

Centers for Medicare & Medicaid Services, HHS

§ 431.865

(f) Provide for a claim-by-claim review where justifiable by data; and

(g) Produce an audit trail that can be reviewed by CMS or an outside auditor.

§ 431.832 Reporting requirements for claims processing assessment systems.

(a) The agency must submit reports and data specified in paragraph (b) of this section to CMS, in the form and at the time specified by CMS.

(b) Except when CMS authorizes less stringent reporting, States must submit:

(1) A monthly report on claims processing reviews sampled and or claims processing reviews completed during the month;

(2) A summary report on findings for all reviews in the 6-month sample to be submitted by the end of the 3rd month following the scheduled completion of reviews for that 6 month period; and

(3) Other data and reports as required by CMS.

§ 431.834 Access to records: Claims processing assessment systems.

The agency, upon written request, must provide HHS staff with access to all records pertaining to its MQC claims processing assessment system reviews to which the State has access, including information available under part 435, subpart J, of this chapter.

§ 431.836 Corrective action under the MQC claims processing assessment system.

The agency must—

(a) Take action to correct those errors identified through the claims processing assessment system review and, if cost effective, to recover those funds erroneously spent;

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

(c) By August 31 of each year, submit to CMS a report of its error analysis and a corrective action plan on the reviews conducted since the cut-off-date of the previous corrective action plan.

FEDERAL FINANCIAL PARTICIPATION

§§ 431.861–431.864 [Reserved]

§ 431.865 Disallowance of Federal financial participation for erroneous State payments (for annual assessment periods ending after July 1, 1990).

(a) *Purpose and applicability*—

(1) *Purpose*. This section establishes rules and procedures for disallowing Federal financial participation (FFP) in erroneous medical assistance payments due to eligibility and beneficiary liability errors, as detected through the Medicaid eligibility quality control (MEQC) program required under § 431.806 in effect on and after July 1, 1990.

(2) *Applicability*. This section applies to all States except Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa beginning July 1, 1990.

(b) *Definitions*. For purposes of this section—

Administrator means the Administrator, Centers for Medicare & Medicaid Services or his or her designee.

Annual assessment period means the 12-month period October 1 through September 30 and includes two 6-month sample periods (October-March and April-September).

Beneficiary liability means—

(1) The amount of excess income that must be offset with incurred medical expenses to gain eligibility; or

(2) The amount of payment a recipient must make toward the cost of services.

Erroneous payments means the Medicaid payment that was made for an individual or family under review who—

(1) Was ineligible for the review month or, if full month coverage is not provided, at the time services were received;

(2) Was ineligible to receive a service provided during the review month; or

(3) Had not properly met enrollee liability requirements prior to receiving Medicaid services.

(4) The term does not include payments made for care and services covered under the State plan and furnished to children during a presumptive eligibility period as described in § 435.1102 of this chapter.

National mean error rate means the payment weighted average of the eligibility payment error rates for all States.

National standard means a 3-percent eligibility payment error rate.

State payment error rate means the ratio of erroneous payments for medical assistance to total expenditures for medical assistance (less payments to Supplemental Security Income beneficiaries in section 1634 contract States and payments for children eligible for foster care and adoption assistance under title IV-E of the Act) for cases under review under the MEQC system for each assessment period.

Technical error means an error in an eligibility condition that, if corrected, would not result in a difference in the amount of medical assistance paid. These errors include work incentive program requirements, assignment of social security numbers, the requirement for a separate Medicaid application, monthly reporting requirements, assignment of rights to third party benefits, and failure to apply for benefits for which the family or individual is not eligible. Errors other than those listed in this definition, identified by CMS in subsequent instructions, or approved by CMS are not technical errors.

(c) *Setting of State's payment error rate.*

(1) Each State must, for each annual assessment period, have a payment error rate no greater than 3 percent or be subject to a disallowance of FFP.

(2) A payment error rate for each State is determined by CMS for each annual assessment period by computing the statistical estimate of the ratio of erroneous payments for medical assistance made on behalf of individuals or cases in the sample for services received during the review month to total expenditures for medical assistance for that State made on behalf of individuals or cases in the sample for services received during the review month. This ratio incorporates the findings of a federally re-reviewed subsample of the State's review findings and is projected to the universe of total medical assistance payments for calculating the amount of disallowance under paragraph (d)6 of this section.

(3) The State's payment error rate does not include payments made on behalf of individuals whose eligibility determinations were made exclusively by the Social Security Administration under an agreement under section 1634 of the Act or children found eligible for foster care and adoption assistance under title IV-E of the Act.

(4) The amount of erroneous payments is determined as follows:

(i) For ineligible cases resulting from excess resources, the amount of error is the lesser of—

(A) The amount of the payment made on behalf of the family or individual for the review month; or

(B) The difference between the actual amount of countable resources of the family or individual for the review month and the State's applicable resources standard.

(ii) For ineligible cases resulting from other than excess resources, the amount of error is the total amount of medical assistance payments made for the individual or family under review for the review month.

