina waiver (compared to about 250 when the waiver was first enrolled). The state confirmed that the waiver expired in June 2006 and these individuals should not have been reported as Katrina enrollees past June.
PA	All	MSIS ID	In 2003/2004 about 3% of the people with claims do not link to the eligibility file. However, most of the problem occurs on encounter claims. By 2005 the linkage problem was mostly corrected.
	Claims	All	PA changed processors and the system change impacted the reported of some OT type of services in the 2005 Q1 file that can not be fixed. 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. The percent of claims paid each month is uneven because the adjudication flow is not always even.

State	File Type	Record Type	Issue
PA	Claims	Delivery cap claims	Starting with Q1 04, 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.
		IP	In Q1 2004 the percent of claims with Family Planning dropped from 1% to 0.
			The Charge on void adjustment claims is positive instead of negative.
		LT	Non-bundled services provided by the facility were moved to the OT file due to state system requirements, until 2004.
			Patient status is missing on most LT claims until Q1 2004 as it was not available in the state system.
		OT	There was a very large increase in the number of claims submitted in the 2004 Q4 OT file. It appears that this is due the presence of many claims paid for earlier periods.
			There are a large number of claims with a Type of Servicde 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.
			In 2004 Pennsylvania transfered to a new processor (EDS) and they should be better able to report waiver claims.

State	File Type	Record Type	Issue
PA	Claims	OT	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.
			Specialty Code is not available for most physician claims.
			Pennsylvania believes that the 1999 to 2002 OT files contain waiver claims, but they all can not be identified by Program Type.
			There aren't any individual PCCM claims until 2003 Q1. Previously they were submitted as service tracking claims.
			Outpatient hospital claims are not billed on a UB-92, so there aren't any UB-92 Revenue Codes on those claims.
			Until Q2 2004 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 Q2 2004 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.
			The diagnosis code on some EPSDT screens is "EPSDT."
		RX	Amount Charged is missing on some claims.
			There are a few claims in Q1 1999 with a Type of Service of 12 (Clinic).
			The Fill Date is reported in both the Fill and Prescribed Date fields. Beginning with Q2 2004 the state will '9' fill the Prescribed Date field as it is not generally available.

State	File Type	Record Type	Issue
PA	Eligibility	1115 Waivers	PA implemented a new Family Planning 1115 waiver on June 1, 2007 (Q3 FY07). A very small of enrollees were reported starting in Q1 FY08 with enrollment expected to increase in Q2 FY08. These enrollees are assigned state-specific eligibility group "PSF00" and mapped to MASBOE 54-55 with a restricted benefits flag of 6.
		Dual Eligibility Codes	Through Q3 FY06, the dual counts in PA's MSIS and MMA files do not compare well; the count of enrollees in dual code 01 was about 30% higher in MSIS and the count of code 04 was about 40% higher in MSIS during these quarters. The state compared the methods for counting enrollment in both MSIS and MMA and made some changes to both sources that will bring the counts more consistent. The majority of changes were made to the MMA processing, as well as some minor changes to MSIS. As a result, in Q4 FY06 the count of dual code 04 in MSIS dropped by about 3,000 from June when enrollees assigned to state-specific eligibility group "PJ 81" shifted from dual code 04 to code 02. This change brought the count of 04s more consistent with what was reported in PA's MMA file. In addition, changes were also made to reporting of dual codes 02 and 08 in PA's MMA file; however, the comparisons will continue to show differences until MSIS data is up-to-date and MSIS and MMA submissions are in sync.
			The dual eligibility flag was 9-filled for all dual eligibles until Q4 FY 2000. In Q4 FY 2000, the eligibles assigned dual flags 8 and 9 were reversed by mistake. This was corrected Q1 FY 2001.
			PA provides full benefits for aged/disabled individuals to 100% FPL, explaining the low number of QMB only.
		Managed Care	Managed care enrollment in Pennsylvania appears to have been under-counted until July 2000. In addition, HMO and BHP enrollment was lower than CMS managed care reports until July 2000 when the counts became more consistent. However, the state believes BHP enrollment continued to be somewhat undercounted until Q1 FY05 when the state made some adjustments to its reporting. This caused a 7% increase in BHP reporting from Q4 FY04 to Q1 FY05 and brought the numbers much closer to the CMS managed care counts.
			Beginning in Q4 FY04, PA changed the managed care plan ID number for several plans. See 7/07 plan ID crosswalk for mapping the old ID numbers to the new ID numbers.

State	File Type	Record Type	Issue
PA	Eligibility	Managed Care	Pennsylvania did not report the approximately 125,000 enrollees of Magellan Behavioral Health that are included in the CMS managed care count until Q4 FY 2000. In addition, Pennsylvania did not report PCCM enrollment in MSIS until Q4 FY 2000 (152,000/month according to CMS data). 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. Prior to FY04, PA used different Plan ID's in its Claim and EL files. The state submitted a crosswalk matching the two sets of ID's. Beginning in FY04, the state started using only one plan ID in both EL and Claims files. Starting in FY07, PA's behavioral health enrollment showed steady increases when the state added several new BHP plans. Pennsylvania shows a substantial increase in enrollment in managed behavioral health care plans across FY 1999, as Pennsylvania incrementally moved counties into the managed care system. In Q1 FY 2000 to Q3, the increase continued, but was more gradual. In January 2004, PA adopted a new system that was able to separately identify the PACE enrollees from the LTC enrollees. Therefore, some enrollees in plan type 05 (LTC) shifted to plan type 06 (PACE) in the Q2 FY04 data. Prior to Q2 FY04, all PACE enrollees were reported in plan type 05. Another shift between LTC and PACE occurred in Q3 FY05. In Q1 FY05, six individuals each month were assigned a Plan ID 1 = "80" (in bytes 1-2), but had the Plan Type 1 field 8-filled. These individuals should have been assigned Plan Type 7 and had the Plan ID field 8-filled. 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.

State	File Type	Record Type	Issue
PA	Eligibility	Managed Care	From December 2005 (month 3, Q1 FY06) to January 2006 (month 1, Q2 FY06), PA's HMO enrollment (Plan Type 01) dropped from about 1.2 million enrollees per month to about 1.0 million enrollees. The decrease occurred across all Plan IDs. The state indicated that this occurred because the state dropped all adult dual eligibles from its Physical Health managed care plan with the implmentation of Part D.
			Starting in the CMS June 2006 report, PA reported 33,127 individuals in a Disease Management 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.
		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 MASOBE 31 - 32 have full Medicaid benefits. In addition, SSI disabled age 65 and older are mapped to MASBOE 11.
			1999 - 2006: PA discovered that they were undercounting Medicaid recipients in the eligibility files. In the Q3 FY06 file, they estimate that claims were submitted for about 26,000 enrollees for which there was no corresponding eligibility record. PA fixed this undercount starting in the Q4 FY06 eligibility file, which caused an increase in reporting across several MASBOE groups, but the biggest increases were in reporting to MASBOE 34 (16,000 enrollees) and to MASBOE 14 (4,000 enrollees). The state is not certain to what extent the problem existed in previous quarters, but they estimate that there are approximately 1.4% too few recipients in earlier files.
			2005: In Q3-4 FY05, PA temporarily switched how it reported disabled SSI recipients in MSIS. For these two quarters, PA reported disabled SSI recipients age 65 and older to MASBOE 12. Both before and after these two quarters, the state consistently reports these recipients to MASBOE 11; however, this change caused some unusual shifts in reporting to MASBOE 11-12 from Q2 to Q3 FY05, and then again from Q4 FY05 to Q1 FY06.
			1999: During the first two months of Q4 FY 1999, there was an increase in enrollment of about 37,000 persons in MAS/BOE 14 - 15. This change reflects the fact that Pennsylvania had to reinstate some people who improperly were terminated from Medicaid because they no longer received welfare. Enrollment returned to its original level during the third month of the quarter.

State	File Type	Record Type	Issue
PA	Eligibility	MASBOE	1999: In Q1 FY 1999, about 700 foster care/adoption assistance children in state groups PC34, TC 33, and TC 34 are incorrectly reported in to MAS/BOE 44, causing an under-count in MAS/BOE 48. This problem was corrected in Q2 FY 1999. 2000: In Q4 FY00, PA made several changes to its MSIS MASBOE reporting. Some groups were dropped as part of the change, meaning that they were incorrectly reported prior to this period. For other groups, MASBOE mapping changed. As a result, overall enrollment dropped by about 112,000 from Q3 FY00 and there were major shifts by MASBOE group. Declines in MASBOE 14, 15, 21, 32, 35, and 42 were only partially offset by increases in MASBOE 41, 44, and 45. The attached chart shows the mapping changes from Q3 FY00 to Q4 FY00. 2005 - 2006: Total child enrollment dropped from 817,000 in October 2005 to about 780,000 by June 2006 (a 5% decrease). This continued into Q1 FY07. Most of this decrease was due to a drop in reporting to MASBOE 34 (state group PS16), although there were also drops in reporting to MASBOE 24 and 44 (MASBOE 14 showed a smaller increase). (Even though child enrollment declined through Q3 FY06, it came back--as discussed above--in Q4 FY06 when the state discovered a reporting error across several MASBOE groups.) In addition, total adult enrollment stayed relatively consistent during this time, however, there appears to be some shifts between MASBOE groups. Enrollment in MASBOE 15 and 17 increased, while MASBOE 25, 35, and 45 all decreased. The state confirmed these numbers, but are uncertain of the cause. The state indicated that there were no policy changes at this time and believes some of the changes might have been the result of improved reporting and data clean-up. 2003: In Q1 FY03, PA corrected a mapping error. Prior to this time, state group PU27 was incorrectly mapped to MAS/BOE 15, instead of MAS/BOE 17. This caused the upward shift in MAS/BOE 17 enrollment in Q1 FY03.

State	File Type	Record Type	Issue
PA	Eligibility	Private Health Insurance	In FY 1999 through Q3 FY 2000, about 17 to 20 percent of Pennsylvania's Medicaid population had private insurance, which is greater than expected. In Q4 FY 2000, the number of eligibles with private insurance dropped dramatically. Prior to this time, Pennsylvania officials indicated they were probably overcounting private insurance eligibles, since persons with Black Lung benefits and Workers' Comp benefits were being counted. In addition, they continued to count persons with private insurance who became Medicare eligible as continuing to have private insurance (when that insurance probably expired).
			The number of enrollees with private health insurance (Health Insurance = 2) dropped from just under 200,000 at the end of Q4 FY05 to about 150,000 in Q1 FY06. The state indicated that this drop was the result of some data clean-up and the new count is more accurate.
		Restricted Benefits Flag	Until Q3 FY 2002, about 18,000 persons in MAS/BOE 45 mistakenly received restricted benefits flag 5: other. They should have received RBF 1: full benefits.
			Pennsylvania's RBF data are unreliable in FY99 through Q3 FY02. In Pennsylvania's Q4 FY 2000 through Q3 FY 2002 files, the restricted benefits flag is miscoded for many dual eligibles in MAS/BOE 21 - 22, 31 - 32, and 41 - 42. In Q3 to Q4 FY 2002, most of the problems are resolved; however, about 2,000 persons in MAS/BOE 31 - 32 still receive restricted benefits flag 0. The state fixed this, for most, but not all, in FY 2003.
			Effective FY03-04, PA assigned restricted benefits flag 5 to all medically needy aged, disabled, and adults (but not 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.
			In Q1 FY05, PA stopped assigning RBF 5 to the majority of medically needy adults by mistake, although most medically needy aged and disabled continued to be assigned RBF 5 after Q1 FY05. Only a subset of medically needy adults (about 6,000 of 35,000) were assigned RBF 5, while the rest were assigned RBF 1. In Q3 FY05, PA resumed assigning RBF 5 to all medically needy adults.

State	File Type	Record Type	Issue
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). The state will work to improve this reporting. In addition, in Q1-4 FY06 about 60-180 aged and disabled non-duals each month were mapped to restricted benefits flag 3. This reporting improved by FY08. PA assigns restricted benefits flag 9 to about 600 individuals each month in MASBOE 31-32. The state indicated that this is due to a data problem they are not able to fix.
		CHIP Code	Pennsylvania has an S-CHIP program, but no M-CHIP program. The state does not report its S-CHIP enrollment.
		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 is able to report actual SSN's 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.
		State-Specific Eligibility	2003 - Current: In Q2 FY03, PA added byte 3 information to its state specific eligibility codes. Byte 3 data identifies LTC residents and HCBC waivers. Also in Q2, PA shifted some of its state specific eligible codes, but this did not affect MASBOE patterns.

State	File Type	Record Type	Issue
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 signficiant drop from December 2006 to December 2007 causing enrollment to be about 46% higher in MSIS. The state has been asked to clarify if MSIS reporting is still reliable.
		xREVIEW NOTE	Watch in Q2 FY08 that new FP enrollees are assigned RBF 6, MASBOE 54-55, and Waiver Type F.
RI	All	MSIS ID	The is a small linkage problem between claims and eligibility but it occurs mostly on encounter claims and by 2005 the linkage is very good.
	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.
		All	The 1999 claims files have serious problems that can't be fixed due to the limitations of the source files (MARS). Rhode Island will have to change their system in order to fix most of these problems. Although the reporting has improved a bit, the system has not been changed. The date of payment on void adjustments is the date of payment of the original and not the date the void was adjudicated.
		IP	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-92 form. There are no DRGs. There is only one UB-92 Revenue Code on each claim because that is all that is available in the source files. Most of claims have an accommodation code and a few have only a ancillary code.
		LT	The diagnosis code is missing on most LT claims until Q1 2004 when they are reported on 100% of the claims. The file does not contain leave days.

State	File Type	Record Type	Issue
RI	Claims	LT	There are not claims with a Type of Service of Mental Hospital for the Aged.
		OT	A large percent of claims are for Type of Service 33 (Rehabilitation Services), and most of these have a Place of Service of 53 (Community Mental Health Center).
			There aren't any claims with a Type of Service of 34 (PT and other therapies).
			About 30 percent of the claims in the OT file have a Type of Service of 19 (Other Services).
			2004 Q1-2 - the date of payment on voids is the date of payment on original claims. This was corrected starting with 2004 Q3.
			In 1999 and 2000, there are some very large Medicare Coinsurance and Deductible payments that can't possibly be correct. Rhode Island was unable to fix them. They should be ignored.
			There are some Supplemental Claims with a Type of Service of HMO.
			Many claims with a Type of Service of 11 (Outpatient Hospital) have a pharmacy revenue code.
			RI bills supplimental payments to HMO's with Type of Claim = 5 and Type of Service = 20.
		RX	The Quantity of Service on most claims is 0.
			Date Prescribed is always missing.
			There aren't any claims with a Program Type of 2 (Family Planning). ??check that this is right since this actually said a Type of Service of FP??
	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. Currently, state officials have indicated that most of these participants are assigned health insurance code 2; however, the state has been asked to change this to either 3 or 4 in the future, probably FY07 at the earliest. RIte Share claims for these participants are included in MSIS. RI's RIte Share enrollment level was estimated at about 6,400 in March 2007 (1115 document).

State	File Type	Record Type	Issue
RI	Eligibility	1115 Waivers	Beginning in 1994, Rhode Island had 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 1/97, it also covered children 8-19 years 100-250%, but then that group also became the first M-CHIP population. Until 1/01, it also covered pregnant women 185-250% when this group was transferred to M-CHIP as well. However, in 11/02 RI switched to covering "unborn children" < 250% FPL under a separate -- S-CHIP plan. From 1/98 to 1/01, 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 1/01.
			RI had a Katrina Waiver Approved on 2/17/06, but did not include these enrollees in their MSIS reporting. Total enrollment count was small (<75 individuals).
		County Codes	Rhode Island has 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.
		Dual Eligibility Codes	Overall, the total count of duals in RI's MSIS and MMA files compares well, but the count of code 02 (QMB+) is lower in MSIS and the count of 08 is higher. The state is reviewing this reporting for 2008 file submissions.
			Starting with FY03 MSIS data, RI did a review of Medicare data matching which resulted in about a 10% (3,000 person) increase in the state's total dual count.
			Effective by at least 2001, RI extended full Medicaid benefits to all aged/disabled up to 100 percent FPL. However, it is unclear where they enrollees are being reported as there are no full duals being reported to MASBOE 31-32. The state is reviewing this reporting for 2008 file submissions.
			Prior to Q2 FY 2002, more than 95 percent of Rhode Island's dual eligible population receive the dual flag 09.
		Managed Care	Starting in the June 2006 CMS managed care enrollment counts for RI, 28 individuals were reported as enrolled in 'PACE Organization of Rhode Island' managed care. However, RI's MSIS file does not include any PAC enrollment. The state will include this reporting starting in FY08.
			Some people with PLAN TYPE = 01 (comprehensive) have 8-filled PLAN IDs. This is caused by a problem with the program used to generate MSIS data. The problem was fixed in FY 2000.

State	File Type	Record Type	Issue
RI	Eligibility	Managed Care	The 2007 June CMS report included about 33,000 individuals enrolled in United Health Care Dental - Rite Smiles. RI's MSIS FY07 reporting does not include any dental managed care enrollment. We've asked the state to review why these two sources are not consistent.
			RI overreported HMO enrollment from Q2 FY00 through Q1 FY03. This overreporting was because the state continued reporting enrollees to Plan IDs 'HCO8064' and 'PHO8260'. There should not have been any enrollees in these plans after 12/31/99. The plan type code should have been 8-filled.
		MASBOE	All Years: RI reports about 200-300 persons under age 65 to MASBOE 31. These enrollees should probably be reported to MASBOE 32; however the state does not program an age break for enrollees assigned to MASBOE 31 and 32.
			1999-2003: Until Q2 FY03 almost 100-350 persons were incorrectly included in MASBOE 44-45 (state groups GA & GC) who were state only enrollees, not title XIX enrollees.
			2001: In Q2 FY 2001, Rhode Island moved a large group of adults previously reported in MAS/BOE 45 to MAS/BOE 55 (state group CN) as it implemented M-CHIP coverage for adults.
			2000: In July 2000, Rhode Island increased its income threshold for the aged and disabled reported into MAS/BOE 41 and 42. This caused many enrollees previously enrolled in MAS/BOE 21 and 22 to move.
			2002-Present: In FY 2002, Rhode Island reported in MSIS about 12 percent more SSI enrolled than what SSA reported. This increased to 15-17 percent in FY 2003-2005. The state indicated that there might be about 2,000-3,000 enrollees that still carry the SSI category code but are no longer getting SSI. They should have probably moved into another MASBOE group; however the state is not able to separate them out. The state is reviewing SSI reporting for FY08 data submission.

