

services not received, any payment incorrectly denied, and any payment that does not account for credits or applicable discounts.

Last action means the most recent date on which the State agency took action to grant, deny, or terminate program benefits based on the State agency's eligibility determination; and is the point in time for the PERM eligibility reviews unless the last action occurred outside of 12 months prior to the sample month.

Medicaid means the joint Federal and State program, authorized and funded under Title XIX of the Act, that provides medical care to people with low incomes and limited resources.

Negative case means a case containing information on a beneficiary who applied for benefits and was denied or whose program benefits were terminated, based on the State agency's eligibility determination or on a completed redetermination.

Payment means any payment to a provider, insurer, or managed care organization for a Medicaid or SCHIP beneficiary for which there is Medicaid or SCHIP Federal financial participation. It may also mean a direct payment to a Medicaid or SCHIP beneficiary in limited circumstances permitted by CMS regulation or policy.

Payment error rate means an annual estimate of improper payments made under Medicaid and SCHIP equal to the sum of the overpayments and underpayments in the sample, that is, the absolute value of such payments, expressed as a percentage of total payments made in the sample.

Payment review means the process by which payments for services are associated with cases reviewed for eligibility. Payments are collected for services received in the review month or in the sample month, depending on the case reviewed.

PERM means the Payment Error Rate Measurement process to measure improper payment in Medicaid and SCHIP.

Provider means any qualified provider recognized under Medicaid and SCHIP statute and regulations.

Review cycle means the complete timeframe to complete the improper payments measurement including the

fiscal year being measured; generally this timeframe begins in October of the fiscal year reviewed and ends in August of the following fiscal year.

Review month means the month in which eligibility is reviewed and is usually when the State took its last action to grant or redetermine eligibility. If the State's last action was taken beyond 12 months prior to the sample month, the review month shall be the sample month.

Review year means the Federal fiscal year being analyzed for errors by Federal contractors or the State.

Sample month means the month the State selects a case from the sample for an eligibility review.

State agency means the State agency that is responsible for determining program eligibility for Medicaid and SCHIP, as applicable, based on applications and redeterminations.

State Children's Health Insurance Program (SCHIP) means the program authorized and funded under Title XXI of the Act.

States means the 50 States and the District of Columbia.

Undetermined means a beneficiary case subject to a Medicaid or SCHIP eligibility determination under this regulation about which a definitive determination of eligibility could not be made.

§ 431.970 Information submission requirements.

(a) States must submit information to the Secretary for, among other purposes, estimating improper payments in Medicaid and SCHIP, that include but are not limited to—

(1) All adjudicated fee-for-service (FFS) and managed care claims information, on a quarterly basis, from the review year with FFS claims stratified by service;

(2) Upon request from CMS, provider contact information that has been verified by the State as current;

(3) All medical and other related policies in effect and any quarterly policy updates;

(4) Current managed care contracts, rate information, and any quarterly updates applicable to the review year for SCHIP and, as requested, for Medicaid;

§ 431.974

(5) Data processing systems manuals;
(6) Repricing information for claims that are determined during the review to have been improperly paid;

(7) Information on claims that were selected as part of the sample, but changed in substance after selection, for example, successful provider appeals;

(8) Adjustments made within 60 days of the adjudication dates for the original claims or line items with sufficient information to indicate the nature of the adjustments and to match the adjustments to the original claims or line items;

(9) For the eligibility improper payment measurement, information as set forth in § 431.978 through § 431.988;

(10) A corrective action plan for purposes of reducing erroneous payments in FFS, managed care, and eligibility; and

(11) Other information that the Secretary determines is necessary for, among other purposes, estimating improper payments and determining error rates in Medicaid and SCHIP.

(b) Providers must submit information to the Secretary for, among other purposes, estimating improper payments in Medicaid and SCHIP, which include but are not limited to, Medicaid and SCHIP beneficiary medical records.

§ 431.974 Basic elements of Medicaid and SCHIP eligibility reviews.

(a) *General requirements.* (1) States selected in any given year for Medicaid and SCHIP improper payments measurement under the Improper Payments Information Act of 2002 must conduct reviews of a statistically valid random sample of beneficiary cases for such programs to determine if improper payments were made based on errors in the State agency's eligibility determinations.

(2) The agency and personnel responsible for the development, direction, implementation, and evaluation of the eligibility reviews and associated activities, including calculation of the error rates under this section, must be functionally and physically separate from the State agencies and personnel that are responsible for Medicaid and

42 CFR Ch. IV (10-1-06 Edition)

SCHIP policy and operations, including eligibility determinations.

(3) Any individual performing activities under this section must do so in a manner that is consistent with the provisions of § 435.901, concerning the rights of recipients.

(b) *Sampling requirements.* The State must have in effect a CMS-approved sampling plan for the review year in accordance with the requirements specified in § 431.978.

(c) *Review requirements.* The State must conduct eligibility reviews in accordance with the requirements specified in § 431.980.

§ 431.978 Eligibility sampling plan and procedures.

(a) *Plan approval.* For the review year beginning October 1, 2006, the agency must submit a Medicaid and a SCHIP sampling plan for both active and negative cases to CMS for approval by November 15, 2006. For review years beginning October 1, 2007 and beyond, the agency must submit a Medicaid or SCHIP sampling plan (or revisions to a current plan) for both active and negative cases to CMS for approval by the August 1 before the review year and must receive approval of the plan before implementation. The agency must notify CMS that it will be using the same plan from the previous review year if the plan is unchanged.

(b) *Maintain current plan.* States must keep the plan current, for example, by making adjustments to the plan when necessary due to fluctuations in the universe. The State must review and determine that the approved plan is unchanged from the previous review year and submit a revised plan for CMS approval if changes have occurred.

(c) *Sample size.* Total sample size must be estimated to achieve within a 3 percent precision level at 95 percent confidence interval for the eligibility component of the program.

(d) *Sample selection.* The sample must be stratified in accordance with § 431.978(d)(3). Cases must be selected each month throughout the fiscal year under review. Each month throughout the year and before commencing the eligibility reviews, States must submit to CMS a monthly sample selection list