

§ 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

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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

that identifies the cases selected in that month.

(1) *Eligibility universe-active cases*—(i) *Medicaid*. The Medicaid active universe consists of all active Medicaid cases funded through Title XIX for the sample month. Cases for which the Social Security Administration, under a section 1634 agreement with a State, determines Medicaid eligibility for Supplemental Security Income recipients are excluded from the universe. All foster care and adoption assistance cases under Title IV-E of the Act are excluded from the universe in all States. Cases under active fraud investigations shall be excluded from the universe. If the State cannot identify cases under active fraud investigations for exclusion from the universe previous to the sample selection, the State shall drop these cases from review if they are selected in the sample and are later determined to be under active fraud investigation at the time of selection.

(ii) *SCHIP*. The SCHIP active universe consists of all active SCHIP and Medicaid expansion cases that are funded through Title XXI for the sample month. Cases under active fraud investigations shall be excluded from the SCHIP active universe. If the State cannot identify cases under active fraud investigations for exclusion from the universe previous to sample selection, the State shall drop these cases from review if they are selected in the sample and are later determined to be under active fraud investigation at the time of selection.

(2) *Eligibility universe-negative cases*. The Medicaid and SCHIP negative universe consists of all negative cases for the sample month. Cases denied or terminated based upon incomplete applications or cases where beneficiaries who do not complete the redetermination process are excluded. The negative case universe is not stratified.

(3) *Stratifying the universe*. Each month, the State stratifies the Medicaid and SCHIP active case universe into three strata:

(i) Program applications completed by the beneficiaries in which the State took action in the sample month to approve such beneficiaries for Medicaid or SCHIP based on the eligibility determination.

(ii) Redeterminations of eligibility in which the State took action in the sample month to approve the beneficiaries for Medicaid or SCHIP based on information obtained through the completed redetermination.

(iii) All other cases.

(4) *Sample selection*. Each month, an equal number of cases are selected from each stratum for review, unless otherwise provided for in the plan approved by CMS.

§ 431.980 Eligibility review procedures.

(a) *Active case reviews*. The agency must verify eligibility for all selected active cases for Medicaid and SCHIP for the review month for compliance with the State's eligibility criteria.

(b) *Negative case reviews*. The agency must review all selected negative cases for Medicaid and SCHIP for the review month to determine whether the cases were properly denied or terminated.

(c) *Payment review*. The agency must identify all Medicaid and SCHIP payments made for services furnished, either in the first 30 days of eligibility or in the review month for applications under § 431.978(d)(3)(i) and redeterminations under § 431.978(d)(3)(ii) in accordance to State policy or from the sample month for all other cases under § 431.978(d)(3)(iii), to identify erroneous payments resulting from ineligibility for services or for the program.

(d) *Eligibility determination*. The agency must verify program eligibility for all active cases in the sample based on acceptable documentation contained in the case file or obtained independently through the review process.

(1) *Active cases—Medicaid*. The agency must—

(i) Review the cases specified at § 431.978(d)(3)(i) and § 431.978(d)(3)(ii) in accordance with the State's categorical and financial eligibility criteria as of the review month and identify with a specific beneficiary payments made on behalf of such beneficiary for services received in the first 30 days of eligibility or in the review month;

(ii) For cases specified in § 431.978(d)(3)(iii), if the last action was 12 months prior to the sample month, review in accordance with the State's categorical and financial eligibility