State	File Type	Record Type	Issue
RI	Eligibility	Private Health Insurance	RI's Q2 FY06 file shows an apparent shift of about 30,000 enrollees from health insurance code '1' (no insurance coverage) to code '2' (third party insurance). We've asked the state if there a reason for this increase in reporting of third party insurance. Then, from month 2 to month 3 in Q4 FY06, it appears another 8,000 enrollees appear to have shifted from code 1 to code 2. The state believes it incorrectly shifted individuals in Part D and a Dental Benefits Manager program into HI code 2. So, from Q2 FY06 forward, HI reporting became unreliable. RI will fix HI reporting starting in Q1 FY08.
			In Q1 FY 2002, there was a noticeable increase in insurance coverage. This was likely an error, since the Q1 FY 2003 rates returned to the previous levels.
			RI's RIteShare program was implemented in 2001 and participants should have been assigned health insurance code 3 (or 4 if an employer also pays part of the premium in addition to the state). However, most of these participants receive HI code 2. There is no way to identify these participants. The state has been asked to start assigning HI code 3 or 4 to these enrollees starting in Q1 FY08. (The ~50 enrollees assigned to HI code 3 through Q1 FY06 are not RIteShare participants.)
		Restricted Benefits Flag	A small number of full dual and non-dual enrollees are assigned restricted benefits flag 3 each month. RI hopes to fix this assignment in FY08.
			In FY 2000, a MAS/BOE coding flaw resulted in a lower than expected proportion of person with restricted benefits code 3 being reported to MAS/BOE 31 - 32.
			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.
			Until FY 2002, by mistake, M-CHIP parents in MAS/BOE 55 were assigned restricted benefits flag 9. They should have been assigned flag 1 ("full benefits"). This was fixed in FY 2002. However, about 2,000 persons in other groups continued to receive flag 9 throughout FY 2002.
			Medically needy enrollees are assigned restricted benefits code 5 ("other").

State	File Type	Record Type	Issue
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 their correction records to be included in MSIS. Analysis of Rhode Island's corrections shows that most are not changing key data elements.
		CHIP Code	The MSIS M-CHIP count differs from SEDS in some quarters, but the MSIS numbers appear to be more reliable. In particular, the counts of M-CHIP children consistently remain about 10-12% lower than the counts in SEDS. RI indicated that the two systems use slightly different methods of counting, but the MSIS counts are more precise. Beginning 1/97, Rhode Island covered children 8-19 years 100-250% FPL as an M-CHIP group. Then, in 1/01 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 1115 program while the parents were previously covered under the state's 1931 provisions. Then, effective 11/02, RI added an S-CHIP program covering unborn children up to 250% FPL (including undocumented aliens). S-CHIP children are not reported to MSIS.
		SSN	Rhode Island has been reporting temporary SSNs as “666xxxxxx” since "666" is a sequence of numbers that will never be used by SSA as a valid "area code". In Quarter 3, 2007, the state identified 1,740 individuals with a SSN beginning with “666”. The state has been asked to 9-fill these SSNs starting with "666" in its Q1 FY08 file submission.
		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. We've asked the state to ask CMS for permission to 9-fill the TANF data element.
		Waivers	RI included Waiver W8 (HCBS Habilitation) in the state’s waiver crosswalk, but it does not report any enrollment in MSIS. The state explained that there has not been any enrollment in this waiver, yet. RI's Q2 FY05 MSIS EL file incorrectly included enrollment in waiver ID 99, with waiver type 9. All waiver ID values of 99 should be replaced with 88 and all waiver type values of 9 should be replaced with 8 in this quarter's submission only.

State	File Type	Record Type	Issue
RI	Eligibility	Waivers	In Q1 FY05, RI reversed the identifiers for Waiver W2 (HCBS DEA) and W3 (HCBS MRDD). Enrollees reported to W2 should have been reported to W3, and vice-versa. The state corrected this error in its Q2 FY05 file.
		xNEXT REVIEW	check that RI starts 9-filling some SSNs (see 5/8/08 emails)
	Encounter	IP	In 2002, Patient Status is missing on most IP encounter records.
			In 2002, UB-92 Revenue Codes are missing on most IP encounter records.
SC	Claims	Adjustments	The files do not contain any IP/LT/OT adjustment claims. South Carolina expects to be able to start submitting them at the end of 2004.
		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.
		IP	A large percent of the claims are for crossovers
			The average Medicaid Amount Paid on crossover claims is higher than expected in some quarters.
			There is a big drop in IP crossover claims after 2001. This may be due to the method of reimbursement for crossover services.
			There aren't any claims with a Patient Status of 30 (Still a Patient).
			The state submits very large expenditures on service tracking claims.
		IP/LT	In Q3 2004, South Carolina made Disproportionate Share Hospital (DSH) payments for two prior quarters in addition to the current quarter, so the DSH amounts appear to be very large for Q3 2004.
		LT	Through 2001 submission 1, over 13 percent of claims are for ICF/MR
			Admission date is usually missing.
			Patient Status is missing on most LT claims.
			On the South Carolina LT files, diagnosis codes are only available on claims for Type of Service 04 (IP psych claims).

State	File Type	Record Type	Issue
SC	Claims	LT	Patient liability has an ETR of 100percent, but is actually present in the file.
			Leave days are usually missing. The field is usually '0' filled instead of '9' filled when the days are unknown.
		OT	Through 2001 submission 1, very rich list of places of service (lots of detail)
			Transportation capitation claims were mostly submitted as service tracking claims until 2007 Q2. 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.
			The number of PCCM capitation claims is somewhat lower than expected based on the person months of enrollment in PCCM managed care.
			Q1 FY 1999 file has over a thousand FFS claims with a Type of Service of 21 (PHP Capitation Payment). This problem was corrected in Q2 to Q4
		RX	Date Prescribed is always missing.
	Eligibility	1115 Waivers	SC had a Katrina 1115 waiver approved on 10/21/05.
			From 2003 through December 2005, SC had a prescription drug only 1115 demonstration program for low income seniors up to 200 percent FPL. This program -- called SilverRXCard program -- was reported as state-specific eligibility code 1092 and was mapped to MASBOE 51. To be on Silvercard, an individual had to be over 65 and not have any other pharmacy coverage through private health insurance. These enrollees were assigned to dual code 09, but some SLMB only and QI persons fell in this category and remained with a dual code 03 or 06.
			Beginning in 1993, SC implemented an 1115 program adding family planning only coverage. In 2001, enrollees in this program are reported to MASBOE 54-55.
			In FY06, reported no enrollment to its Family Assistance 1115 waiver, type 1, and ID A. The state explained that it no longer enrolls individuals in this waiver. The enrollees that were previously assigned to this waiver ID are now assigned as 1902(R)2 (waiver type 1, ID 1).
		County Codes	South Carolina submitted files using state county codes instead of FIPS county codes from Q1 FY 1999 to Q2 FY 2001. The state has submitted a crosswalk of state codes to FIPS.

State	File Type	Record Type	Issue
SC	Eligibility	Date of Birth	South Carolina had some problems with their date of birth variable in 1999 Q2. Some of their records have "9-filled" DOBs. A few other records indicate, implausibly, that the eligible was born in 2000.
		Dual Eligibility Codes	In FY 1999, about 13 percent of duals were coded with 09. The proportion of duals with 09 grew throughout FY 2000, however. By Q4 of FY 2002, 34 percent of duals received code 09. Dual coding was greatly improved in Q1 FY 2003. Generally, no one was assigned dual code 09 after 2003, except for persons in the Silver RX program. The Silver Rx program ended 12/05. Beginning in FY99, South Carolina generally reported only two values for dual eligibles -- 02 (QMB plus full Medicaid) and 09 (eligible is entitled to Medicare, but reason for Medicaid eligibility is unknown). However, in Q3 FY 2002, SC reported a few enrollees (fewer than 50) with dual eligibility flags 03, 06, and 07. In Q4 FY 2002, all enrollees were in dual eligibility groups 02 and 09 again. In FY 2003, fuller dual reporting began. 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. Enrollment in dual code 08 increased 14 percent from Q4 FY05 to Q1 FY06. The state believes this increase is related to the start-up of the Part D program. For its 1115 Silvercard drug program (also referred to as "SilveRxCard"), which began in 2003 and ended in 12/05 (Q1 FY06), SC defaulted to dual code 00 in cases where the state could not determine whether an individual was Medicare eligible. Dual code 09 was used if the state knew the Silver Rx enrollee was dual eligible and the person did not qualify under dual codes 03 or 06. In FY06, SC discovered a problem with its reporting of QMBs in MSIS resulting in an undercount of enrollees in dual code 02 and an overcount of enrollees in dual code 08 up to this time. In Q4 FY06, about 33,000 duals shifted from dual code 08 to code 02 to fix this error. Most of these duals were mapped to MASBOE 11-12 and MASBOE 31-32. A small number of dual code 08 enrollees remained in MASBOE 11-12 after the shift, but all 08s in MASBOE 31-32 moved to dual code 02.

State	File Type	Record Type	Issue
SC	Eligibility	Dual Eligibility Codes	Starting in Q1 FY06 with the monthly dual flags, SC's data show that in Month 1 of each quarter, about 300 full benefit duals (dual codes 02, 04, and 08) are assigned restricted benefits flag '3' (restricted Medicaid benefits related to Medicare cost-sharing). These numbers taper off by Month 3 of each quarter, but we generally expect that full benefit duals are assigned RBF 1 (entitled to full scope of benefits). This problem was corrected in FY 08.
		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.
			In 2001, CMS also reports 4,000 enrollees in a "high-risk channeling project" as an other managed care plan. The enrollees in this project are not reported in MSIS as a managed care plan. According to state officials, this plan terminated August 2002.
			Through Q3 FY06, SC reported all PACE enrollees to a 9-filled Plan ID, which is an invalid plan ID number. This was corrected in Q4 FY06 when the State started reporting PACE enrollees to several valid plan IDs.
			Behavioral health enrollment dropped from about 250 persons to about 2 persons during Q2 FY06 when the state terminated enrollment in the program.
			South Carolina's Physician's Enhanced Program (PEP) is a hybrid PCCM program. In MSIS, it is coded as Plan Type 08 ("other"). In CMS data, it has been reported in several categories over time, including "other" (6/99), PCCM (6/00 and 6/02), BHP (6/03), PIHP (6/04), and PAHP (6/05 forward).
			There was a shift in SC's managed care enrollment from month 1 to month 2 in Q3 FY08 when a PCCM company dropped out of Medicaid, causing over 20,000 individuals to move from PCCM enrollment to either HMO managed care or FFS. Enrollment increases occurred across most of the HMO plans reported in MSIS.
		MASBOE	2006 - 2007: SC's total Medicaid enrollment declined by about 9 percent from October 2006 (Q1 FY07) to September 2007 (Q4 FY07). This was primarily due to drops in reporting to MASBOE 14 (cash children), 34 (poverty-related children), and 55 (waiver adults). The state was not able to identify any reason for this decline.

State	File Type	Record Type	Issue
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. 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. 2000 - 2003: In Q1 FY 2000 and Q1 FY 2001, South Carolina categorized disabled SSI beneficiaries aged 65 and older as "disabled." That is, they were mapped to BOE 2. In FY 1999 and the remaining quarters of FY 2000 and FY 2001 to FY 2003, these individuals were categorized as aged (BOE 1). All Years: South Carolina provides full Medicaid benefits for the aged and disabled up to 100 percent FPL. 2008: In FY08, SC reported about 1100 persons age <65 yrs. to MASBOE 11, 31 and 41. In addition, 3500 persons age >64 yrs. were reported to MASBOE 32 and 42. The state was asked to correct this problem in the future. 2001: Beginning in May 2001, South Carolina reinstated approximately 45,000 persons whose Medicaid eligibility was improperly terminated when they lost welfare benefits. 2004 - 2005: SC has a large group of enrollees (about 80,000) who are enrolled in a 1115 family planning waiver under state-specific eligibility code 3055. These family planning enrollees were incorrectly mapped to MASBOE 44-45 instead of MASBOE 54-55 though FY04. Generally, these enrollees were assigned restricted benefits flag 5. Beginning in Q1 FY05, they were reported to MASBOE 54-55 and assigned RBF 6. 2006: Enrollment in MASBOE 51 ended in Q2 FY06 when SC terminated its SilverCard program. 2003: In the summer of FY 2003, child and adult enrollment dropped in SC, when the state moved to a new automated eligibility redetermination system.

State	File Type	Record Type	Issue
SC	Eligibility	MASBOE	2002 - 2005: In the fall of 2002, SC implemented a SLMB-only program for 135 to 175 percent FPL (state code 1049 mapped to MAS/BOE 31). However, this program only lasted until December 2002. Then, in January 2003, SC implemented a prescription drug only program for low income seniors up to 200 percent FPL. This program -- called the SilveRxCard program -- is reported as state-specific eligibility code 1092 and is mapped to MAS/BOE 51. Many of the eligibles also qualify for Medicare cost-sharing as SLMB-only enrollees. To be on Silvercard, an individual must be over 65 and not have any other pharmacy coverage through private health insurance. Some SLMB and QI persons fall in this category and remain with a dual code 03 or 06. The Silver Rx program ended in 12/05.
			All Years: SC reports about 3,000 persons age 65+ to MASBOE 32 (poverty-related disabled). These enrollees should probably be reported to MASBOE 31. The state has been asked to review this reporting for future file submissions.
		Race/Ethnicity	In each quarter, about four percent of South Carolina's eligibles have an "unknown" race.
		Restricted Benefits Flag	A small number of individuals in MASBOE 11-12 and 41-42 are assigned restricted benefits flag '3' in FY06 and 07. We generally expect that all enrollees in these MASBOE groups are receiving a full scope of Medicaid benefits and would be assigned RBF 1. This problem was corrected in FY08.
			Until FY05, a subset of enrollees in MAS/BOE 44 - 45 were assigned restricted benefit flag code 5 (other) since they only qualified for family planning benefits (state group 3055). These individuals should have been mapped to MASBOE 54-55. Starting in Q1 FY05, family planning enrollees were assigned restricted benefits flag 6 and mapped to MASBOE 54-55.
			Beginning in 2008, SC is expected to begin implementation of 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. MPF enrollees will be assigned RBF code 8 in MSIS.
			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 has been asked to clarify what restrictions are involved.

State	File Type	Record Type	Issue
SC	Eligibility	Restricted Benefits Flag	From FY03 through Q1 FY06, restricted benefits flag 5 was also assigned to enrollees in MAS/BOE 51 - 52, who received prescription drug benefits only through South Carolina's 1115 waiver for low income seniors.
		Retroactive/Correction Records	SC has consistently reported a small number of retroactive and correction records to quarters dating back to 1998. The state has been asked to restrict these type of records to the three previous quarters, but has not changed its practice.
		CHIP Code	South Carolina reports its M-CHIP enrollment. The state does not have an S-CHIP program until April 2008 when the state implemented Health Connections Kids that covers children in families with 150 - 200% FPL.
			In Q3 FY08, SC included the new Healthy Connection Kids (S-CHIP) enrollees in its MSIS reporting (state-specific eligibility code 3099, and maybe 5099, 6099, but have asked state to clarify if the last two are S-CHIP); however, these enrollees were reported incorrectly to MASBOE 99. In addition, these individuals were assigned valid codes in other monthly fields, such as Plan Type. These enrollees should have been assigned to MASBOE 00 and had the monthly fields 0-filled (except state eligibility code and the CHIP flag). We've asked the state to fix this reporting by either resubmitting Q3 FY08 or through correction records.
			M-CHIP enrollment dropped about 6% in the first month of FY00 and about 10% in the first month of FY01. The state reported that it moved older children from M-CHIP to Medicaid at these times.
		TANF/1931	Effective Q2 FY 2002, South Carolina no longer reported TANF data. However, the state 1-filled this data element, instead of 9-filling it. In Q1 FY05, the state started 9-filling this data element.
		Waivers	SC's Q3-4 FY05 files did not include data for enrollees in the state's Katrina waiver. The state submitted retro/correction records in its Q2 FY06 file to correct this missing information from earlier quarters.
		xxReview Note	SC implemented a new S-CHIP program in April 2008; however, for the Q3 FY08 review we did not have SEDS data to compare this new enrollment reporting. When the Q3 SEDS data becomes available, it would be good to go back and double-check the S-CHIP reporting in MSIS (will have to look at state specific groups in MSIS since CHIP flag and MASBOE assignments were incorrect).

