

cases that were certified eligible in the fourth month prior to the month of case selection;

(ii) Identify claims paid for services furnished to all individuals during the review month (and, if indicated, any months prior to the review month in the agency's selected spenddown period) for these cases;

(iii) Stratify the cases by dollar value of the claims into three strata; and

(iv) Select a second statistically valid sample within each group subject to the sample size requirements specified in paragraph (b)(3) or (j)(1) of this section.

§ 431.816 Case review completion deadlines and submittal of reports.

(a) The agency must complete case reviews and submit reports of findings to CMS as specified in paragraph (b) of this section in the form and at the time specified by CMS.

(b) In addition to the reporting requirements specified in § 431.814 relating to sampling, the agency must complete case reviews and submit reports of findings to CMS in accordance with paragraphs (b)(1) through (6) of this section for review periods beginning after July 1, 1990. The agency must not combine or otherwise integrate case findings from the MAO and AFDC strata to meet the case percentage deadlines as specified in paragraphs (b)(1) through (6) of this section.

(1) *Active case eligibility reviews—MAO stratum.* (i) The agency must complete case eligibility reviews and report the findings electronically through the system prescribed by CMS for 90 percent of all active MAO cases within 105 days of the end of the review month for which those cases were reviewed, within 125 days for 95 percent of all active MAO cases, and within 150 days for 100 percent of all MAO active cases.

(ii) The agency must submit a report on cases selected for the review month.

(2) *Active case eligibility reviews—AFDC stratum.* (i) The agency must complete case eligibility reviews for AFDC ineligible and overpaid error cases caused by ineligible individuals and report the findings electronically through the system prescribed by CMS within 105 days of the end of the review

month for which those cases were reviewed for 90 percent of the total reviews; within 125 days of the end of the review month for which those cases were reviewed for 95 percent of the total reviews; and within 150 days of the end of the review month for which those cases were reviewed for 100 percent of the total reviews.

(ii) The agency must report findings electronically through the system prescribed by CMS for 100 percent of the State agency-reported eligible individuals within 30 days after the final time-frame required by the AFDC program as specified in program regulations at 45 CFR 205.40(b)(2)(ii).

(3) *Negative case eligibility reviews.* The agency must submit a monthly progress report on negative case reviews completed during the month unless the agency has an approved superior system in effect. The agency must submit a report on its findings by June 30 of each year for the previous April-September sampling period and by December 31, for the October-March sampling period.

(4) *Payment reviews.* (i) The agency must submit payment review findings electronically through the system prescribed by CMS.

(ii) The agency must complete payment review findings for 100 percent of the active case reviews in its sample and report the findings within 60 days after the first day of the month in which the claims collection process begins. The agency must wait 5 months after the end of each review month before associating the amount of claims paid for each case for services furnished during the review month unless retrospective sampling is elected.

(iii) The agency must make any necessary corrections to claims payments during the month the claim is paid and the following month. CMS will take necessary action to reject any State adjustment adversely affecting the error rate, for example, by not paying claims on error cases.

(5) *Summary of reviews and findings.* The agency must submit summary reports of the findings for all active cases in the 6-month sample by July 31 of each year for the previous April-September sampling period and by January 31 for the October-March sampling

§ 431.818

period. These summary reports must include findings changed in the Federal re-review process.

(6) *Other data and reports.* The agency must report other requested data and reports in a manner prescribed by CMS.

§ 431.818 Access to records: MEQC program.

(a) The agency, upon written request, must mail to the HHS staff all records, including complete local agency eligibility case files or legible copies and all other documents pertaining to its MEQC reviews to which the State has access, including information available under part 435, subpart I, of this chapter.

(b) The agency must mail requested records within 10 working days of receipt of a request, unless the State has an alternate method of submitting these records that is approved by CMS or has received, on an as-needed basis, approval from CMS to extend this timeframe by 3 additional working days to allow for exceptional circumstances.

§ 431.820 Corrective action under the MEQC program.

The agency must—

(a) Take action to correct any active or negative case action errors found in the sample cases;

(b) Take administrative action to prevent or reduce the incidence of those errors; and

(c) By September 15 each year, submit to CMS a report on its error rate analysis and a corrective action plan based on that analysis. The agency must submit revisions to the plan within 60 days of identification of additional error-prone areas, other significant changes in the error rate (that is, changes that the State experiences that increase or decrease its error rate and necessitate immediate corrective action or discontinuance of corrective actions that effectively control the cause of the error rate change), or changes in planned corrective action.

§ 431.822 Resolution of differences in State and Federal case eligibility or payment findings.

(a) When a difference exists between State and Federal case eligibility or

42 CFR Ch. IV (10–1–06 Edition)

payment findings, the Regional Office will notify the agency by a difference letter.

(b) The agency must return the difference letter to the Regional Office within 28 calendar days of the date of the letter indicating either agreement with the Federal finding or reasons for disagreement and if the agency desires a conference to resolve the difference. This period may be shortened if the Regional Office finds that it is necessary to do so in order to meet a case completion deadline, and the State still has a reasonable period of time in which to respond to the letter. If the agency fails to submit the difference letter indicating its agreement or disagreement with the Federal findings within the 28 calendar days (or the shorter period designated as described above), the Federal findings will be sustained.

(c) If the Regional Office disagrees with the agency's response, a difference conference will be scheduled within 20 days of the request of the agency. If a difference cannot be resolved, the State may request a direct presentation of its position to the Regional Administrator. The Regional Administrator has final authority for resolving the difference.

MEDICAID QUALITY CONTROL (MQC) CLAIMS PROCESSING ASSESSMENT SYSTEM

SOURCE: Sections 431.830 through 431.836 appear at 55 FR 22170, May 31, 1990, unless otherwise noted.

§ 431.830 Basic elements of the Medicaid quality control (MQC) claims processing assessment system.

An agency must—

(a) Operate the MQC claims processing assessment system in accordance with the policies, sampling methodology, review procedures, reporting forms, requirements, and other instructions established by CMS.

(b) Identify deficiencies in the claims processing operations.

(c) Measure cost of deficiencies;

(d) Provide data to determine appropriate corrective action;

(e) Provide an assessment of the State's claims processing or that of its fiscal agent;