

to enable the Secretary to produce national improper payment estimates for Medicaid and the State Children's Health Insurance Program (SCHIP).

§ 431.954 Basis and scope.

(a) *Basis.* The statutory bases for this subpart are sections 1102, 1902(a)(6), and 2107(b)(1) of the Act, which contain the Secretary's general rulemaking authority and obligate States to provide information, as the Secretary may require, to monitor program performance. In addition, this rule supports the Improper Payments Information Act of 2002 (Pub. L. 107–300), which requires Federal agencies to review and identify annually those programs and activities that may be susceptible to significant erroneous payments, estimate the amount of improper payments, report such estimates to the Congress, and submit a report on actions the agency is taking to reduce erroneous payments. Section 1902(a)(27)(B) of the Act requires States to require providers to agree to furnish the State Medicaid agencies and the Secretary with information regarding payments claimed by Medicaid providers for furnishing Medicaid services.

(b) *Scope.* (1) This subpart requires States under the statutory provisions cited in paragraph (a) of this section to submit information as set forth in § 431.970 for, among other purposes, estimating improper payments in the fee-for-service (FFS) and managed care components of the Medicaid and SCHIP programs and to determine whether eligibility was correctly determined. This subpart also requires providers to submit to the Secretary any medical records and other information necessary to disclose the extent of services provided to individuals receiving assistance, and to furnish information regarding any payments claimed by the provider for furnishing such services, as requested by the Secretary.

(2) All information must be furnished in accordance with section 1902(a)(7)(A) of the Act, regarding confidentiality.

(3) This subpart does not apply with respect to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands or American Samoa.

§ 431.958 Definitions and use of terms.

Active case means a case containing information on a beneficiary who is enrolled in the Medicaid or SCHIP program in the month that eligibility is reviewed.

Active fraud investigation means a beneficiary's name has been referred to the State Fraud and Abuse Control or similar investigation unit and the unit is currently actively pursuing an investigation to determine whether the beneficiary committed fraud.

Adjudication date means either the date on which money was obligated to pay a claim or the date the decision was made to deny a claim.

Agency means, for purposes of the PERM eligibility reviews and this regulation, the agency that performs the Medicaid and SCHIP eligibility determinations under PERM and excludes the State agency as defined in the regulation.

Application means an application form for Medicaid or SCHIP benefits deemed complete by the State, with respect to which such State approved or denied eligibility.

Beneficiary means an applicant for, or recipient of, Medicaid or SCHIP program benefits.

Case means an individual beneficiary.

Case error rate means an error rate that reflects the number of cases in error in the eligibility sample for the active cases plus the number of cases in error in the eligibility sample for the negative cases expressed as a percentage of the total number of cases examined in the sample.

Case record means either a hardcopy or electronic file that contains information on a beneficiary regarding program eligibility.

Eligibility means meeting the State's categorical and financial criteria for receipt of benefits under the Medicaid or SCHIP programs.

Improper payment means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and includes any payment to an ineligible recipient, any duplicate payment, any payment for