State	File Type	Record Type	Issue
SD	Claims	Encounter	There are no encounter data in Q1 1999. However, the state in its application stated that managed care encounter data would be included in the claims files. South Dakota only has one plan.
		IP	In Q1 to Q4 1999, South Dakota mapped Crippled Children's Hospitals to the IP file with Type of Service 01 (Inpatient Hospital). They can be identified with a provider ID in the format of 021xxxx.
			The UB-92 revenue codes are missing on many I.H.S claims.
		LT	There are no original, non-crossover claims in Q1 1999 with Other Third Party Payment (or Third Party Liability/TPL).
			The IP covered days are mostly missing on claims with a Type of Service 04 (Inpatient Psychiatric Services for those Under Age 22) KFF says SD does not cover this service.
			There are very few diagnosis codes on the file.
		OT	Virtually everyone is enrolled in Delta Dental managed care. In 1999 the PHP capitation claims are actually encounter claims from Delta Dental with the Medicaid Amount Paid by DD to their providers. Starting in 2000, this problem is straightened out and the file contains the true dental capitation claims with a Type of Service 21 (PHP).
			In 1999, some lab claims are incorrected reported with a Type of Service of Physican. This was corrected starting in 2000.
			IHS claims are billed on a UB-92, with a Type of Service of 12 (Clinic). These claims have revenue codes, but do not have Service Codes.
		RX	The state put the fill date in both the Fill and Prescribed Date fields.
	Eligibility	County Codes	25 to 30 persons are assigned county code 131, an invalid FIPs entry. In addition, 7200 persons each quarter are assigned county code 999. In Q1 FY 2003, SD curtailed the use of county code 131. They also drastically cut the number assigned to county code 999.
		Dual Eligibility Codes	Until Q1 FY 2003, South Dakota assigned the dual flag 09 to over 50 percent of their dual eligibles, because they could not correctly identify the dual groups to which these people belong. In Q1 FY 2003, the dual coding was improved, although the state slightly reduced the number of full benefit duals.

State	File Type	Record Type	Issue
SD	Eligibility	Dual Eligibility Codes	In Q2 FY07, SD reported a small number (<5) individuals to dual code 09.
		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 are enrolled in dental care.
		MASBOE	1999 - 2006: Children in state aid category code 53 (Non IV-E foster care children) were reported to MAS/BOE 44 in error until Q2 FY06. (The state aid category is reported to bytes 2-3.) They should have been reported to MAS/BOE 48. The state corrected this mapping starting with the Q2 FY06 file causing a decrease in reporting to MASBOE 44 and an increase in MASBOE 48. 2006 - 2007: Total enrollment decreased about 5% across several MASBOE groups from August (Q4 FY06) to September 2006, and then rebounded back in October (Q1 FY07). The cause for this pattern is unknown.
		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.
		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.
		Retroactive/Correction Records	Retro/correction records submitted in Q1 FY06 forward left the quarterly dual field blank. This is a problem for about 3,000 records included in the Q1-4 FY06 and Q1-3 FY07 files that affect quarters prior to FY06 when the quarterly dual flag was still required. These retro/correction records correctly populate the new monthly dual field, so the last monthly code can be substituted for the quarterly dual code.
		CHIP Code	From Month 1 of Q3 FY07 to the end of Q4 FY07, SD's M-CHIP enrollment count jumped about 20 percent (about 7,000 enrollees per month to about 9,000). Most of the jump was due to a correction in the eligibility system processing and probably means that M-CHIP enrollment was undercounted prior to Q4 FY07. South Dakota reports its M-CHIP children and S-CHIP children. However, the S-CHIP program was not implemented until Q4 2000. In Q4 FY05, SD's M-CHIP count in MSIS was about 44% lower than the count reported in the CMS SEDS system. The state discovered that there was an error in the SEDS reporting and confirmed that the MSIS count is correct.

State	File Type	Record Type	Issue
SD	Eligibility	CHIP Code	In Q3-4 FY04, SD's S-CHIP count in MSIS was about 20% lower than the count reported in the CMS SEDS system. The state discovered that there was an error in the reporting to SEDS and confirmed that the MSIS counts are correct.
		SSN	South Dakota has between 400 to 800 records on each file with duplicate SSNs. The state has reviewed this duplicates, but is not able to make improvements due to limitations of their data system. Duplicate records are created by the source files that read into the eligibility system and are not always able to be merged.
		State-Specific Eligibility	In Q1 FY03, SD moved to a new coding system for its state specific eligibility codes. Until Q1 FY03, the aid category information was in bytes 1-2. In Q1 FY03, this information shifted to bytes 2-3.
		TANF/1931	South Dakota cannot identify their TANF recipients. This field is 9-filled for all eligibles.
		Waivers	Starting in Q1 FY05, SD did not 0-fill the Waiver Type 1-3 and Waiver ID 1-3 data fields for all persons reported as “not enrolled” in MASBOE 00. The state corrected this error starting with Q2 2006.
TN	All	All	All records except for those submitted in the FFY 2005 files contain the original state RID (Medicaid ID) in the MSIS ID fields. The FFY 2005 files all have the current RID instead of the original RID. The state has submitted a cross reference file that needs to be used to replace those MSIS ID's with the original RIDs if the files are to be used across FFYs.
	Claims		From 1999-2002 virtually everyone was enrolled in an HMO, except for LTC services and records for crossover claims with Medicare Coinsurance and Deductibles. 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. However, the Plan ID is sometimes, but not always reported through 2004 Q4. The state has been asked to report it consistantly.

State	File Type	Record Type	Issue
TN	Claims	All	Starting in July 2002 and continuing on Tennessee has been paying the managed care plans a $10 administrative fee and then paid the plans on a FFS basis for services provided to their members. These FFS claims are being produced from the plans encounter data systems but include the Medicaid Amount paid. Two of the managed care organizations (MCOs) have been working under that arrangement since July 2001. The MSIS claims files for July 2001 - June 2002 will not be corrected.
			Starting with 2005 Q4 there is a reduction in the number of claims as TN reduced enrollment and implemented a limit of 5 prescriptions per month per enrollee.
			BHO Pharmacy Claims were carved out of managed care during the period of HMO enrollment.
			The MSIS reporting for 2004 is based on legacy files for the most part as the result of a system change. There are several problems with those files that can not be corrected, including incomplete reporting and some missing variables.
		Capitation	Starting in Q3 2007, 2 HMO plans returned to a full risk status (000000031A, 000000032A). This means that these plans will not be submitting any FFS claims after that time. There are still some plans who are providing no-risk based services so there claims are submitted as FFS and the capitation amount is for the administrative fee only.
			The FFS claims from BHO's stopped in Q2 2006 as the BHO's returned to full risk status then.
			There was a massive adjustment to capitation claims in August 1999. Until the state becomes current with their submissions, they will only submit original and debit adjustment capitation claims. When an original claim is adjusted in the Tennessee system, the original is replaced with a credit claim, voiding the original and the original no longer exists in their files. In Q3 1999 when the massive adjustment took place, in the state system there are only credit and debit claims that cancel each other out. We requested that until they become current, that they not submit the credit capitation claims.
		Dental	Dental services were also carved out the managed care plans starting with July 1 2002 and they were included in the MSIS files as encounters with $0 paid. Tennessee has been asked to resubmit these claims properly flagged as FFS with the Medicaid Amount Paid.
		IP	The IP file only contains encounter and FFS crossover claims due to managed care enrollment from Q1 1999 through Q2 2002.

State	File Type	Record Type	Issue
TN	Claims	IP	TN does not report DRGs.
			TN does not report covered days on all claims.
			There aren't any claims with a Type of Service 02 or 04 in the LT file. However, there are some Type of Service 04 encounter claims in the IP and OT files. The state has been asked to move them to the LT file in future submissions.
		IP/LT	There is a big increase in the number of IP and LT FFS claims in 2006 Q2. It is likely due to a claims timing issue.
		LT	There is a big drop in the percent of Type of Service 05 (ICF/MR) claims in Q4 2000.
			There is a shortfall of claims in Q4 1999 because Tennessee did massive adjustments. The claims show up in later quarters.
			There is an increase from about 10,000 FFS claims in Q1 to Q3 2000 to about 50,000 in Q4 2000.
		OT	Dental services were carved out from the managed care organizations (MCOs) starting with October 2002 and administered by a Dental Benefits Manager (DBM). Claims for those services were also included in the MSIS claims files, but again as encounter claims, not FFS. These claims will be converted to FFS and the Medicaid Amount Paid included and resubmitted to CMS starting with Q1 2003 (Oct. 2002).
			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.
			Starting with Q3 2002 with the switch from encounter to FFS claims, the Program Types of FQHC and RHC are not reported and there is a big drop in the number of waiver claims. Beginning with Q1 2005 a small number of FQHC, RHC and waiver claims are reported.
		RX	The 2002 Q2 and Q3 files are missing the RX claims paid by plans, but wouldn't have been paid by the state. Starting with Q4 2002, all paid claims are included in the file.
			The Fill Date is also entered in the Prescribed Date field from Q3 2002 forward on FFS claims.
			The days supply is missing on about 15% of the claims.
			The adjustment claims do not have the NDC.

State	File Type	Record Type	Issue
TN	Claims	RX	Starting in 7/96, all BHO pharmacy services were carved out of managed care and starting with July 2000 the pharmacy claims for duals were carved out. Tennessee began carving out all the remaining pharmacy services starting with July 2003. These services were submitted as encounter claims with $0 Medicaid paid. The expenditures have not been reported as service tracking claims. This results in a vast under-reporting of RX expenditures in the MSIS files. CMS has requested that Tennessee resubmit the MSIS files starting with 2002 Q4 with the corrected Medicaid Amount paid and the claims flagged as FFS, not encounter. Any expenditures they can not report as individual claims will be submitted as service tracking.
	Eligibility	1115 Waivers	TN renewed its TennCare 1115 waiver in October 2007. The renewed waiver included a demonstration expansion of Medically-Needy non-pregnant adults who would have been eligible as medically needy under the state plan. There was a delay getting individuals enrolled under the waiver, so few (if any) individuals were reported to this waiver (MASBOE 55) in Q1-2 FY08. The state expects that the numbers will increase in later FY08.
			TN had a Katrina 1115 waiver approved on 10/6/05, which was implemented in Q4 FY05.
			TN has had a long standing 1115 waiver demonstration to extend eligibility to low-income persons (including the aged and disabled) who would not otherwise have qualified for Medicaid. For many years, the waiver also moved the vast majority of Medicaid enrollees to managed care, although this changed over time.
		Dual Eligibility Codes	In Q1-4 FY07, TN mapped roughly 500-1400 aged and disabled non-duals per month to RBF code 3 (restricted, dual eligibility). It appears that these non-duals (dual code 00) are in MASBOE 31 and 32 (poverty-related aged and disabled enrollees) and mapped to state groups 000012, 000042, and 000099. It is uncertain whether these enrollees were assigned the wrong RBF or the wrong dual code. The state improved this reporting in Q1 FY08 and expects further improvements later in FY08.
			In Q1-2 FY07, TN mapped about 100-300 aged and disabled full duals per month to restricted benefits code 3 (restricted, dual eligibility). We believe these duals should have been assigned restricted benefits flag 1 since they should be receiving a full scope of Medicaid benefits. This mapping only occurred in Q1-2 and appears corrected in Q3 FY07.

State	File Type	Record Type	Issue
TN	Eligibility	Dual Eligibility Codes	TN had a major shift in the number and distribution of duals in Q4 FY04 when the state implemented a new computer system. As a result, total duals in MSIS increased by 7 percent, and the number of partial duals more than doubled. Dual code shifts involved substantial increases in 01, 02 and 03, and a decline in 08. In early 2006, TN implemented new policies that restricted Medicaid enrollment and affected dual counts. The state's total dual enrollment dropped 6% from Q1 to Q2 FY06. In addition, the new policies restricting enrollment caused many full duals (codes 02, 04, 08) to shift to partial benefit status (code 03) during FY06. TN implemented new cutbacks in Medicaid eligibility for the aged and disabled and general TennCare cutbacks that restricted Medicaid enrollment and affected dual counts starting in Q4 FY05. Total dual enrollment fell about 6% during FY06. In addition, many full duals (codes 02, 04, 08) shifted to partial benefit status (code 03) as a result of the new state Medicaid policies. Total dual enrollment dropped from Q3 FY05 to Q4 FY05. Eligibility cutbacks were made to the TennCare program resulting in some duals being dropped in August 2005, however, they should still be counted in MSIS for this quarter since the dual code is a quarterly value. It appears that the state underidentified some duals during this quarter. This should be fixed in MAX with the EDB link. Differences in MSIS and MMA dual codes occurred until April 2006 because MMA did not use eligibility data to help assign dual codes until that time. Prior to Q1 FY03, the vast majority of full benefit duals were assigned dual code 08. Another problem was that all enrollees (including the partial duals) were assigned to HMOs and BHPs, even though partial duals did not qualify for this coverage. The error was fixed in Q1 FY03, but then in Q1 FY05, partial duals had the managed care fields 0-filled instead of 8-filled by mistake. This problem was corrected in Q2 FY05. TN reports many enrollees in MASBOE 11-12 to dual code 08 as the state does not have income information for many of these individuals due to a long standing court case requiring the state to maintain Medicaid eligibility for persons leaving SSI.

State	File Type	Record Type	Issue
TN	Eligibility	Dual Eligibility Codes	TN had some major problems with is dual eligible reporting until Q1 FY03. Until Q1 FY03, many duals were incorrectly assigned dual codes 01 and 03, as well as restricted benefits code 3. Instead, they qualified for full Medicaid benefits, and they should have been assigned dual codes 02, 04, or 08 and restricted benefits code 1. When this problem was corrected in Q1 FY03, <10,000 persons were assigned dual codes 01 and 03, plus restricted benefits code 3, compared to 52,000 with this set of codes in Q4 FY02. This gives some sense of the problem's proportion. In Q1 FY03, there was also a major decrease in duals reported to dual code 08, with more going to dual codes 02 and 04.
			TN reports QI-1 enrollees to dual code 03 (SLMB-only) since the state does not have a separate code for this group.
		Managed Care	TN reports Managed Care plan "First Health Service Corp" (plan ID 000000061A) to plan type 08. This plan is limited to pharmacy benefits management.
			Although TN started reporting enrollment in Doral Dental (its pharmacy benefits manager plan) to MSIS in Q4 FY04, the state did not start reporting dental enrollment to the CMS June managed care report until 2006. The enrollment counts in the two sources do not compare well in 2006 or 2007. The CMS count was about 45 percent lower in June 2006 and 55 percent lower in June 2007(cause unknown).
			In June 2007, MSIS HMO counts compared well with CMS counts. However, CMS BHP counts were 33 percent lower than MSIS counts because 2 BHP plans (AmeriChoice and AmericGroup) were not included in TN's CMS data.

State	File Type	Record Type	Issue
TN	Eligibility	Managed Care	Beginning in July 2002, TN converted its managed care system so that its HMOs and BHPs were no longer bearing risk. Instead, TN pays them a capitated fee to process FFS claims for their enrollees from their network of providers. In addition, starting in Q4 FY04, TN began reporting to plan type 02 and 08 for its dental and pharmacy programs, which also have capitated administrative fees. Although states should not report non-risk plans in MSIS managed care reporting, TN received special permission from CMS to continue reporting HMO, BHP, dental, and pharmacy plan enrollment in MSIS. TN expressed that these plans are considered "shared risk" by the state since the plans can be penalized for not meeting defined targets or goals in their contracts. However, starting in January 2006 (Q2 FY06), BHPs went back to full risk-based and BHP reporting from Q2 FY06 forward is again consistent with how CMS defines managed care for MSIS. In addition, effective April 1, 2007 (Q3 FY07), two HMO plans moved to full-risk (AmeriChoice and AmeriGroup Community Care) and it is expected that others will follow in the future. Enrollment in these full-risk plans can be identified by their Plan IDs (000000031A and 000000032A, respectively), but total HMO enrollment will continue to be a mixture of full-risk and share-risk plans. TN will continue to update CMS & MPR when the status of its managed care plans changes.
			In Q4 FY04, TN began including PACE reporting (Plan Type 06) in its managed care reporting.
			Beginning in July 2002, TN converted its managed care system so that its HMOs and BHPs were no longer bearing risk. Instead, TN paid their network providers a capitated fee to process FFS claims for their enrollees. As a result, in July, enrollees were shifted from managed care plan types 01 and 03 to plan type 08 and continued to be reported to HMO and BHP Plan IDs. However, these non-risk plans are not considered to be managed care plans, so the Plan Type and Plan ID fields should have been 8-filled from July - December.
		MASBOE	All Years: Since the early 1990's, TN has had an 1115 waiver to enroll the vast majority of its Medicaid population in HMOs. The waiver also greatly expanded eligibility.
			All Years: Tennessee reports a much higher number of eligibles in MAS/BOE 11 and 12 than expected, given the number of SSI recipients in the state. This may relate to a long-standing court case from 1987, requiring the state to maintain Medicaid eligibility for persons leaving SSI.

State	File Type	Record Type	Issue
TN	Eligibility	MASBOE	2002: After many quarters of growth, child and adult enrollment dropped about four percent in January 2002 (cause unknown). 2003: In Q1 FY03, TN had some major changes to its MASBOE reporting. First, as mentioned in the duals section, the state has been incorrectly reporting many persons to MASBOE 31-32 as restricted benefits dual eligibles. When this problem was corrected, enrollment declined in MASBOE 31-32 and increased in MASBOE 21-22 and 41-42. 2005: By mistake, several thousand persons were reported to MASBOE 99 instead of MASBOE 00 in Q1 FY05. All Years: Researchers should be aware that many persons age 65 and older are mapped to MASBOE 12. However, since these are disabled SSI recipients, their MASBOE mapping was not changed. 2003: As a result of a major reverification effort, there were enrollment declines in MASBOE 44-45 and 52-55 in Q1 FY03. Many, but not all, of these enrollees appeared to shift to MASBOE 14-15, 24-25 and 34-35. Nevertheless, there were still noticeable declines in disabled, child and adult enrollment in Q1 FY03. 2003: More declines occurred in MASBOE 54-55 in Q3 FY03 as TennCare made another round of eligibility redeterminations, although overall child and adult enrollment rebounded by the end of the year. 2002: Total reported enrollment declined by 2.5% in March 2002 because the state had not yet received all data before running the MSIS file. This will be corrected through retroactive records. 1999: In FY99 Q1-4, over 4,000 individuals younger than age 65 were reported into MAS/BOE 31. This problem was generally corrected in FY00 Q1. 2005-present. TN continues to have disabled persons age 65 or older reported to MASBOE 12, 22, 32 and 42.

