

criteria as of the last action and identify with a specific beneficiary payments made on behalf of such beneficiary for services received in the sample month. If the last action occurred more than 12 months prior to the sample month, review in accordance with the State’s categorical and financial eligibility criteria as of the sample month and identify payments made on behalf of the specific beneficiary for services received in the sample month;

(iii) Examine the evidence in the case file that supports categorical and financial eligibility for the category of coverage in which the case is assigned, and independently verify information that is missing, older than 12 months, likely to change, based on self declaration, or otherwise as needed, to verify eligibility; and

(iv) For managed care cases, also verify residency and eligibility for and actual enrollment in the managed care plan during the month under review.

(v) If the case is ineligible under paragraphs (d)(1)(i) through (d)(1)(iv) of this section, review the case to determine whether the case is eligible under any coverage category within the program.

(vi) As a result of paragraphs (d)(1)(i) through (d)(1)(v) of this section—

(A) Cite the case as ineligible or ineligible based on the review findings and identify with the particular beneficiary the payments made on behalf of the particular beneficiary for services received in the first 30 days of eligibility, the review month or sample month, as appropriate; or

(B) Cite the case as undetermined if after due diligence an eligibility determination could not be made and identify with the particular beneficiary the payments made on behalf of the particular beneficiary for services received in the first 30 days of eligibility, the review month or sample month, as appropriate.

(2) *Active cases—SCHIP.* In addition to the procedures for active cases as set forth in paragraphs (d)(1)(i) through (d)(1)(v) of this section, once the agency establishes SCHIP eligibility, the agency must verify that the case is not eligible for Medicaid by determining that the child has income above the Medicaid levels in accordance with the

requirements in § 457.350 of this chapter. Upon verification, the agency must—

(i) Cite the case as eligible or ineligible based on the review findings and identify with the particular beneficiary the payments made on behalf of the particular beneficiary for services received in the review month or sample month, as appropriate; or

(ii) Cite the case as undetermined if after due diligence an eligibility determination could not be made and identify with the particular beneficiary the payments made on behalf of the particular beneficiary for services received in the review month or sample month, as appropriate.

(e) *Negative cases—Medicaid and SCHIP.* The agency must—

(1) Identify the reason the State agency determined ineligibility;

(2) Examine the evidence in the case file to determine whether the State agency’s denial or termination was correct or whether there is any reason the case should have been denied or terminated; and

(i) Record the State agency’s finding as correct if the case record review substantiates that the individual was not eligible; or

(ii) Record the case as an error if there is no valid reason for the denial or termination.

§ 431.988 Eligibility case review completion deadlines and submittal of reports.

(a) States must complete and report to CMS the findings, including the error causes if known, for all active case reviews listed on the monthly sample selection lists, including cases dropped from review due to active fraud investigations and cases for which eligibility could not be determined. States must submit a summary report of the active case eligibility and payment review findings to CMS by July 1 following the review year.

(b) The agency must report by July 1 following the review year, information as follows:

(1) Case and payment error rates for active cases.

(2) Case error rates for negative cases.

(3) The number and amounts of undetermined cases in the sample and the total amount of payments from all undetermined cases.

(4) The number of cases dropped from review due to active fraud investigations.

§ 431.992 Corrective action plan.

The State agency must submit to CMS a corrective action plan to reduce improper payments in its Medicaid and SCHIP programs based on its analysis of the error causes in the FFS, managed care, and eligibility components.

§ 431.998 Difference resolution process.

(a) The State may file, in writing, a request with the Federal contractor to resolve differences in the Federal contractor's findings based on medical or data processing reviews on FFS and managed care claims in Medicaid and SCHIP. The State must have a factual basis for filing the difference and must provide the Federal contractor with valid evidence directly related to the error finding to support the State's position that the claim was properly paid.

(b) For a claim in which the State and the Federal contractor cannot resolve the difference in findings, the State may appeal to CMS for final resolution.

(1) The difference in findings must be in the amount of \$100 or greater; and

(2) The agency must provide CMS with the facts and valid documentation to support its determination that the claim was correctly paid, as well as the Federal contractor's justification for upholding its initial error finding.

(3) CMS will make the final decision on the claim. There will be no further judicial or administrative review of CMS' decision.

(c) All differences, including those pending in CMS for final decision that are not resolved in time to be included in the error rate calculation, will be considered as errors for meeting the reporting requirements of the IPIA. Upon State request, CMS will calculate a subsequent State-specific error rate that reflects any reversed disposition of the unresolved claims.

§ 431.1002 Recoveries.

(a) *Medicaid*. States must return to CMS the Federal share of overpayments based on medical and processing errors in accordance with section 1903(d)(2) of the Act and related regulations at part 433, subpart F of this chapter. Payments based on erroneous Medicaid eligibility determinations are addressed under section 1903(u) of the Act and related regulations at part 431, subpart P of this chapter.

(b) *SCHIP*. Quarterly Federal payments to the States under Title XXI of the Act must be reduced in accordance with section 2105(e) of the Act and related regulations at part 457, subpart B of this chapter.

PART 432—STATE PERSONNEL ADMINISTRATION

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AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

SOURCE: 43 FR 45199, Sept. 29, 1978, unless otherwise noted.

Subpart A—General Provisions

§ 432.1 Basis and purpose.

This part prescribes regulations to implement section 1902(a)(4) of the Act, which relates to a merit system of State personnel administration and training and use of subprofessional staff and volunteers in State Medicaid programs, and section 1903(a), rates of