(iii) For erroneous payments resulting from failure to properly meet beneficiary liability, the amount of error is the lesser of—

(A) The amount of payments made on behalf of the family or individual for the review month; or

(B) The difference between the correct amount of beneficiary liability and the amount of beneficiary liability met by the individual or family for the review month.

(iv) The amount of payments made for services provided during the review month for which the individual or family was not eligible.

(5) In determining the amount of erroneous payments, errors caused by technical errors are not included.

(6) If a State fails to cooperate in completing a valid MEQC sample or individual reviews in a timely and appropriate fashion as required, CMS will establish the State's payment error rate based on either—

(i) A special sample or audit;

(ii) The Federal subsample; or

(iii) Other arrangements as the Administrator may prescribe.

(7) When it is necessary for CMS to exercise the authority in paragraph

(c)(6) of this section, the amount that would otherwise be payable to the State under title XIX of the Act is reduced by the full costs incurred by CMS in making these determinations. CMS may make these determinations either directly or under contractual or other arrangements.

(d) *Computation of anticipated error rate.* (1) Before the beginning of each quarter, CMS will project the anticipated medical assistance payment error rate for each State for that quarter. The anticipated error rate is the lower of the weighted average error rate of the two most recent 6-month review periods or the error rate of the most recent 6-month review period. In either case, cases in the review periods must have been completed by the State and CMS. If a State fails to provide CMS with information needed to project anticipated excess erroneous expenditures, CMS will assign the State an error rate as prescribed in paragraph (c)(6) of this section.

(2) If the State believes that the anticipated error rate established in accordance with paragraph (d)(1) of this section is based on erroneous data, the State may submit evidence that demonstrates the data were erroneous. If the State satisfactorily demonstrates that CMS's data were erroneous, the State's anticipated error rate will be adjusted accordingly. Submittal of evidence is subject to the following conditions:

(i) The State must inform CMS of its intent to submit evidence at least 70 days prior to the beginning of the quarter.

(ii) The State may request copies of data that CMS used to compute its anticipated error rate within 7 days of receiving notification of its projected error rate.

(iii) The State has up to 40 days before the quarter begins to present the evidence.

(iv) The evidence is restricted to documentation of suspected CMS data entry errors, processing errors, and resolutions of Federal subsample difference cases subsequent to calculation of the error rate projection as contained in the original notice to the State.

(v) The State may not submit other evidence, such as that consisting of revisions to State errors as a result of changes to the original State review findings submitted to CMS.

(vi) The State may not submit evidence challenging the error rate computational methodology.

(3) Based on the anticipated error rate established in paragraph (d)(1) or (d)(2) of this section, CMS reduces its estimate of the State's requirements for FFP for medical assistance for the quarter by the percentage by which the anticipated payment error rate exceeds the 3-percent national standard. This reduction is applied against CMS's total estimate of FFP for medical assistance expenditures (less payments to Supplemental Security Income beneficiaries in 1634 contract States and payments to children found eligible for foster care and adoption assistance under title IV-E of the Act) prior to any other required reductions. The reduction is noted on the State's grant award for the quarter and does not constitute a disallowance, and, therefore, is not appealable.

(4) After the end of each quarter, an adjustment to the reduction will be made based on the State's actual expenditures.

(5) After the actual payment error rate has been established for each annual assessment period, CMS will compute the actual amount of the disallowance and adjust the FFP payable to each State based on the difference between the amounts previously withheld for each of the quarters during the appropriate assessment period and the amount that should have been withheld based on the State's actual final error rate. If CMS determines that the amount withheld for the period exceeds the amount of the actual disallowance, the excess amount withheld will be returned to the States through the normal grant awards process within 30 days of the date the actual disallowance is calculated.

(6) CMS will compute the amount to be withheld or disallowed as follows:

(i) Subtract the 3-percent national standard from the State's anticipated or actual payment error rate percentage.

(ii) If the difference is greater than zero, the Federal medical assistance funds for the period, excluding payments for those individuals whose eligibility for Medicaid was determined exclusively by the Social Security Administration under a section 1634 agreement and children found eligible for foster care and adoption assistance under title IV-E of the Act, are multiplied by that percentage. This product is the amount of the disallowance or withholding.

(7) A State's payment error rate for an annual assessment period is the weighted average of the payment error rates in the two 6-month review periods comprising the annual assessment period.

(8) The weights are established as the percent of the total annual payments, excluding payments for those individuals whose eligibility for Medicaid was determined exclusively by the Social Security Administration under a section 1634 agreement and children found eligible for foster care and adoption assistance under title IV-E of the Act, that occur in each of the 6-month periods.

(e) *Notice to States and showing of good faith.* (1) When the actual payment error rate data are finalized for each annual assessment period ending after July 1, 1990, CMS will establish each State's error rate and the amount of any disallowance. States that have error rates above the national standard will be notified by letter of their error rates and the amount of the disallowance.