State	File Type	Record Type	Issue
TN	Eligibility	MASBOE	2005-2006: In Q4 FY05, TN implemented major cutbacks to its 1115 expansion that restricted Medicaid enrollment. These policy changes resulted in significant decreases in reporting to MASBOE 24-25 and 51-55; however, there were some offsetting increases in MASBOE 14-15, 31-32, and 44-45, so that overall aged/disabled enrollment only declined slightly. Declines continued in FY06, especially among the aged (13%) and adults (11%), and somewhat in FY07. In addition, these cutbacks caused many full benefit duals to move to partial benefit status. 2007: Over 20,000 enrollees shifted from MASBOE 44-45 (state groups 30, 34, 36) to MASBOE 14-15 (state group 31) during Q4 FY07. This occurred because as of July 2007, TN “de-linked” the application process so that recipients who qualified for TANF no longer automatically qualified for Medicaid. Recipients now have to apply for TANF and Medicaid separately. When the twelve-month extended benefits period expires, recipients must apply for recertification under both programs. As a result, TN started reassigning more recipients to MASBOE 44 and expects this to continue until all MASBOE 14 recipients have cycled through the recertification process. 1999-2004: Beginning in 1999, by mistake, thousands of persons age 65 and older were mapped to MASBOE 52 and 55 who should have been mapped to MASBOE 51. And, persons age 65 and older were mistakenly mapped to MASBOE 22, 32, and 42 instead of 21, 31, and 41. This was corrected in Q4 FY04. 2004: In Q4 FY04, TN implemented a new computer system. As a result, enrollment by state specific code changed considerably for some groups, even though the state codes per se were unchanged (except that 4 leading zeros were added). In addition, TN submitted a new eligibility crosswalk, correcting some MASBOE errors, particularly with regard to aged enrollees. This led to many changes by MASBOE group. Some changes in dual code reporting also occurred. 2005: In Q4 FY05, TN implemented a Katrina waiver.

State	File Type	Record Type	Issue
TN	Eligibility	MSIS ID	Through Q4 FY04, TN reported the ORIGINAL RID (state Medicaid ID number) in the MSIS ID field in the eligibility file. However, from Q1-Q4 FY05, the state's new data contractor switched to sending the CURRENT RID instead of the ORIGINAL RID in the MSIS ID field (the RID changes when an enrollee has a change to some key data fields, such as managed care plan or BOE; therefore the "current" is not always the same as the "original"). If someone's RID had changed, then a different number was used as a "current' RID compared to the "original" RID. The state sent a cross reference file that contains the SSN and all RID's with the "original" in the first RID field and "current" in the last. This file can be used with the FY05 files to replace the CURRENT with the ORIGINAL RIDs (this link will be used in the creation of the MAX files).
		Private Health Insurance	Prior to July 2004, TN was not able to verify 3rd party insurance status. TN implemented a new computer system in 7/04 allowing the state to start verifying this status. It was determined that only a small percent of enrollees would be flagged as verified, causing a significant decrease in the reporting of private insurance in Q4 FY04. In FY05, increases in private insurance rates were reported as the state improved its TPL system.
		Restricted Benefits Flag	Starting in Q1 FY06, TN started assigning restricted benefits code 2 (individual is eligible for Medicaid but only entitled to restricted benefits based on alien status) for undocumented immigrants that qualify for emergency services under TN's Medicaid program. Until Q1 FY03, many more dual eligibles were assigned restricted benefits code 3 than should have been. In Q1-3 FY07, TN mapped roughly 5-10 individuals per month in MASBOE 41 (other, aged) to restricted benefits flag 4 (restricted, pregnancy) and state groups 000010 and 000016. These aged individuals should have been assigned RBF 1 (full benefits) instead of receiving the restricted benefits for pregnancy. The state will fixed this in Q4 FY07.
		CHIP Code	From Q1 through Q3 FY05, a subset of M-CHIP children (about 10,000-15,000 children each month) had the CHIP flag 9-filled by mistake. These children should have been assigned CHIP code 2. This problem was corrected in Q4 FY05 data.

State	File Type	Record Type	Issue
TN	Eligibility	CHIP Code	CMS approved an S-CHIP expansion for TN, called CoverKids, in January 2007 (Q2 FY07) for children under age 19 with family income at or below 250% FPL and who are not eligible for Medicaid or TennCare. Additionally, pregnant women who meet other eligibility criteria can receive maternity coverage through CoverKids. This new expansion did not start covering children until April 2007, however, TN is opting not to report this new S-CHIP enrollment information in MSIS. Enrollment in SEDS should start in Q3 FY07. In addition, there was about a 3,000 decrease in M-CHIP enrollment reported in MSIS from January to February 2007 when this expansion was implemented, so it is possible that some enrollees shifted over to this new coverage. Then, in FY04, Q4, the state began reporting over 50,000 children each month as M-CHIP children in MSIS. Again, the motivation was to get the higher FFP rate for some children (using the provisions of U.S.C. 1397ee(g), according to state officials). The first set of M-CHIP children were reported to the CMS SEDS system, but the enrollment beginning in Q4 FY04 is not. In addition, the state's Title XXI plan does not indicate an active M-CHIP program during Q4 FY04 and forward. SEDS data for M-CHIP, however, started showing enrollment in FY07 allowing for a comparision of what is reported in MSIS. TN's Q4 FY07 M-CHIP count in MSIS is 14 percent higher than the most recent count reported in SEDS (Q3 FY07. TN indicated that a lower age cutoff age of 18 years in MSIS compared to 19 years in SEDS. In addition, some enrollees in MSIS were assigned multiple state-specific eligiblity codes resulting in some enrollees mistakenly being assigned CHIP code 2 when they should have been assigned CHIP code 1. It is believed that the net effect of these issues resulted in an overcount of M-CHIP enrollment in MSIS that will be corrected in TN's Q1 FY08 file. These issues with reporting of M-CHIP enrollment go back to the Q4 FY04 file when this M-CHIP enrollment was first reported in MSIS. During FY 1999 - FY 2002, the data varies widely from CMS' SEDS system. The state could not explain the discrepancy. In addition, the M-CHIP data in MSIS approximately doubles in Q1 FY 2001, due to growth in state group 87 ("TennCare Uninsured"). This increase does not appear in the SEDS numbers. However, MSIS and SEDS are consistent in that both data sets show a gradual decline in M-CHIP enrollment across FY 2001 and FY 2002.

State	File Type	Record Type	Issue
TN	Eligibility	CHIP Code	Tennessee has had an M-CHIP program for many years, but did not have an S-CHIP program until 2007. MSIS data show enrollment in the M-CHIP program from FY99 - FY02 and then again from Q4 FY04 forward. When CHIP was first enacted, TN identified a group of children already covered under TennCare as M-CHIP enrollees, so the state could get the higher FFP rate for some children. Over time, fewer children met the definition of the M-CHIP coverage group, so that none were reported by FY03.
		SSN	TN is submitting what appear to be valid SSNs for 100 percent of Medicaid enrollees each quarter, but there are problems. 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. TN does not have any records with the SSN field 9-filled. MPR staff used the high group test to check the SSNs submitted in TN's FY07 Q3 MSIS file and found that 1.24 percent (n=16,138) of the reported SSNs did not pass the SSA high group test, because of invalid numbers in the AAA fields. TN has since indicated that the state reports some individuals with an AAA of "888" as a pseudo SSN. In Q3 FY08, the state will start 9-filling the SSN field for these individuals where SSN information is not available.
		TANF/1931	Tennessee under-reported the number of TANF recipients in their FY 1999 MSIS files. The state corrected this issue over time, so that by FY 2002 the numbers were close. However, effective FY03 through FY06, TANF counts were no longer reliable. By Q1 FY07, TN reported about 397,000 TANF enrollees in MSIS compared to about 162,000 TANF enrollees reported by ACF. The state did an extensive comparison of the methodology used to report MSIS counts vs. ACF counts and discovered that the ACF counts are wrong (only reporting new enrollees instead of total enrollment). The state believes the MSIS is accurate.
		Waivers	TN’s Waiver ‘09’ (HCBWMRDD) was approved 1/1/05, however enrollment information was not reported in TN’s Q2-3 FY05 files. The state estimated that enrollment in this waiver was about 90 individuals during Q2 FY05 and about 270 individuals during Q3 FY05. Information for waiver enrollees was correctly added to the file starting in Q4 FY05.

State	File Type	Record Type	Issue
TN	Eligibility	xREVIEW NOTE	(1) In Q1 FY08, look for change in M-CHIP count in MSIS when TN is supposed to fix age break and EL code assignments. Review anom note to ensure correctly reflects change (e.g., confirm that MSIS was previously overcounting M-CHIP). (2) see if state starts 9-filling SSNs in Q1 FY08; (3) watch new 1115 enrollment in FY08 to see if indeed it is an eligibility expansion -- then enrollees in it should be reported to MASBOE 55 (1115, adult), and assigned Waiver Type = 1 (1115).
	Encounter	OT	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.
		RX	The Fill Date is missing, only the Prescribed Date is populated from 1999 Q1 - 2002 Q2.
			The NDC is missing on adjustment encounter records.
			The Type of Service is missing on most RX encounter records.
TX	Claims	All	The provider ID numbering system was changed Q3 2001. The old and new IDs need to be crosswalked in order to adjust claims.
			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
			Texas initiated a co-payment program for Medicaid in December 2002. These co-payments can not be included in the IP, OT or RX files as there isn't a Patient Liability variable.
			In Q4 2002, Texas started a patient co-pay program. These payments can only be reported in the LT file in the Patient Liability field.
		Crossovers	There are a few crossover claims with very large Medicare Coinsurance and/or Deductible Amounts Paid. Texas will code the Coinsurance field as 99996 and put the Medicaid Amount Paid in the Deductible field.
			Most crossover claims have Medicare coinsurance/deductible amounts, but have a $0 amount paid.

State	File Type	Record Type	Issue
TX	Claims	IP	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.
		IP/OT	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.
		LT	From Q1 1999 to Q4 2000 the, LT files are missing the following data elements: Admission Date, Patient Liability, and TPL. The following variables are missing in the Q1 1999 file: Diagnosis and Covered Days. The following variables are missing in the 1999 files, but are reported starting with Q1 2000; Charge, Leave Days, Patient Liability. The state had to build the Q1 1999 file from very incomplete old records. NHIC's new claims system promises much more complete data starting Q3 2000. from a Long Term Care claims history file that did not contain data essential to MSIS reporting. This was due to a new Long Term Care Claims Management System that was developed, however, the history data was not available for MSIS processing." Texas expects to have these data for FY 2000 because their system will have captured these data.
			The diagnosis codes are missing on many claims and is inconsistantly reported quarter to quarter.
			Leave days are missing starting in 2005 Q1.
			Patient Status is missing on most LT claims.
			Some resubmittal adjustment claims are reported as originals.
		OT	In Q4 1999 almost two percent of the claims have the invalid diagnosis code of "02."
			The OPD claims do not have UB-92 revenue codes.
			The Q2 and Q4 1999 OT files have some claims with a date of adjudication prior to the quarter.
			TX submits a few HMO capitation claims with a type of claim of FFS instead of capitation. This are premium payments for private health insurance.

State	File Type	Record Type	Issue
TX	Claims	OT	There are a few claims in Q4 1999 with dates of service after the quarter.
			The capitation payments for transportation managed care were paid to providers once a month as a lump sum payment until Q1 2005.
			There is a big change in the distribution of claims by Type of Service starting with Q3 2001 because the state changed its system and in the process reviewed how they were assigning Type of Service. The revised hierarchy they began using in Q3 2001 results in many more lab/Xray services being pulled out of physician, clinic, etc. claim and being put in lab/xray where they belong. Currently their Q3 2001 claims from NHIC does not have any claims reported with a Type of Service of 19. This is clearly an error and they are investigating.
			About 8 percent of the claims have the invalid combination of an 8 filled Service Code and a Service Code value of 0. Some claims have invalid Service Codes.
			In Q2 1999, five percent of the services codes aren't valid.
			In 2006/2007 there are 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.
			Place of Service is missing or invalid on about 15 percent of the claims.
			Other Third Party Payment (or Third Party Liability/TPL) is not on most claims because it is carried at the header level.
			There are a few claims with missing MSIS ID's.
		RX	All compound drugs are coded as "COMPOUND" in the NDC field.
			Claims without NDC's do not have the service code in the NDC field. That field is blank filled for those claims. The state hopes to correct this starting in FFY 2008.
			No claims have a Other Third Party Payment (or Third Party Liability/TPL).

State	File Type	Record Type	Issue
TX	Eligibility	0-filling	From Q1 FY05 - Q3 FY06, some individuals had several data elements blank-filled (state specific code, CHIP flag, MASBOE, and Plan IDs 1-4). In addition, these individuals also had other data elements that were 0-filled (TANF flage, the restricted benefits flag, Plan Type 1-4, Waiver Type 1-3, and Waiver IDs). TX believes these that the blank-filled data elements should have been 0-filled as well. This was fixed in Q4 FY06.
		Dual Eligibility Codes	During Q3 FY07, a small number of individuals (< 1000) had dual codes that lacked a leading zero (thus were only one byte). This problem was not apparent in either Q2 or Q4 FY07 and TX could not identify the records cited having this problem.
			In FY07, the number of 1929(b) enrollees reported to dual code 09 was 16% 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 those enrollees reported to dual code 09 who are confirmed duals.
			Through Q1 FY06, the distribution of partial dual counts in MSIS and MMA did not compare well since in MSIS TX was reporting ALL 1929(b) duals to dual code 09, even if they should have been reported to codes 01 or 03 if they qualified as QMB only or SLMB only status. This caused the comparison of total partial duals to compare well across sources, however, the counts of 01 and 03 were less in MSIS and the count of 09 was higher in MSIS since all the 01s and 03s were included in the 09 count. However, in Q2-4 FY06, TX corrected this dual code 09 reporting in MSIS, making the MSIS and MMA dual code distributions more consistent.
			In FY03, TX began assigning dual codes 09 and 00 to enrollees in its 1929(b) waiver. They do not qualify for prescription drug coverage. Most are reported to MASBOE 41-42. TX agreed to use dual code 09 for this group when the dual status was known. It appears that the remaining 1929b enrollees were assigned dual code 00, even though many were probably duals (especially those who were aged). In Q1 FY05, TX improved its 1929b coding so that the vast majority of aged 1929b enrollees were assigned dual code 09.
			In Q2 FY06, TX changed its programming so that 1929(b) 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), with the remaining 1929(b) enrollees who are duals assigned dual code 09. This resulted in an increased count for partial duals.

State	File Type	Record Type	Issue
TX	Eligibility	Dual Eligibility Codes	TX had some inconsistent dual code and restricted benefit flag coding in FY06. In month 1 of each Q1-4 FY06, about 400-500 full benefit duals are assigned RBF '3'. In addition, about 300-400 partial benefit duals are assigned RBF 1. These numbers taper off by month 3 of each quarter. Futhermore, about 2,500 aged and 1,000 disabled who are reported to MASBOE 31-32 each month are not reported to be duals (the dual code is 0-filled). However, everyone reported to MASBOE 31-32 is assigned RBF 3. The state fixed this reporting starting Q1 FY07.
			During Q1-3 FY06, none of the persons reported to MASBOE 51 (1115/aged) were reported as duals; however, the majority of these individuals (Katrina evacuees) are reported to be under age 65. The state indicated that only minimal data were collected for these enrollees and was not able to verify whether they are assigned the correct BOE. No Katrina enrollees were reported after Q3 FY06.
			During Q1 FY06, TX reported s small number of individuals with dual codes 01, 03, 06, and 09 to MASBOE 11-12 each month. It seems odd that SSI recipients would be assigned these codes. The state fixed this reporting in Q1 FY07.
		Managed Care	In Q4 FY05, TX reports a major increase in PCCM enrollment (345,000 to over one million) when the state expanded its Medicaid PCCM program into an additional 197 counties. However, PCCM enrollment showed declines starting in Q4 FY06 and into FY07. The state indicated that the decrease occurred because TX minimized the service area of two plans. (Indeed, TX later indicated that two PCCM plans ended in March 2007.)
			Beginning in Q1 FY 2000, Texas exhibits a significant upswing in PCCM (Plan Type 07), Comprehensive Managed Care (Plan Type 01), and Behavioral Managed Care (Plan Type 03). The numbers in MSIS are consistent with what we see in external CMS data, although there was a PCCM discrepancy in FY 2002 (the state believes the MSIS numbers are more accurate).
			There was an 11 percent increase in reporting to Plan Type 01 (HMO) from Q3 FY06 to Q4 FY06. Enrollment continued increasing into FY07. This increase was primarily due to the addition of several new managed care plans. TX reaffirmed this for Q2 FY07.

