

§ 431.810 Basic elements of the Medicaid eligibility quality control (MEQC) program.

(a) *General requirements.* The agency must operate the MEQC program in accordance with this section and §§ 431.812 through 431.822 and other instructions established by HCFA.

(b) *Review requirements.* The agency must conduct MEQC reviews in accordance with the requirements specified in § 431.812 and other instructions established by HCFA.

(c) *Sampling requirements.* The agency must conduct MEQC sampling in accordance with the requirements specified in § 431.814 and other instructions established by HCFA.

§ 431.812 Review procedures.

(a) *Active case reviews.* (1) Except as provided in paragraph (a)(2) of this section, the agency must review all active cases selected from the State agency's lists of cases authorized eligible for the review month, to determine if the cases were eligible for services during all or part of the month under review, and, if appropriate, whether the proper amount of recipient liability was computed.

(2) The agency is not required to conduct reviews of the following cases:

(i) Supplemental Security Income (SSI) recipient cases in States with contracts under section 1634 of the Act for determining Medicaid eligibility;

(ii) Foster care and adoption assistance cases under title IV-E of the Act found eligible for Medicaid; and

(iii) Cases under programs that are 100 percent federally funded.

(b) *Negative case reviews.* Except as provided in paragraph (c) of this section, the agency must review those negative cases selected from the State agency's lists of cases that are denied, suspended, or terminated in the review month to determine if the reason for the denial, suspension, or termination was correct and if requirements for timely notice of negative action were met. A State's negative case sample size is determined on the basis of the number of negative case actions in the universe.

(c) *Alternate systems of negative case reviews—(1) Basic provision.* A State may be exempt from the negative case

review requirements specified in paragraphs (b) and (e)(2) of this section and in § 431.814(d) upon HCFA's approval of a plan for the use of a superior system.

(2) *Submittal of plan for alternate system.* An agency must submit its plan for the use of a superior system to HCFA for approval at least 60 days before the beginning of the review period in which it is to be implemented. If a plan is unchanged from a previous period, the agency is not required to re-submit it.

The agency must receive approval for a plan before it can be implemented.

(3) *Requirement for alternate system.* To be approved, the State's plan must—

(i) Clearly define the purpose of the system and demonstrate how the system is superior to the current negative case review requirements.

(ii) Contain a methodology for identifying significant problem areas that could result in erroneous denials, suspensions, and terminations of applicants and recipients. Problem areas selected for review must contain at least as many applicants and recipients as were included in the negative case sample size previously required for the State.

(iii) Provide a detailed methodology describing how the extent of the problem area will be measured through sampling and review procedures, the findings expected from the review, and planned corrective actions to resolve the problem.

(iv) Include documentation supporting the use of the system methodology. Documentation must include the timeframes under which the system will be operated.

(v) Provide a superior means of monitoring denials, terminations, and suspensions than that required under paragraph (b) of this section.

(vi) Provide a statistically valid error rate that can be projected to the universe that is being studied.

(d) *Reviews for erroneous payments.* The agency must review all claims for services furnished during the review month and paid within 4 months of the review month to all members of each active case related in the sample to identify erroneous payments resulting from—

(1) Ineligibility for Medicaid;