(i) The State has 65 days from the date of receipt of this notification to show that this disallowance should not be made because it failed to meet the national standard despite a good faith effort to do so.

(ii) If CMS is satisfied that the State did not meet the national standard despite a good faith effort, CMS may reduce the funds being disallowed in whole or in part as it finds appropriate under the circumstances shown by the State.

(iii) A finding that a State did not meet the national standard despite a good faith effort will be limited to extraordinary circumstances.

(iv) The burden of establishing that a good faith effort was made rests entirely with the State.

(2) Some examples of circumstances under which CMS may find that a State did not meet the national standard despite a good faith effort are—

(i) Disasters such as fire, flood, or civil disorders that—

(A) Require the diversion of significant personnel normally assigned to Medicaid eligibility administration; or

(B) Destroyed or delayed access to significant records needed to make or maintain accurate eligibility determinations;

(ii) Strikes of State staff or other government or private personnel necessary to the determination of eligibility or processing of case changes;

(iii) Sudden and unanticipated workload changes that result from changes in Federal law and regulation, or rapid, unpredictable caseload growth in excess of, for example, 15 percent for a 6-month period;

(iv) State actions resulting from incorrect written policy interpretations to the State by a Federal official reasonably assumed to be in a position to provide that interpretation; and

(v) The State has taken the action it believed was needed to meet the national standard, but the national standard was not met. CMS will consider request for a waiver under this criterion only if a State has achieved an error rate for the sample period that (after reducing the error rate by taking into account the cases determined by CMS to be in error as a result of conditions listed in paragraphs (e)(2) (i) through (iv) of this section) is less than its error rate for the preceding sample year and does not exceed the national mean error rate for the sample period under review (unless that national mean error rate is at or below the 3-percent national standard). If the agency has met this error reduction requirement or had error rates of 3 percent or below for the prior two review periods, and its error rate for the review period under consideration is less than one-third above the national standard, CMS will evaluate a request for a good faith waiver based on the following factors:

(A) The State has fully met the performance standards in the operation of a quality control system in accordance with Federal regulations and CMS guidelines (e.g., adherence to Federal case completion timeliness requirements and verification standards).

(B) The State has achieved substantial performance in the formulation of error reduction initiatives based on the following processes:

(1) Performance of an accurate and thorough statistical and program analysis for error reduction which utilized quality control and other data:

(2) The translation of such analysis into specific and appropriate error reduction practices for major error elements; and

(3) The use of monitoring systems to verify that the error reduction initiatives were implemented at the local office level.

(C) The State has achieved substantial performance in the operation of the following systems supported by evidence of the timely utilization of their outputs in the determination of case eligibility:

(1) The operation of the Income and Eligibility Verification System in accordance with the requirements of parts 431 and 435 of this chapter, and

(2) The operation of systems that interface with Social Security data and, where State laws do not restrict agency access, records from agencies responsible for motor vehicles, vital statistics, and State or local income and property taxes (where these taxes exist).

(D) The State has achieved substantial performance in the use of the following accountability mechanisms to ensure that agency staff adhere to error reduction initiatives. The following are minimum requirements:

(1) Accuracy of eligibility and liability determinations and timely processing of case actions are used as quantitative measures of employee performance and reflected in performance standards and appraisal forms:

(2) Selective second-party case reviews are conducted. The second-party review results are periodically reported to higher level management, as well as supervisors and workers and are used

in performance standards and appraisal forms; and

(3) Regular operational reviews of local offices are performed by the State to evaluate the offices' effectiveness in meeting error reduction goals with periodic monitoring to ensure that review recommendations have been implemented.

(vi) A State that meets the performance standards specified in paragraphs (e)(2)(v) (A) through (D) of this section will be considered for a full or partial waiver of its disallowance amount. The State must submit only specific documentation that verifies that the necessary actions were accomplished. For example, a State could submit worker performance standards reflecting timeliness and case accuracy as quantitative measures of performance.

(3) The failure of a State to act upon necessary legislative changes or to obtain budget authorization for needed resources is not a basis for finding that a State failed to meet the national standard despite a good faith effort.

(f) *Disallowance subject to appeal.* (1) If a State does not agree with a disallowance imposed under paragraph (e) of this section, it may appeal to the Departmental Appeals Board within 30 days from the date of the final disallowance notice from CMS. The regular procedures for an appeal of a disallowance will apply, including review by the Appeals Board under 45 CFR part 16.

(2) This appeal provision, as it applies to MEQC disallowances, is not applicable to the Administrator's decision on a State's waiver request provided for under paragraph (e) of this section.

[55 FR 22171, May 31, 1990, as amended at 61 FR 38398, July 24, 1996; 66 FR 2666, Jan. 11, 2001]

Subpart Q—Requirements for Estimating Improper Payments in Medicaid and SCHIP

SOURCE: 71 FR 51081, Aug. 28, 2006, unless otherwise noted.

§ 431.950 Purpose.

This subpart requires States and providers to submit information necessary