State	File Type	Record Type	Issue
TX	Eligibility	Managed Care	Texas has at least two PACE programs (Bienvivir Senrio Health Services and the Basics at Jan Werner), but PACE enrollment is not included in the EL files. TX expects to identify these enrollees in MSIS starting in FY08. PACE enrollment is included in the June Medicaid managed care maintained by CMS.
		MASBOE	All Years: Most disabled SSI recipients age 65 or older are reported to MASBOE 11.
			1999 - 2002: From Q1 FY 1999 - Q2 FY 2002, Texas reports about 2,000 to 5,000 eligibles in MAS/BOE 55. These eligibles are not part of an 1115 Medicaid Waiver. Rather, the individuals are made eligible through a TANF 1115 waiver, which extended Medicaid benefits after the individual's state time limit had expired. The waiver expired 3/31/02, but the eligibility created by the waiver continued. Because the waiver expired, this group was moved to MAS/BOE 45 in Q3 FY 2002.
			2006: From Q1-Q3 FY06, TX reported a few individuals to MASBOE 99. The state fixed this reporting in Q4 FY06.
			2003: Texas began reporting BCCPTA enrollees under MAS/BOE 3A in Q1 FY 2003.
			2003: In September 2003, TX changed the medically needy financial rules for adults in MASBOE 25, causing an enrollment decline. In effect, the changed rules eliminated spend-downers.
			2005 - 2006: Starting in Q4 FY05 through Q3 FY06, TX reported Katrina 1115 waiver enrollees (Waiver ID "G1") to MASBOE 51-55. During FY06, the vast majority of individuals assigned to MASBOE 51 (Katrina evacuees) were reported to be under age 65. The state indicated that they only collected minimal data for these enrollees and it is not certain if the BOE is correct. Reporting to MAS 5 ended after Q3 FY06 when the waiver ended.
			2006: TX reported a decrease in TX's reporting to MASBOE groups 14 and 15 during Q2 FY06 (8% and 14%, respecitively). The state confirmed these decreases, but was not able to determine a cause.
			2003: In September 2003, Texas implemented a TANF sanction policy that caused many adults (20,000) to lose Medicaid coverage, but not their children. Enrollment declined in MAS/BOE 14 - 15, but most children appeared to have transferred to MAS/BOE 44.

State	File Type	Record Type	Issue
TX	Eligibility	MASBOE	All Years: TX has a so-called 1929b 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.
			During Q3 FY07, approximately 500 - 1,000 individuals were classified under MASBOE 88, all apparently belonging to state-specific eligiblity group "118888." Because many fields (such as the record's RBF and CHIP indicator) are 8-filled for the same number of records, we believe these records reflect individuals who should have otherwise been classified as MASBOE '00' and have had their other data elements 0-filled as well.
		Private Health Insurance	In July 2002, private health insurance reporting increased to about 147,000 from about 120,000 in June 2002. The state believes this to be correct.
		Restricted Benefits Flag	Through FY06, Texas assigned code 5 ("other") to all aged and disabled persons in the so-called 1929b waiver program in MAS/BOE 41 - 42 who are living at home, these persons used to be in a HCBC 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.
			TX's Money Follows the Person (MFP) program was approved in January 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. MPF enrollees will be assigned RBF code 8 in MSIS.
			In FY05 and Q1-4 FY06, TX had inconsistent dual code/RBF coding for a small group of duals. See dual discussion.

State	File Type	Record Type	Issue
TX	Eligibility	Restricted Benefits Flag	TX also assigns code 5 to children and adults in MAS/BOE 24 - 25 whose date of initial coverage is complicated by a spend-down liability. However, in September 2003, Texas changed the financial rules for medically needy adults, so that very few adults qualified as a result of spend-down. This caused a reduction in MASBOE 24-25 enrollees assigned restricted benefits code 5.
		CHIP Code	Texas reported its M-CHIP children until it phased out in Q1 FY 2003. The state's S-CHIP program, which began in April, 2000, is not reported into MSIS.
		SSN	Texas reports about 500 duplicate SSNs each quarter. The state is aware of the problem and periodically works at reducing it.
		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.
		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 8% higher than the ACF count in Q1 FY06, still within our expected range of difference.
		Waivers	During Q3 FY07, 1,377 individuals were reported having Waiver ID1 = '0' for all three months rather than '00'; meanwhile, Waiver ID2 and ID3 were left completely blank. TX indicated they could not find the same problems in their data.
			During Q2 FY07, enrollment in TX's 1915(b)(c) waiver (STAR+PLUS) abruptly ceased with approximately 60,000 enrollees in the first month and 0 in the second and third months. The waiver then resumed in Q3 FY08 with approximately 130,000 enrollees in all months of the quarter. TX confirmed that the drastic change was due to three plans ending during Q2, whereupon the STAR+PLUS program expanded to core service areas beyond Harris County (Houston) where it orginated and was originally limited to.
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.
			UT asked to change to a new MSIS ID numbering scheme in 2003 Q4, but the request was denied.

State	File Type	Record Type	Issue
UT	Claims	All	Starting in FFY 2004 Q1, the HMO's began providing services on a FFS basis. The state reimburses the plans for those services plus a 9% administrative fee and they are reported in the MSIS files as service tracking claims.
		Capitation	There are not any PCCM capitation claims in the OT file as they are paid on a FFS basis.
			There are very few capitation claims for people enrolled in HMOs in 1999 and Q1/Q2 2000. The HMO capitation claims were added starting in Q3 2000. (Utah resubmitted the Q1/Q2 OT file and was unable to include the HMO capitation claims as those source files had been lost in the state system.) In 2006 and 2007 UT submitted their BHO capitation payments with a Type of Service of HMO capitation.
		IP	No claims have a Patient Status of 30 (Still a Patient).
		LT	The "Admission Date" and "Patient Status" are missing on most nursing home/institutional claims because Utah does not retain the data on the input record.
			The LT file contains some diagnosis codes that contain unreadible characters.
		Managed Care	Starting in July 2003, UT switched 2 of their 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 (Melina and Healthy U) do not. UT is resubmitted the 2004 Q1-4 EL files to remove all the HMO enrollees and the OT capitation claims. They are adding Service Tracking claims with the expenditures from the 2 plans. They will continue with this until they are 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.
		OT	The average expenditure for claims with a Type of Service 12 (Clinic) jumped from about $400 to $700 in Q3 1999 and continued at the $700+ level in 2000.
			The 2002 Q3/4 OT files do not contain any claims with a Place of Service of ER.
			There is a shortfall of HMO capitation clamis in Q1 2003 because some of these claims were deleted from their system.
			Physician specialty codes are missing on over 60 percent of the claims.

State	File Type	Record Type	Issue
UT	Claims	OT	Place of Service are missing on over 20 percent of the 1999-2001, Original Non-crossover claims. Utah accepts a place-of-Service Code of "other" from providers. Since this cannot be translated, a high number of claims will have the "99" value (unknown or not listed).
			Most claims for children have a Program Type of 1 (EPSDT).
		RX	There is a small percentage of claims with a 12 byte NDC. These come from a manual system that is being phased out. The NDC's probably have a leading 0.
			The fill date is also reported in the prescribed date field. UT will fix starting in 2004.
	Eligibility	1115 Waivers	UT had a Katrina waiver approved on 3/20/06.
			Utah's 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.
		County Codes	Utah uses a state-specific county code in FY 1999 and FY 2000, instead of the FIPS county codes. This problem was corrected in their FY 2001 files. The state supplied MPR with a crosswalk that links together the state county information with the correct FIPS county code.
		Dual Eligibility Codes	Between 85 - 90 percent of persons age 65 and older are reported as dual eligibles, a somewhat lower than expected proportion. UT has been unable to resolve this issue.
			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.
			The number of QMB-only dual eligibles (dual eligibility flag = 01) is much lower in Q1 FY 2000 than in any of the other FY 1999 or FY 2000 quarters. In Q1 FY 2000, there are roughly 250 QMB onlies, whereas there are about 1000 per quarter in the rest of the FY 1999 and FY 2000 quarters.

State	File Type	Record Type	Issue
UT	Eligibility	Dual Eligibility Codes	Through FY02, some persons in MAS/BOE 21 - 22 and 41 - 42 were reported to have dual codes 01 and 03. State officials say this was due to a timing problem. Both dual eligibles who have to spend down to qualify for full Medicaid benefits (through the medically needy program) and those who contribute to the cost of their institutional care were not initially classified as qualifying for full Medicaid benefits.
			From Q1-Q4 FY06, no one was reported to dual codes 03 and 06 even though at the end of FY05 UT reported about 700 enrollees to dual code 03 and about 400 enrollees to dual code 06. It appears they had the dual code field 0-filled. UT's monthly MMA files for 2006 show that UT continued to have enrollees assigned these dual codes. The state is reviewing this error to ensure that these individuals are captured in UT's FY07 data file.
			The number of dual eligibles increased by about 20 percent from Q4 FY02 to Q1 FY03, as the state improved its identification of dual eligibles. Most of the increase occurred with dual code 02.
		Managed Care	HMOs: Enrollment by individual HMOs varied considerably quarter to quarter during FY02 and FY03. Enrollment starts out high in month 1 of each quarter and then drops by about 10% by month 3. Enrollment is high again in month one of the next quarter. This drop (cause unknown) occurs across several eligibility groups, but is most noticeable for poverty-related children.
			Long-Term Care: From the start, UT has also 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. This plan has never been included in the June managed care data reported to CMS (through 2006).
			PCCM and Transportation: Even though UT is reported to have PCCM enrollment and a transportation managed care plan in CMS data, enrollment for these types of managed care is not reported in MSIS through FY06. The state indicated that their PCCMs are not like other state PCCMs as they don’t get paid capitation fees for services covered under the PCCM plan (UT only pays when a service occurs). Non-emergency transportation was reported to be 161,000 in the June 2005 CMS data. The state is reviewing the transportation reporting for FY07 as it probably should be included in MSIS.

State	File Type	Record Type	Issue
UT	Eligibility	Managed Care	In July 2002, UT switched to no-risk managed care which affected the way HMO plans operated in Medicaid. Prior to that time, the plans operated as standard HMOs; however, the change to no-risk HMOs meant that the plans were paid on a FFS basis with an administrative fee attached. By mistake, the state continued to report these plans as HMOs (plan type 1) in MSIS through FY03 instead of dropping them from the state's managed care reporting. It should also be noted that in 9/02 the IHC HMO plan switched to a PCCM. This switch was not made in MSIS data and IHC continued to be reported as an HMO through Q4 FY03. As discussed above, UT does not report PCCM enrollment in MSIS, so IHC should have been dropped from managed care reporting as well. Also, in 10/02, the UMed HMO plan phased out. 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 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 reporting enrollment in several S-CHIP plans in MSIS. The enrollment being reported was for current Medicaid children who used to be in S-CHIP.
		MASBOE	2002-Present: By mistake, UT has been reporting its 1115 expansion group of pregnant women to MASBOE 35, instead of MASBOE 55. They are in state group P82 (this can be corrected in MAX).

State	File Type	Record Type	Issue
UT	Eligibility	MASBOE	1999 - 2001: In FY 1999, FY 2000, and FY 2001, MAS/BOE was incorrectly assigned for about 36 state-specific groups. Many (but not all) were reported into MAS/BOE 31 - 35 when they should have been reported into MAS/BOE 14 - 15 and 41 - 45. This represented about 15 percent of monthly enrollment in FY 2001. Groups that were mismapped included some 1931 eligibles, some of the institutionalized qualifying under the 300 percent FPL rules, the working disabled, TMA enrollees, and persons meeting AFDC rules, but not qualifying for cash.
			2005: UT reported a large increase in MASBOE 55 enrollment from September to October 2004 (Q1 FY05) when the state conducted an open enrollment period for its Primary Care Network (PCN) program.
			2005: From October to November 2004 (Q1 FY05), UT reported unusually large enrollment increases in MASBOE 24-25 and large decreases in MASBOE 44-45. These shifts in enrollment occurred because the state no longer required automatic enrollment for some groups of recipients causing some shifts in state groups.
			1999 - 2000: Prior to Q4 FY 2000, Utah had been under-counting the number of poverty-related children. During this time, roughly 30,000 had been assigned state-specific eligibility codes which caused them to be mapped to MAS/BOE 44. Beginning in Q4 FY 2000, this problem was corrected. These children were correctly assigned to state-specific eligibility codes which are mapped to MAS/BOE 34.
		Restricted Benefits Flag	Some enrollees in UT's Primary Care Network 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, UT started assigning RBF '5' (other) for this group, except for a few (<5) who were identified as duals.
			Some eligibles outside of MAS/BOE 31 and 32 receive RBF = 3 (restricted benefits based on dual eligibility status).
			In FY06, about 2,000 aged/disabled full benefit duals and about 1,800 aged/disabled non-duals all assigned RBF 3. UT is reviewing its RBF assignment for FY07 to verify that only partial benefit duals are assigned RBF 3 and individuals receiving full Medicaid benefits are assigned RBF 1.

State	File Type	Record Type	Issue
UT	Eligibility	CHIP Code	S-CHIP enrollment increased from about 24,000 to over 30,000 from month 1 to month 2 in Q3 FY04 (April to May 2004). This increase is almost a 25% increase in one month. The state confirmed this is correct and that the increase is the result of increased CHIP outreach at that time. S-CHIP enrollment continued to grow through FY05.
			Utah reports enrollment in its S-CHIP program in MSIS. The state does not have an M-CHIP program.
		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.
		TANF/1931	The TANF flag was not reliable in FY 2000, but it looks reasonable for FY 2001 - 2004.
			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, although a small number of individuals were reported each month with TANF flag = 1. These individuals should have had the TANF flag 9-filled as well.
		xREVIEW NOTE	When finished FY07 data, ask for an updated MSIS xwalk for UT, along with the aid code defintions. The last one we have is dated 2002, and it does not include a few new groups (see Marilyn 10/24/08 email).
VA	All	Data System Change	Virginia implemented a new system in March 2003.
	Claims	All	VA has a very small pre-PACE program with only about 20 enrollees. The billing is done outside Medicaid and so there are not any capitation pyament claims.
		Capitation	PCCM capitation claims are not included in the 1999 to 2001 files.
			Update: The date when individual PCCM capitation claims will be available is Q1 2002. (email from R North 1/8/2002)
		IP	From 2004-2006, the service code indicator on IP claims was reported as '10' (other state service codes), instead of 02 (ICD-9).
			DRGs were not included in the claims files until Q1 2001. Before that Virginia assigned DRGs as a post payment process solely for cost settlement.

State	File Type	Record Type	Issue
VA	Claims	IP	The percent of crossover claims is much higher than expected. For example, in Q1 2005 40% of enrollees are in managed care, but 82% of the claims are crossovers. They appear to be true crossover claims because of the level of reimbursement.
			Over 20 percent of the 1999 and Q1 2000 claims have a Medicaid Amount Paid of $0 as there is a 21 day limit for adult IP care. Expenditure after 21 days are paid as a cost settlement.
			The state stopped reporting Family Planning in Q4 2003.
		LT	??KFF says Virginia does not cover IP Psych <22
			Leave days are not carried in the state's claims files.
			The percent of claims with Patient Liability is less than expected. This is because the providers aren't always consistent about including that information on the claims.
		OT	The percent of claims with CPT-4 codes dropped from 81 percent in Q1 1999 to 67 percent in Q4. This is the result of the movement of some FFS recipients to managed care.
			The servicing and billing provider ID numbers are usually the same. When available they are putting the attending provider ID in the servicing field.
			Virginia was unable to submit HMO capitation claims for the first 2 months of Q1 FY 1999 because they had aged off the system.
			Virginia pays a capitation rate to various county-based agencies for transportation services. The payment is based on the estimated number of Medicaid enrollees, not for specific enrollees. Until Q4 2004 these capitation payments were not in MSIS files either as service tracking or individual capitation claims. People covered by transportation managed care were not flagged in the MSIS EL files as enrolled in Other managed care. Starting with Q4 2004 the transportation capitation claims will be included as service tracking claims and enrollees will be in the EL file in Other managed care.
		RX	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.
	Eligibility	County Codes	Virginia assigns county codes 983 - 997 to institutions in the state. List is included in anomalies file.

State	File Type	Record Type	Issue
VA	Eligibility	County Codes	Virginia assigns special FIPS codes 510 - 840 to cities that are independent entities.
		Dual Eligibility Codes	When VA extended full Medicaid benefits to aged/disabled persons to 80% FPL in Q4 FY01, many of these persons were incorrectly assigned dual code 01 and restricted benefits code 3. They should have been assigned restricted benefits code 1. The correct dual code would be 02 if they were dual eligibles. This problem was fixed in Q1 FY 2003.
			VA's count of enrollees in dual code 06 decreased from month 3 of Q1 FY07 (December 2006) to month one of Q2 (January 2007). Reporting to 06 then increased again over the rest of Q2 and Q3. The counts continued to fluctuate in FY07 and into FY08.
		Managed Care	PCCM enrollment dropped from about 77,000 in month 3 of Q4 FY05 (August 2005) to about 68,000 in month 1 of Q1 FY06 (September 2005), an 11% decline. The state indicated that a lot of enrollees were moving around between plans at this time which might explain the change.
			Each month from Q2 FY07 through Q3 FY08, Virginia reported several thousand (7,000-11,000) HMO enrollees with 0-filled plan Ids. The state contact explained that these individuals are not actually enrolled in HMOs. We asked the state to submit correction records for these individuals.
			In Q3 FY 1999, the mix of HMOs changed somewhat and overall HMO enrollment increased, while PCCM enrollment declined. Another shift in managed care enrollment occurred in Q1 FY 2002, with PCCM enrollment declining and HMO enrollment increasing.
			VA started reporting PACE enrollment (Plan Type 06) in Q2 FY08.
			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.
			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.

State	File Type	Record Type	Issue
VA	Eligibility	Managed Care	Starting in Q2 FY07, VA changed its managed care Plan ID assignments.
		MASBOE	2006: Child enrollment dropped by about 3 percent (13,000 enrollees) from July to September 2006 after the Medicaid proof-of-citizenship rule was implemented.
			2005: In September 2005 (Q4 FY05), VA started reporting Hurricane Katrina evacuees (state groups 919). However, by mistake, these enrollees were mapped to MASBOE 99. They should have been mapped to MASBOE 51, 54, and 55 instead. The state corrected this error starting in Q1 FY06; however, the waiver ended in spring 2006 and Katrina evacuees were not reported in MSIS after Q2 FY06.
			2003 - 2004: Child enrollment under the poverty-related provisions (MASBOE 34) was growing quite dramatically in FY 2003 and FY 2004, but there do not seem to be any specific policy-related changes that would have contributed to this growth.
			2007: In Q3 FY07, one individual was reported to MAS 3, but the BOE was left blank. Other monthly data fields were populated. Based on the state-specific code assignment (group 059A), it is assumed that the BOE should be 2.
			2003: In Q1 FY 2003, a few enrollees were mapped to MAS/BOE 99 by mistake, instead of MAS/BOE 00. A few mapping changes also occurred. For example, state group 083 began to be reported to MASBOE 16-17 instead of MASBOE 44-45.
			2005: A small number (<5) of persons had the MASBOE field left blank for different months of FY05. We assume these persons should have had the MASBOE field 0-filled, but did not receive confirmation from the State. This problem did not occur in FY06.
			All Years: Virginia has an outreach program to children in September of each year. Enrollment is often retroactive three months.
			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.
			2003 - current: Effective FY 2003, Virginia has an 1115 program to extend family planning services to enrollees in MAS/BOE 55 (state group 080).

State	File Type	Record Type	Issue
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 of SSI disabled >65 years to MASBOE 11. Finally, VA has a state administered SSI supplement.
			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).
			2001- current: Virginia began reporting BCCA eligibles in Q4 FY 2001.
			2000 - current: 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.
		Private Health Insurance	In Q1 1999, there were about 12,000 Medicaid eligibles each month who were reported as "ineligible" in the HEALTH INSURANCE field. This problem was corrected in the Q299 - Q499 files.
		Restricted Benefits Flag	In Q1-2 FY06, VA started reporting about 4,000 enrollees with restricted benefits flag 9 each month. These are Katrina evacuees (state groups 919 and 920) who should have been assigned RBF 1. From Q3 FY06 forward, VA continued to report a small number of enrollees in MASBOE 34 to RBF 9 (cause unknown). The state has been asked to review this reporting.

State	File Type	Record Type	Issue
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 are determined to have asthma, congestive heart failure, coronary artery disease, and/or diabetes may opt out of traditional Medicaid into this new "Health 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 live in institutions, and those who have 3rd party insurance. VA is not able to report this enrollment in MSIS; however, the state estimated enrollment at about 5,800 (Sept 2008). VA expects to have changes made to its system to allow reporting to RBF 7 to begin in January 2009. It is expected that enrollment will increase over time.
			A small number of aged and disabled non-duals (roughly 20-30 each month) are mapped to restricted benefits code 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 are entered separately in the MMIS system and in these cases there is inconsistent information in the two subsystems. The state is working to correct the issue.
			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.
			In some (but not all) quarters BCCPTA women (state group 66) are assigned restricted benefits code 5. Also, many medically needy persons are assigned restricted benefits code 5 effective October 2002.
			Until October 2002, restricted benefits code 4 was assigned mostly to pregnant women in MASBOE 35. However, effective October 2002, only persons in MASBOE 55 (state group 080--Family Planning Waiver) are assigned restricted benefits code 4. Starting in Q1 FY05, VA started assigning restricted benefits code 6 to these family planning only enrollees.

State	File Type	Record Type	Issue
VA	Eligibility	Restricted Benefits Flag	Beginning in July 2008, VA expects to begin implementation of 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. MPF enrollees will be assigned RBF code 8 in MSIS starting Q4 FY08.
			Effective Q4 FY01, aged/disabled persons qualifying for full Medicaid benefits to 80% FPL were incorrectly assigned restricted benefits code 3 instead of code 1. This problem was fixed in Q1 FY03.
		Retroactive/Correction Records	VA only looks at changes made to birthdate, sex, and SSN when submitting correction records.
		CHIP Code	VA began reporting S-CHIP adults in Q4 FY05 (state group '005' reported to MASBOE 00). This group is part of an 1115 S-CHIP waiver (not a Medicaid waiver) that extends coverage to pregnant women with income 133-200% FPL. Premium assistance coverage for children will follow eventually.
			Starting in FY04, VA 8-filled the Plan Type 1-4 and Plan ID 1-4 fields for S-CHIP enrollees instead of 0-filling them. The State corrected this error in Q3 FY06.
			Until the fall of 2002, Virginia only had an S-CHIP program, and was reporting all of its S-CHIP eligibles into MSIS. The numbers in MSIS are greater than in SEDS until Q4 FY 2001. The state assures us that the MSIS numbers are correct; however, there may also have been some problems with double counting. SEDS and MSIS are comparable beginning in Q4 FY 2001. Effective September 2002, the state has an M-CHIP program as well, and many children appear to transfer from S-CHIP to M-CHIP. The M-CHIP expansion provides that Medicaid children of all ages are covered to 133% FPL.
		SSN	Virginia put 3 leading 8s and then a date (usually the date of birth) in the SSN field when the SSN is unknown. This caused many records to have duplicate SSNs, plus it was incorrect. Unknown SSNs should be 9-filled. This was corrected starting with Q4 FY 2002, according to the state. However, some level of duplicate SSNs will continue even after 9-filling. Starting in 2003, the state's SSN reporting was greatly improved.

State	File Type	Record Type	Issue
VA	Eligibility	State-Specific Eligibility	Each quarter, VA typically show 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've talked to the state about this reporting and 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.
			Effective Q1 FY03, VA inserted a leading "0" before all its state specific codes.
		TANF/1931	TANF data are not reliable in Virginia. The state began 9-filling the TANF field in Q1 FY 2003.
		Waivers	In FY05, VA reported a small number (<5) persons with some of the monthly waiver fields left blank. These fields should have been 8-filled for monthes the persons was not enrolled in any waivers, assuming they were enrolled in a waiver for at least one other month of the quarter.
			In FY05, VA incorrectly reported its Family Planning Only Waiver (F1) as an 1115 waiver (Waiver Type 1). Enrollees should have been reported to Waiver Type 'F'. The State fixed this in Q1 FY06.
			Waivers Z3 (Alzheimer's Assisted Living Waiver) and H5 (Health Insurance Demonstration Program) are noted in VA's approved crosswalk but are not reported with any enrollment in MSIS. The state reported that enrollment for Z3 began 9/1/05, but no one has been enrolled, yet. Waiver H5 was never implemented.
			Katrina evacuees were included in VA's Q4 FY05 September data (state specific codes 919A and 919C); however, these enrollees were reported to MASBOE 99, and they were not reported to the Katrina waiver code. They should have been reported to MASBOE 51, 54 or 55, dependent on age. In addition, they should have been assigned to waiver type 'A' and waiver ID 'EA'. The state fixed these errors starting in Q1 FY06; however, the waiver ended in spring 2006 and Katrina evacuees were not reported in MSIS after Q2 FY06.
			Since Q4 FY07, Virginia has been incorrectly 0-filling the waiver ID and waiver type fields for a few current enrollees each month. As a result, in all months of each quarter of Q3 FY08, the number of individuals reported with waiver type 0 and ID 00 differs from the number of individuals reported with MAS/BOE 00. We asked the state to address this issue

State	File Type	Record Type	Issue
VA	Eligibility	Waivers	Waiver S3 (Day Support Waiver for MP Individuals) became effective 7/1/05 and shows enrollment starting in Q4 FY05.
VT	Claims	All	Across the four files, there are fewer than expected adjustment claims. Specifically, less than one percent of the claims are adjustment claims.
		IP	About half the claims are for crossovers in 1999 and it drops to about 1/3 in 2000 and forward.
			The state does not use DRGs.
		LT	There are no original, non-crossover Q1 1999 claims with a Type of Service of 05, ICF/MR. However, this was a one quarter correction and they occur in subsequent quarters.
			VT uses state specific Revenue Codes for Home Health and Hospice services and not service codes
			Through 2001, all OT claims regardless of service, have something in the diagnosis field.
			The number of claims jumps from about 482,000 in Q2 2000 to 670,000 in Q3 2000.
			About 1/3 of the 1999 claims have a Type of Service of 19 (other services). In 2000 that percent started to decline and in Q3 2000, it was only 19%.
			Vermont stopped reporting Physician Specialty codes in Q3 1999.
			VT reports very few leave days.
		OT	Vermont stopped including Specialty Code in Q3 1999.
			The State has State-specific Revenue Codes for Home Health and Hospice Services.
			Through 2001, all OT claims, regardless of Type of Service, have something in the diagnosis code field.
			From 2003 Q4 - FFY 2005, VT has been submitting most of their individual PCCM capitation payments as Service Tracking claims because the do not have a MSIS ID. They are reported with a Type of Claim=2, Adjustment Indicator = 5 and the MSIS ID missing (or coded with a leading &)
			The number of claims jumps from about 482,000 in Q2 2000 to 670,000 in Q3.
			About one third of the 1999 claims have a Type of Service of 19 (Other Services). In 2000 that percent started to decline and in Q3 2000 it was only 19 percent.

State	File Type	Record Type	Issue
VT	Claims	RX	The fill date is reported in both the Fill Date and Prescribed Date fields.
			There was a big increase in the number of RX claims between Q1 and Q2 1999.
			All QMB-only, SLMB-only, and QI1 eVermont's 1115 demonstration, these eligibles qualify for pharmacy benefits, but no other Medicaid services (except Medicare cost-sharing expenses, as appropriate).
	Eligibility	0-filling	In Q2-4 FY06, a very small number (1-3) of records have the Type of Record 0-filled and the Federal Fiscal Year/Qtr 0-filled.
		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 populations was included. 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.
			Parts of VT's "Global Committment 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 will transfer 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. The shift of the VHAP population began to occur in October 2005 in MSIS data. It is not clear when enrollment in the public MCO began. CMS managed care data suggest most enrollees are reported to be members of the state public MCO in June 2006. However, MSIS FY06 data do not show this pattern. Instead, most enrollees have PCCM enrollment. MPR is asking for clarification on the waiver status.
			Beginning in 1995, Vermont implemented a 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.

State	File Type	Record Type	Issue
VT	Eligibility	Dual Eligibility Codes	There are some differences in VT's dual counts in MSIS compared to MMA, particularly with counts for dual codes 03, 04, and 08. In addition, VT reports enrollees to dual code 06 in its MMA files, but no one is reported to this code in MSIS. The state is reviewing why these counts are different.
			Prior to FY03, dual eligibles in state groups BD, B6, IA, and ID were assigned to incorrect dual codes. Duals in BD and B6 should have been assigned dual code 08, and IA and ID should have been assigned to 04.
			Most QMB only, SLMB only, and QI1 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.
			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 1115 waiver (presumably the program provided drug wraparound benefits). Enrollment in dual code 09 continued for those in the 1115 who did not meet the partial dual financial requirements.
		Managed Care	Beginning in FY00Q1, Vermont transitioned everyone with Plan Type = 01 (Comprehensive Managed Care) into Plan Type = 07 (PCCM). This change was made because the state's two managed care plans (Blue Cross and Kaiser) left the program. Then, in 2006, when VT's new 1115 (Global Commitment to Health) was implemented, VT may have transferred most enrollees to the state's new public MCO instead. However, in FY06 MSIS, VT continued to report only PCCM enrollment, but the June 2006 CMS data show HMO enrollment (in the state public MCO) of about the same size. VT has been asked to clarify whether the PCCM reporting was erroneous and should have been HMO enrollment instead.
		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.

State	File Type	Record Type	Issue
VT	Eligibility	MASBOE	All Years: Beginning in 1995, Vermont implemented a 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.
			1999 - 2002: In FY 1999 through FY 2002, enrollees of state-specific eligibility groups RR and R1 were mistakenly included in MSIS. These are members of the Refugee Resettlement Program. 200 or fewer persons are enrolled in the program each month.
			2001: In FY 2001, Vermont stopped reporting into MAS/BOE 16 - 17 (optional reporting groups), instead reporting all TANF eligibles into MAS/BOE 14 - 15.
			2002: In FY 2002, approximately ten people each month were mapped to MAS/BOE 39. These are enrollees of state-specific eligibility groups BG and BH. They are BCCPT enrollees and should have been mapped to MAS/BOE 3A.
			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.
			2006: 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 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 3 specific Home Health care services and not full Medicaid benefits.
			2001: In Q1 to Q2 FY 2001, a few hundred persons were reported into MAS/BOE 97. These persons are not Medicaid eligible.
			2006: From Q2-Q4 FY06, individuals (about 30) in state-specific eligibilty group "VO" (VPharm-3) were reported to MASBOE 51 instead of MASOBE 00. All monthly data elements should have been 0-filled as well.

State	File Type	Record Type	Issue
VT	Eligibility	MASBOE	2003 - 2004: In FY03 and Q1 FY04, state group 'BD' is incorrectly assigned to MASBOE 52 instead of MASBOE 42. This was corrected in Q2 FY04, causing a shift of about 400 enrollees from MASBOE 52 to 42.
			All Years: VT does not report enrollees to MASBOE 31 - 32 because all QMB only, SLMB only, and QI1 eligibles are 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
		Private Health Insurance	The number of individuals reported to have private insurance increased from 9.4 percent in September to 14.2 percent in October 2002. This increase may have been related to improved record keeping related to the MMA effort in Q1 FY03.
			The number of enrollees reported to Health Insurance flag "2" (receiving 3rd party insurance) increased from about 17,000 enrollees per month at the end of Q1 FY06 to about 38,000 enrollees per month at the beginning of Q2 FY06. We've asked the state to review this increase.
		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 FY07 the state will start crosswalking the old data element to the new, expanded data elements so these new fields will be populated.
			VT reports about 40 percent of its enrollees with unknown race/ethnicity information. The state does not require that enrollees provide this information.
		Restricted Benefits Flag	Restricted benefits flag 5 ("other") is assigned to enrollees of Vermont's 1115 demonstration, which provides aged and disabled enrollees with pharmacy benefits only. 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.

State	File Type	Record Type	Issue
VT	Eligibility	Restricted Benefits Flag	In FY06, VT started reporting state-specific eligibility group "WM" (MASBOE 51-52) with RBF 5 as they are part of VT's 1115 waiver (Choices for Care waiver administered by the Department of Aging and Independent Living) and are eligible for only 3 specific Home Health care services and not full Medicaid benefits.
			VT does not assign any individuals to RBF 2, but we've asked the state if it is possible to start reporting to this code. The state is reviewing its data processing, but has not responded.
		Retroactive/Correction Records	Nevertheless, even after Q1FY03, Vermont continues to submit a few correction records that are very old (up to about 20 years old). The number of such records is small and the state does not think this practice has an effect on its data.
			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.
			VT's correction records were not reliable until Q1 FY03 since they disenrolled many persons who should not have been disenrolled. The correction records included in the Q1FY03 file appear to be reliable.
		CHIP Code	Vermont reports its S-CHIP eligibles into MSIS. The state does not have an M-CHIP program.
			In Q2-4 FY05, VT's count of S-CHIP enrollment in MSIS does not compare well to the CMS SEDS system; however, the state confirmed that the MSIS counts are correct. The two data sources compared well again starting in Q1 FY06.
		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.

State	File Type	Record Type	Issue
VT	Eligibility	TANF/1931	Until FY 2000 Q3, everyone in MAS/BOE 14-17 received TANF benefits. There were some 1931 eligibles on the file who did not receive TANF benefits during this period, but those persons were mapped to MAS/BOE 44 and 45 in aid categories TC, T5, TR, and T8.
		Waivers	Vermont has people in its LTC Waiver program who may begin or end their participation without completing the month. They will report that enrollment even if only one day of the month is covered.
		xREVIEW NOTE	Issues to summarize in Q4 FY06 review for VT to address before submtting Q1 FY07: (1) MMA comparision; (2) populating the expanded race/ethnicity codes; and (3) RBF 2. Future reporting: VT added new state codes (ZA, ZB, ZC) that will not be used until Q1 FY08 for the state's ESI and Catamount Health programs.
WA	All	MSIS ID	Washington puts extra "S"s in the MSIS ID field on some records. These need to be dropped in order to properly link claims and eligibility.
			WA is implementing a new MMIS system effective Q1 FY09. The state is planning to send a cross reference file cross-walking the former MSIS-IDs to the new MSIS-IDs.
	Claims	Capitation	Their desease management program is for case management only and they will start submitting the capitation payments with Type of Service of PCCM starting in 2008.
			In Q2 to Q4 2000 there are a few capitation claims with a Type of Service of 19.
			Until 2001 there aren't any PCCM capitation claims, although there is some PCCM enrollment.
		Encounter	There is a big drop in OT encounter claims starting with Q2 2001.
		IP	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.
		LT	Over 99 percent of the claims have a Patient Status of 30 (Still a Patient) which is higher than expected. Also, no one has a Patient Status of 20 (Expired/Died).

State	File Type	Record Type	Issue
WA	Claims	LT	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, their 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.
			Washington does not cover Leave Days.
			From 2006 Q3 to 2007 Q2 the Type of Service was incorrectly reported as PHP capitation on LT Service Tracking claims.
			Washington does not have diagnosis codes on nursing home claims.
		MSIS ID	In 2002, about 8 percent of people with claims did not link to the MSIS eligibility file. This linkage problem continues through 2008. The state suspects that some of these may be Family Planning Only waiver enrollees and some mental health retro claims. They have been unable to send a cross reference file and provide a complete explanation.
		OT	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.
			In 2003 Q3, WA submitted a large number of claims that don't link with the EL file. The total number of claims in that quarter increased by the same percentage. There are claims for about 80,000 people enrolled in their FP Only wiaver and were submitted with an incorrect MSIS ID.
			In 1999, the waiver and BHO capitation expenditures are reported as service tracking claims and the individual claims that were availale are in the OT file as encounter claims, with a program code reported in the Billing Provider ID field (or service code indicator - check)
			There are the following state-specific diagnosis codes on the file: V950,V990, and V960). According to Washington, "These are valid Washington MMIS codes with the decimal removed as required (i.e. V95.0 -DAY HEALTH CARE; V96.0 - EPSDT/HEALTHY KIDS)."
			There are no claims classified as HH in the Q2-4 2004-2005 Q1 OT files due to a state system problem. The state planned to correct this with the 2005 Q1 files, but didn't.

State	File Type	Record Type	Issue
WA	Claims	OT	WA includes the BHP capitation claims made to their Regional Support Networks with the waiver service tracking claims.
			Washington did not 8-fill the place of service on the capitation claims on their 1999 files (Q1-Q4). CMS will raise the error tolerance on these files and ask the state to fix the problem in 2000. CMS would like to get their files approved, hence the reason that they are raising the error tolerance vs. asking them to resubmit. CMS will ask the state to properly 8-fill the field on their 2000 files. ??has this happened??
			There are some duplicate state-specific Service Codes with different definitions. They have the same Service Code Indicator. This is under investigation with the state.
		RX	The Date Prescribed was also put in the Fill Date field on all claims from 1999 to 2002. This means that there will appear to be duplicate claims when there are refills. It also makes it difficult to properly adjust the claims.
			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.
		Supplemental Cap Claims	Claims with services codes 0351M, 0365M, 0366M, 0367M ??should be or are?? recoded Type of Service 20. The first 0351M is a supplemental premium payment related to newborns. The plans are allowed to use this code for the first 90 days or so of a person's life until they can be officially added to the system. 0365M is a capitation payment related to delivery; 0366M is a managed health care payment related to FQHC or RHC and delivery; 0367M has to do with BHP+ and maternity. Codes appear to be related to compensating plans for adding a newborn.

State	File Type	Record Type	Issue
WA	Claims	Waiver Claims	It has been difficult for WA to include claims in the MSIS files for the six programs that are not processed in the WA MMIS (some waiver, some not) as they are collected and paid in a different manner from the MSIS. As a result thay have been submitted differently in different years as the state attempted to do the best possible job of reporting given the limitations of the external data system. The programs are: 11 - Division of Developmental Disability (a mix of individual and combined data is available), 12 - MH Disabled (only lump sum payments are available) , 13 - Division of Alcohol & Substance Abuse (WA believes that these are actually included as individual claims in MSIS for this time period, 14 - Aging (individual claims are available), 15 - Economic Services Administration (lump sum payments only), 16 - Children's Administration (individual claims available), 17 Juvenile Rehab Administration (these are being provided to the state by another source).
	Eligibility	0-filling	Washington's data are not consistent across variables with regard to the number of persons who are ineligible each month. In FY 2000Q3 - FY 2000Q4 about 1,200 ineligibles (MAS/BOE 00) each month are not coded as ineligible for the following variables: TANF, RBF, Plan Type 1 - 4, Plan ID 1 - 4, CHIP Code. Many of these problems continued in FY 2001 forward. In addition, from FY99 forward, about 25 - 300 current enrollees each month have TANF, RBF, and plan type fields 0-filled by mistake. The state's research shows that these individuals should not be reported in the MSIS data and the state will make this fix when they implement their new MMIS in December 2008.
		County Codes	Washington's county code data were not reliable until Q1 FY 2002.
		Data System Change	Through Q4 FY07, WA submitted its eligibility files about five weeks after the end of the quarter. Since WA has elected not to submit retroactive or correction records, we were concerned that the submission date did not allow for many possible correction/retro changes to be included in the file. Particularly as the monthly counts for some MASBOE groups start high in month 1 of each quarter and then drop in months 2 and 3. Month 1 of the next quarter starts high again. It was possible that the data were undercounting Medicaid enrollment in months 2 and 3 of each quarter. Starting in Q1 FY08, WA delayed their file submissions until closer to the due dates and it appears to have helped make the data more complete, thereby smoothing out the seam effect.

State	File Type	Record Type	Issue
WA	Eligibility	Data System Change	WA will be implementing a new MMIS in December 2008 and effective with the Q1 FY09 file submission.
		Date of Death	In Q1 FY 1999, 587 individuals were reported to have a date of death before 1998.
		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 similiar 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 adjument that occurred around this time.
			In FY 1999, Washington reported some eligibles with Dual Eligibility Flag = 00 and Dual Eligibility Flag = 02 in MAS/BOE 31 and 32. We generally expect that eligibles in MAS/BOE 31 and 32 would receive Dual Eligibility Flags 01, 03, 05, 06, or 07. This problem decreased substantially across FY 1999, however.
			Three percent of QMB full enrollees in Washington's Q1 FY 2003 file did not receive Medicare Part A, according to an analysis by CMS. Washington believes this is due to the fact that the state does not pay Part A premiums retroactively when it is not deemed cost-effective to do so.
		HIC Numbers	The percent of duals with valid HICs fell from 99 percent in Q1 FY05 to 54 percent in Q2 FY05, and then back to 99 percent in Q3 FY05. This was the result of a problem with WA's eligibility data processing system that caused this drop in Q2 before being corrected in Q3.
			More than 96 percent of Washington's non-dual eligibles have the HIC number 9-filled. Technically, the HIC number should be 8-filled for non-dual eligibles.
		Managed Care	In February 2007, WA's PCCM enrollment increased from about 3,500 enrollees per month to over 60,000 when the state started Chronic Care management for FFS clients. After identifying clients who would benefits from chronic care management, the state pays the provider a fee to provide these services. The state expects that the enrollment will 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 (cause unknown). We've asked the state to clarify why it appears that Chronic Care enrollment is not included in the CMS report.

State	File Type	Record Type	Issue
WA	Eligibility	Managed Care	In June 2004, 2005, and 2006, WA reports about 60,000 persons as PAHP enrollees in the CMS managed care report. These persons were enrolleed in WA's pilot Disease Management Programs. The state was not able to include these individuals in MSIS data; however, starting in Q1 FY06, WA's MMIS was changed to identify these DM enrollees for whom a monthly payment was generated. As a result of this change, PCCM enrollment increased from 4,000 in Q4 FY05 to 67,000 in Q1 FY06. Prior to Q1 FY06, very few monthly DM payments were generated. The program ended June 30, 2006 causing PCCM enrollment in MSIS to drop back down to about 4,000 enrollees per month in August 2006.
			Through FY06 Q2, WA mistakenly reported enrollees in Plan ID # 7520000 to Plan Type 01 (HMO enrollees). These enrollees should have been reported to Plan Type 06 (PACE).
			The Q2 FY02 MSIS file loaded on the CMS Data Mart is an old submission that contains an error in the count of HMO enrollment. The January 2002 count is reported at about 290,000 instead of the 435,000 count reported in a later MSIS file submission. CMS was unable to load the later file into their database; however the newer file was used to create the 2002 MAX file. Therefore, the error does not show up in MAX.
			From FY 1999 to FY 2001, managed care enrollment generally increased from the first month of the quarter to the third. It then decreased somewhat at the beginning of the next quarter.
			Washington was not reporting claims or enrollment information for its behavioral managed care plan in MSIS during FY 1999, FY 2000, and FY 2001. According to CMS data, enrollment in the BHP plan ranged from about 1.4 million in FY 1999 to about 750,000 in FY 2001. BHP enrollment was added for FY 2002.
			In Q3 FY04, WA's reported BHP enrollment was 16% higher in MSIS compared to the CMS June managed care report. However, the state indicated that an error was made in the CMS data and the MSIS data is more reliable.

State	File Type	Record Type	Issue
WA	Eligibility	Managed Care	The Department of Social and Health Services administers the BHP program and provides only one plan ID in MSIS in contrast to 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. The behavioral managed care "enrollment" count for each month reflects TOTAL Medicaid eligibles (including all full and partial duals). We've asked the state to clarify how coverage would work for these groups.
		MASBOE	All Years: From FY 1999 forward, 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 their file submissions in FY08, which helped make the data more complete, thereby smoothing out the seam effect. 2003-2004: Due to a state programming error, there is a drop in MASBOE 31-32 enrollment in Q4FY03. Then, in Q1 FY04, enrollment in MASBOE 31-32 returns to the levels reported in Q3 FY03. 2004: Enrollment in MASBOE 14-15 increased at the beginning of Q2 FY04. Enrollment in MASBOE 14 increased about 12% and enrollment in MASBOE 15 increased about 18% from December 2003 to January 2004 (cause unknown). 2000-2001: Enrollment among children and adults grew by over 70,000 (a 10 percent increase) from March to May, 2000, but then declined by 40,000 by the end of Q4 FY 2000 (cause unknown). Effective Q4 FY 2001, Washington extended family planning benefits to adults in an 1115 demonstration. 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. 1999-2000: Enrollment in MAS/BOE 16 - 17 declined from roughly 34,000 in June 1999 to less than 1,000 in FY 2000.

State	File Type	Record Type	Issue
WA	Eligibility	MASBOE	2005: In Q4 FY05, WA removed roughly 5,000 undocumented clients (MASBOE 35) from the MSIS file. These individuals qualified for emergency service related to pregnancy, but not under Title XIX Medicaid. WA moved coverage for this group to S-CHIP (using the unborn children provisions) which the state does not report in MSIS.
			2006 - 2007: 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 FY07.
			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.
			2003-2004: In FY03 and Q1 FY04, some persons were reported to MASBOE 99 by mistake. In addition, a few persons were reported to MASBOE 17 who should have been reported to MASBOE 15.
		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/Pacfic 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 their method of race code processing.
		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. MFP enrollees will be assigned RBF code 8 in MSIS and are expected to start being reported in Q4 FY08.

State	File Type	Record Type	Issue
WA	Eligibility	Restricted Benefits Flag	WA assigns restricted benefits flag 5 to persons in the medically needy group. Previously, the state also assigned RBF 5 to women in MAS/BOE 35 who only qualify for family planning benefits in the post-partum period, as well as women in MASBOE 55 covered by an 1115 family planning only waiver. However, effective Q2 FY06, WA began assigning RBF code 6 to these family planning only enrollees in MASBOE 35 and 55.
			Until Q1 FY 2002, Washington had a problem with the Restricted Benefit Flag (RBF), as it relates to the Dual Eligibility Flag. Many eligibles with Dual Eligible Flags 01, 03, 05, 06, and 07 are reported to have RBF = 1 (individual is entitled to the full scope of Medicaid benefits). These dual eligibility groups should receive RBF = 3 (individual is eligible for Medicaid, but only entitled to restricted benefits based on dual eligibility status). Some discrepancy between the Dual Eligibility Flag and the RBF is expected, since the Dual Eligibility Flag is a root field, and the RBF is a monthly variable. However, this is a greater difference than we expect to see. There was also a problem with the restricted benefits flag for 1115 enrollees. Even though 1115 enrollees beginning in FY 2001 only qualify for family planning benefits, they are reported to have restricted benefits flag 1, full benefits until Q1 FY 2002 data when WA correctly started assigned RBF 5 to this group.
			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.
		CHIP Code	Washington operates an S-CHIP program, but does not report enrollment in MSIS. The state does not have an M-CHIP program.
			Each month in FY 1999 - FY 2001, 30 - 60 individuals in MAS/BOE 00 were coded with blank CHIP Codes.
		State-Specific Eligibility	Effective Q1 FY01, MSIS DQ reports switched to using a 4 byte state specific eligibility code for WA. Prior to this, the 6 byte state specific code meant that there were thousands of state specific code combinations making these codes difficult to use.
		TANF/1931	Almost all eligibles in MAS/BOE 14-17 are TANF recipients (through FY06).
			In FY 2002, Washington TANF data are about 15 percent lower than ACF counts (cause unknown), while the FY03 and FY04 data are 10% lower. TANF counts are more consistent across the two sources starting in FY05 forward.

State	File Type	Record Type	Issue
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).
			In Q1 FY05 - Q2 FY06, WA reported all enrollees in WA's 1915(b) waivers to waiver ID 2, even if they only had one waiver. If an individual is only enrolled in one waiver, it should be reported in waiver ID 1.
			In Q2-3 FY07, WA reported a small number (<5) of enrolles with a blank Waiver Type and Waiver ID in some months. It appears that this beneficiary should be assigned to the "not enrolled in waiver" category, waiver type "8" and ID "88". The state will make this fix once they move to the new MMIS system.
		xREVIEW NOTE	(1) WA will be changing MMIS system effective Q1 FY09--send state Q4 FY08 DQ reports with the Q4 review (see 5/29/08 emails) so state can use as basis of comparison to ensure that new system is providing same reporting. Also, there might be a change in ID assignments--coordinate xref file requests with MPR/CMS; (2) See 9/10/08 email indicating new system will allow retro/correction records to be submitted; (3) look for MFP enrollment to RBF 8 in Q4 FY08. (4) watch consistency of race/ethnicity reporting in new MMIS.
	Encounter	IP	Only one UB-92 Revenue Code is reported, so if there is an accommodation code, then there aren't any ancillary codes.
		RX	NDC code is missing on RX encounter claims.
			Days Supply is missing on RX encounter claims.
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.
			Wisconsin is not an SSN state, but submits their MSIS EL files using SSN rules. They assign Temp Ids to people who don't have a SSN (usually babies) and then when the enrollee gets a SSN they use that for the MSIS ID. Wisconsin uses the SSN with an additional byte on the end as their permanent MSIS ID numbers. The extra byte is "0" unless there someone else has previously enrolled in the system with the same SSN.
	Claims	Adjustments	The files may contain some denied claims.

State	File Type	Record Type	Issue
WI	Claims	Capitation	There are two non-comprehensive plan types that appear on the eligibility file with capitation claims with a Type of Service of 20. They are Plan ID 65 (PACE) and Plan ID 66 (Other managed care). Wisconsin will start reporting the capitation claims for Other Managed Care with a Type of Service of 21 (PHP) starting with the 2001 files.
			The PHP capitation rate is very high as it is used to cover Aged/Blind/Disabled managed care services.
			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 month prior to the managed care enrollment. Also, this results in the adjustments not linking to the original claims by date of payment.
		IP	There are no claims with a Program Type of Family Planning.
		OT	The void adjustment claims have the span dates on the claim header, while the originals and resubmissions have the line item service date.
			Wisconsin's system requires diagnosis codes on all claims regardless of Type of Service.
			There are fewer than expected PHP capitation claims compared to the person months of enrollment in a PHP in 2003.
			Emergency Room use is under-reported because it is only picked up using UB-92 revenue codes which are not always/often used. Wisconsin plans a system change to pick up ER information for all ER services. ??Have they done this?? ??by place of service or revenue codes??
			Wisconsin does not require Provider ID Number Servicing on outpatient hospital claims
			UB-92 code 001 occurs on many outpatient hospital claims as Wisconsin uses it for rate reimbursement.
			Wisconsin has two Service Codes that can have different meanings but are not distinguishable on the MSIS claims. These codes are W0500 and W0520.
		RX	Prior authorization drugs have eleven "8"s in the NDC field.

State	File Type	Record Type	Issue
WI	Claims	Waivers	In Q4 FY 2001 OT files, Wisconsin included all the waiver claims going back to service dates in January 2000. These claims have state-specific procedure codes, no diagnoses, and a mean expenditure of $553. WI only reports their 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.
	Eligibility	1115 Waivers	In 1999, WI implemented a major 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. Effective September 2002, Wisconsin added a SeniorCare program (Pharm Plus) to its 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, but changed to cover only those drugs excluded from Part D coverage. Wisconsin's 1115 waiver also extends Familiy Planning benefits, effective Q2 FY 2003. REVISE: Effective February 2008, WI implemented a new BadgerCare Plus program that replaces all of BadgerCare as well as family coverage under the Medicaid program. The new program expands health coverage for both children and their parents/caretakers. Enrollment should increase in WI's Q2 FY08 file as eligibility levels for these groups has increased substantially to include Medicaid parents with income between 185 - 200%FPL; all children above 185% FPL; and, pregnant women with income between 185 - 300% FPL. In addition, eligibility expanded for caretaker relatives, parents with children in foster care, and youths aging out of foster care. WI had a Katrina waiver approved on 3/24/06. The state implemented the waiver, however it was greatly delayed and the state ended up enrolling very few people. By the time this information was in their system, the MSIS files had already been submitted. Since the state does not submit retro/corr records, the Katrina information was not added to the files. The state estimated that about 700 individuals were enrolled each month from September - December 2005.

State	File Type	Record Type	Issue
WI	Eligibility	County Codes	For about 10,000 eligibles, Wisconsin reports county codes other than the standard FIPS codes. These codes are for Relief to Needy Indian Person (RNIP) agencies, juvenile correction agencies, Division of Children and Family Services agencies, and Katie Beckett eligibles.
		Dual Eligibility Codes	Wisconsin assigned dual flag 08 to about 25% (26,000 persons) of its dual population, a higher proportion than expected. This dropped to about 15% in FY06.
			Effective Q1 FY 2003, Wisconsin assigned dual code 09 to persons in its Pharmacy Plus Program not qualifying under other dual codes.
			In FY06, the monthly dual code field was left blank for some non-dual, current enrollees instead of always being 0-filled. This was corrected in Q1 FY07.
			Some disabled duals in MAS/BOE 32 may have full Medicaid benefits. They are in waiver programs allowing them to pay premiums for full Medicaid coverage.
		Managed Care	An error was discovered in WI's FY07 data that applies to previous years. Plan IDs 63 and 67 are 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) for all years. In addition, Plan ID 69 stopped being PACE on 3/31/01, but continued to be reported as PACE in MSIS. Therefore, starting in Q3 FY01, this plan should have been reported as an HMO as well. The state expected to correct the plan type reporting for these plans from 06 (PACE) to 01 (HMO) by its Q1 FY08 file, but that did not happen. We've asked the state to give an update on when this fix will be made. (Plan ID 65 continues to provide PACE services and should continue to be reported to plan type 06 in MSIS.)
			Through June 2005, both MSIS and CMS were reporting about 9,000 individuals with Long Term Care enrollment. This LTC enrollment was reported in the "Family Care" plan in the CMS data and to La Crosse County CMO and Community Care of Portage County (Plan IDs 58 and 59) in MSIS. It appears that WI began reporting enrollment in the "Family Care" program as a Commercial MCO in the June 2006 CMS data, while enrollment in plan IDs 58 and 59 continued to be reported as LTC in MSIS.

State	File Type	Record Type	Issue
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.
			A large HMO was terminated in April 2000, causing over 30,000 enrollees to switch to FFS. In June and July 2000, these eligibles enrolled in another HMO.
		MASBOE	2002 - Present: Effective September 2002, Wisconsin added a SeniorCare program (Pharm Plus) to its 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.
			2006: A report from the Center on Budget and Policy Priorities indicted that Wisconsin experienced enrollment declines attributed to new citizenship documentation requirements in the second half of 2006. MSIS data shows a decline across several eligibility groups between August and December 2006.
			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.
			1999 - Present: In 1999, WI implemented a major 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.

State	File Type	Record Type	Issue
WI	Eligibility	MASBOE	In Q1 FY08, WI reporting 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.
			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.
			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.
			1999 - Present: 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.
		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.
		Race/Ethnicity	Through Q2 FY 2002, a third of Wisconsin's Medicaid population had the race field coded as "unknown." The proportion is down to one quarter by Q4 FY 2002 and less than 20% by FY2006.
		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 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 are assigned RBF 7.

State	File Type	Record Type	Issue
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. MPF enrollees will be assigned RBF code 8 in MSIS.
			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.
		CHIP Code	Wisconsin reported a small number of M-CHIP children until FY1999 Q3, when enrollment increased substantially. M-CHIP children (B1, B2, B3) are reported under MAS/BOE 54, since they are part of the state's 1115 Badger Care demonstration.
			Effective Q2 FY 2001, Wisconsin began to cover adults under its CHIP program. M-CHIP adults are reported into MAS/BOE 55. M-CHIP adult (B4, B5, B6) counts in MSIS are 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 CHIP adults 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%).
			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. WI will not be including this S-CHIP enrollment information in MSIS.

State	File Type	Record Type	Issue
WI	Eligibility	CHIP Code	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.
		SSN	Wisconsin 8-fills 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.
		TANF/1931	Wisconsin is unable to identify TANF recipients. The field is 9-filled for all eligibles.
		Waivers	WI does not report enrollment in the state's 1915(b) and 1915(c) waivers. WI is not able to report this information on a current timeline. This enrollment information was going to be available as part of the state's new MMIS, but that system has been put on hold indefinitely. In the meantime, WI had possibly planned to provide enrollment data based on claims data reconciled the following calendar year. At this point, CMS has decided that they do not want to hold up MSIS processing as long as would be needed to receive this information through retro/correction records to be included in the MSIS system. So, for now the state has been asked to work out a plan for gathering and reporting actual waiver enrollment, not based on claims data, and in a more timely manner. This will involve some operation/system changes and the state is hoping to incorporate into its sytem by 2009.
		xREVIEW NOTES	(1) watch MMA comparision in Q3 FY08 as counts started to diverge a little with implmentation of BC+ in Q2
WV	All	MSIS ID	There was a small claims/eligibility linkage problem in 2003 and 2004.
	Claims	All	There was a major system change that affected the Q4 1999 files.

State	File Type	Record Type	Issue
WV	Claims	All	Due to billing cycles, files contain some claims from months prior to the quarter and there is a "shortfall" (fewer than expected records) in the last month of the quarter. This also results in very uneven number of claims submitted in each quarter of the MSIS claims files. This was corrected in 2006.
			There are a few claims in the file with the incorrect adjustment indicator.
			WV did not process any crossover claims from July 2004 - March 2005 due to a system change. Those 'lost' crossover claims will be included in the Q3 2005 MSIS files.
		Capitation	The 1999 and 2005 Q2 files do not contain individual HMO capitation claims.
		Crossovers	WV did not process any crossover claims from July1, 2004 to March 2005 as they were changing systems. These missing crossover claims should be included in the 2005 Q3 files.
		IP	There are no claims with Program Type of 2 (Family Planning).
			The amount paid on IP service tracking claims is greater than the amount paid as FFS.
		LT	The percent of claims paid per month were especially uneven - also due to system change. Claims are generally paid once a month, but any particular month's payments schedule can slip into the next month.
			Diagnosis codes 1 to 5 are missing on most claims.
		OT	In 2004 Q1 WV started submitting managed care capitation claims as service tracking claims instead of individual capitation payments.
			The Place of Service of ER under-reported until Q4 1999.
			In the Q1 FY 1999 file, there are 11 claims flagged as capitation payments that are actually service tracking claims; these claims have an average Medicaid Amount Paid of $1.3 million.
			UB-92 Revenue Codes are not available for Q2 1999 and mostly missing in Q3 FY 1999.
			There is a big increase in the number of FFS claims in Q3 2000.
		RX	There are claims with Program Type of 2 (Family Planning) in Q1 to Q4 1999, but not after, due to a system change.

State	File Type	Record Type	Issue
WV	Claims	RX	Prescribing Physician ID Number is missing on all claims.
			Other Third Party Payment (or Third Party Liability/TPL) is missing on all claims.
	Eligibility	County Codes	West Virginia correctly used FIPS for the county codes in Q1 to Q2 FY 1999. In Q3 to Q4 FY 1999, however, the state incorrectly used a state-specific county code. The state used FIPS codes in FY 2000.
		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 approximate 28,000 SSI recipients (reported to MASBOE 11-12) reported as duals in MSIS. We feel most of these SSI recipients should be reported 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.
			Starting in Q2 FY06, WV started reporting a very small number (<10) individuals to dual code 99 each month (an invalid code). They appear to be Medicaid enrollees as other data fields are assigned valid codes, such as state-specific codes "AMLTN" and "QDQMB". This was fixed starting in Q1 FY07 and all individuals were assigned a valid code.
			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 "QIA". 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.

State	File Type	Record Type	Issue
WV	Eligibility	Dual Eligibility Codes	Until Q1 FY03, approximately 75 percent of dual eligibles were coded with dual flag 09. The state was able to identify these individuals as dual eligibles, but could not determine the basis of their dual eligibility. Effective Q1 FY03, all full benefit duals went to dual code 08 and partial duals to code 01.
		Managed Care	Because a managed care contract expired at the end of October 1999, managed care enrollment dropped off beginning in November 1999.
			In September 1999, 728 enrollees had the managed care plan type field 9-filled by mistake.
			From month 2 to month 3 of Q2 FY06 (February to March 2006) WV's PCCM enrollment increased from about 13,000 enrollees to about 23,000 enrollees per month. The state explained that they moved to auto assignment at that time which resulted in a large enrollment increase.
			During FY05, HMO enrollment reporting increased (across all Plan IDs) while PCCM enrollment decreased. The Q3 FY05 MSIS data compares well to the CMS June 2005 managed care report. The state confirmed that these counts were correct.
			West Virginia began to use a new set of managed care plans IDs in June 1999.
			In FY03 and FY04, WV's PCCM reporting in MSIS was >10% lower compared to the number reported to CMS managed care reports in June 2003 and June 2004. The state explained that the CMS reporting was problematic and the MSIS numbers are correct. Sources compared well in FY05.
		MASBOE	2006: There was an increase in reporting to MASBOE 31-32 in Q2 FY06 (about 9,000 new enrollees) when WV added SLMB and QI enrollees (dual codes 03 and 06) to the MSIS file.
			2000: Between the end of FY 2000 and the beginning of FY 2001, West Virginia slightly adjusted their age sort for BOE 4 and BOE 5.
			2003: In Q1 FY03, aged nursing home recipients previously mapped to MASBOE 11 were moved to MASBOE 41.
			2001: Beginning in Q3 FY 2001, West Virginia assigned state code RDF and RDFQ to women in the breast and cervical cancer program (BCCP). However, these eligibles were erroneously mapped to MAS/BOE 35 through Q4 FY 2002.

State	File Type	Record Type	Issue
WV	Eligibility	MASBOE	2003: In Q1 FY03, WV began using a new set of state specific eligibility codes as it moved from ACS to a new MMIS contractor, Unisys. This resulted in some redistribution by MASBOE group, as some previous mapping errors were discovered. MASBOE 35 and 45 increased while MASBOE 15 declined. This suggests poverty-related pregnant women were undercounted in the past. 2002: West Virginia reported a higher than expected (roughly 5%) number of eligibles in BOE 1 who are under age 65. The state believes this is caused by reporting all the persons in long-term care and QMB-only to BOE 1. This policy was corrected beginning in September 2002 data. 1998: Medicaid enrollment declined by about 30,000 persons from October 1998 to November 1998. Enrollment fell in most MAS/BOE groups, but fell most dramatically in MAS/BOE 34. 2006: From May to June 2006 (Q3 FY06) there was a shift of about 500 enrollees from MASBOE 41 to MASBOE 21 (state-specific eligibility code "AMLTN" to code "WMLTN"). The state indicated that they started distinguishing enrollees in MLTN and MLTI groups as to whether or not they are are categorically needy or medically needy. This resulted in a "W" being assigned in byte 1 of the state code for individuals that qualify through spenddown. Prior to this change, all MLTN and MLTI codes were prefixed by "A". 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. 2005: In Q1 FY05, WV made some changes to its MASBOE crosswalk causing some shifts in MASBOE reporting. The biggest shift (~130,000 child enrollees) was from MASBOE 34 to MASBOE 44 (state code FCMQCA).

State	File Type	Record Type	Issue
WV	Eligibility	MASBOE	2001: Beginning in Q4 FY 2001, West Virginia decided to change how eligibility for children was determined to insure that all children receive a 12-month continuous enrollment guarantee. This change resulted in a substantial enrollment shift from MAS/BOE 14 and 16 to MAS/BOE 34.
			2003: In Q3-Q4 FY03, About 2,000 persons were assigned to the wrong state eligibility and MASBOE groups. Persons assigned to QAQMB, QBQMB, and QDQMB with dual code of 08 and restricted benefit code of 01 should have been assigned to AMLTN, DMALN, or FDMALH (or smaller groups AMLTI, AMPD, AMPW, DMPC, DMPD, DMPG, DMPT, and DMPW) and thus mapped to MASBOE 41-42.
			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.
			2001-2002: In FY 2001 and FY 2002, West Virginia mistakenly mapped 15- to 18-year-olds in state-specific eligibility groups FCDC and FCSC to MAS/BOE 35. These individuals should have been mapped to MAS/BOE 34. This error was fixed in FY03.
		Private Health Insurance	MSIS data show a 17 percent increase in the number of enrollees with private health insurance from November 2001 to December 2001. The state believes this data to be correct. In Q1 FY03, private insurance coverage increased. Two factors were involved: (1) the state moved to a new contractor, Unisys, and (2) the Q1 FY03 file was delayed in getting approved, so more retroactive changes may have occurred.
			From October 1998 to May 1999, no one was reported to have any private health insurance. Beginning in June 1999, between four and five percent of eligibles are reported as having private health insurance.
			From the end of Q1 FY06 to the start of Q2 FY06, reporting to Health Insurance flag 2 increased from about 23,000 enrollees to about 76,000 enrollees. This was an error and should be corrected in the new Q2 FY06 file submission.
		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 their system.

State	File Type	Record Type	Issue
WV	Eligibility	Restricted Benefits Flag	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. The state fixed its programming so that in Q1 FY07 they were able to include this enrollment with the assignment of RBF 2 to state-specific groups that end with: MIIS, MIIR or MIIU. 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. Implemenation occured 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) start low in Q2 FY07 because the state provided limited coverage in only two counties. WV expects that enrollment counts will pick up in Q1FY08 since the state extended coverage to additional counties in October 2007. The state expects that eventually about 50% of Medicaid enrolllees will be able to participate in this new coverage.
		Retroactive/Correction Records	After not submitting retros for a very long time, WV included retros with its Q1 FY06 file that included a small number of retros back to 1999. The state included only 3 quarters of retro records starting in Q4 FY07. In addition, 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. We've asked the state to review the reporting to this field to correctly identify the type of record and FFY/Q information.
		CHIP Code	WV 9-filled the CHIP code for current enrollees each month starting in Q1 FY03. These enrollees should be assigned CHIP code = 1. The State fixed this starting in FY05. 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 a S-CHIP program, but does not report its S-CHIP enrollment in MSIS.

State	File Type	Record Type	Issue
WV	Eligibility	SSN	It appears that WV is submitting valid SSNs for over 99 percent of Medicaid enrollees, which is higher than generally expected since SSNs are not always available for some enrollees, such as newborns, younger children, or undocumented aliens. However, the state expressed that they have been putting extra efforts into obtaining valid SSNs for most of the Medicaid population and confirmed that they believe these data in MSIS are reliable.
			Through FY05, WV 0-filled missing SSNs instead of 9-filling. This was corrected starting in Q1 FY06.
		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."
			In Q1 FY03, WV began using a new set of state specific eligibility codes as it moved from ACS to a new MMIS contractor, Unisys.
		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.
WY	Claims	Capitation	There aren't any capitation claims as Wyoming doesn't have managed care.
		IP	The percent of claims without an accommodation code jumped from 0 percent to 8 percent in Q1 2003.
			Wyoming does not use DRGs for reimbursement.
		LT	There aren't any claims for Type of Service 02 (Mental Hospital for the Aged).??KFF says WY covers this but not IP Psych <22
			The Admission Date is missing frm 1999-2002.

State	File Type	Record Type	Issue
WY	Claims	LT	Diagnosis Codes are missing on most records prior to Q2 2004.
	Eligibility	1115 Waivers	WY had a Katrina waiver approved on 2/17/06.
		Date of Birth	WY added a new state group (A49) in April 2004 for unborn children which also caused the state to start showing invalid/missing birthdates in their data (about 1,400 per month by Q4 FY06) since the information is not known for these enrollees.
		Dual Eligibility Codes	From Q1 FY 1999 to Q3 FY 2001, Wyoming assigned dual flag 09 to about 35 percent of its dual population, a higher proportion than expected. Beginning in FY 2001Q4, the state had system enhancements, which allowed them to identify most persons this population as SLMB+ (dual flag = 04).
			In FY03, WY assigned <200 persons to dual code 99 each month. These are persons over 65 and over whose eligibility for Medicare could not be confirmed by the state.
			In Q1 to Q3 FY 2002, Wyoming had a lower than expected proportion of Dual Eligibles with valid HIC numbers. The state fixed the problem in Q4 FY 2002.
		Managed Care	Wyoming has no managed care.
		MASBOE	2005 - 2006: WY reported about a 13% decline in enrollment in BOE 5 (adults) from October 2005 to September 2006 (cause unknown).
			2004: In Q1 FY04, WY decided to shift newborn children (state group A53) from MASBOE 34 to MASBOE 44. In addition, the state implemented some improved age sorts for groups mapped to MASBOE 34-35. Finally, the problem related to BCCPTA enrollees was corrected.
			All Years: WY reports SSI disabled age 65+ to MASBOE 11.
			2004: Effective Q1 FY04, ACS became the WY MMIS contractor.
			2004: In about April 2004, WY added a new state specific eligibility code (A49) for unborn children. They are mapped to MASBOE 44.

State	File Type	Record Type	Issue
WY	Eligibility	MASBOE	2004 - 2006: In FY04 and FY05, WY showed about 13% fewer enrollees to MASBOE 11-12 than SSA reports, according to SSI administration data. SSI enrollees in state groups S09, S46, S92, and S93 are reported to MASBOE 42, explaining this discrepancy. Beginning in Q1 FY06, WY mapped individuals in S46 and S94 to MASBOE 12. The state indicated that it felt that S09 and S92 should continue to be reported to MASBOE 42. In FY06, WY reported 6% fewer enrollees to MASBOE 11-12 than what was reported to SSA.
			2002 - 2003: In Q4 FY 2002 and FY03, 1400 enrollees in state group B05 (non-Medicaid Breast & Cervical Cancer program) were assigned to MAS/BOE 35. They should have been assigned MAS/BOE 00. In addition, some individuals in state group D05 (maternal dental care) were mapped to MAS/BOE 51 in error. They should have been mapped to MAS/BOE 00, since this is a state-funded program. Finally, persons in state group B03 and B04 should be mapped to MASBOE 3A, not MASBOE 35.
		Private Health Insurance	The number of enrollees with private insurance showed an unexpected increased in Q4 FY 2002, apparently because the file was submitted later than usual, and more data had become available at the time of submission. In FY03, reported private insurance returned to usual levels. Then in Q3 FY04, private insurance rates increased somewhat because of an error in how the state began to count children with both Medicaid and S-CHIP during a month. Basically, Medicaid children were assigned insurance code 2 if they had any S-CHIP coverage during a month. So if a child had 10 days on Medicaid and 20 days on S-CHIP, she would be assigned insurance code 2. WY stopped assigning the private insurance code for children in this situation in Q4 FY04.
		Restricted Benefits Flag	WY assigns restricted benefits flag 5 (restricted--other) to a small number of enrollees (<10) each month. They are in state codes S50, S51, and S54; however, the state is not sure what benefits they receive causing the assignment of flag 5.
		CHIP Code	Wyoming, which has an S-CHIP program, but not an M-CHIP program, is not reporting its S-CHIP eligibles into MSIS.
		SSN	WY has a slightly higher than expected percent of records with missing SSNs (~7.5%), but is working to improve this data. By FY06, the state was reporting about 5.5% of records with missing SSNs. The state provided a linking file that provides MSIS IDs and SSNs for the FY05-06 period.

State	File Type	Record Type	Issue
WY	Eligibility	TANF/1931	Wyoming TANF data are not reliable. The state began 9-filling the TANF flag in Q1 FY04.
		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.
		xREVIEW NOTE	In previous reviews, WY has been asked to delay its file submission. The Q3 FY08 file was delayed about one month, but was still only about 6-7 weeks after the end of the quarter. See when the next quarter is submitted and whether it is worth raising again.