

(b) The agency must return the difference letter to the Regional Office within 28 calendar days of the date of the letter indicating either agreement with the Federal finding or reasons for disagreement and if the agency desires a conference to resolve the difference. This period may be shortened if the Regional Office finds that it is necessary to do so in order to meet a case completion deadline, and the State still has a reasonable period of time in which to respond to the letter. If the agency fails to submit the difference letter indicating its agreement or disagreement with the Federal findings within the 28 calendar days (or the shorter period designated as described above), the Federal findings will be sustained.

(c) If the Regional Office disagrees with the agency's response, a difference conference will be scheduled within 20 days of the request of the agency. If a difference cannot be resolved, the State may request a direct presentation of its position to the Regional Administrator. The Regional Administrator has final authority for resolving the difference.

MEDICAID QUALITY CONTROL (MQC)  
CLAIMS PROCESSING ASSESSMENT SYSTEM

SOURCE: Sections 431.830 through 431.836 appear at 55 FR 22170, May 31, 1990, unless otherwise noted.

**§ 431.830 Basic elements of the Medicaid quality control (MQC) claims processing assessment system.**

An agency must—

(a) Operate the MQC claims processing assessment system in accordance with the policies, sampling methodology, review procedures, reporting forms, requirements, and other instructions established by HCFA.

(b) Identify deficiencies in the claims processing operations.

(c) Measure cost of deficiencies;

(d) Provide data to determine appropriate corrective action;

(e) Provide an assessment of the State's claims processing or that of its fiscal agent;

(f) Provide for a claim-by-claim review where justifiable by data; and

(g) Produce an audit trail that can be reviewed by HCFA or an outside auditor.

**§ 431.832 Reporting requirements for claims processing assessment systems.**

(a) The agency must submit reports and data specified in paragraph (b) of this section to HCFA, in the form and at the time specified by HCFA.

(b) Except when HCFA authorizes less stringent reporting, States must submit:

(1) A monthly report on claims processing reviews sampled and or claims processing reviews completed during the month;

(2) A summary report on findings for all reviews in the 6-month sample to be submitted by the end of the 3rd month following the scheduled completion of reviews for that 6 month period; and

(3) Other data and reports as required by HCFA.

**§ 431.834 Access to records: Claims processing assessment systems.**

The agency, upon written request, must provide HHS staff with access to all records pertaining to its MQC claims processing assessment system reviews to which the State has access, including information available under part 435, subpart J, of this chapter.

**§ 431.836 Corrective action under the MQC claims processing assessment system.**

The agency must—

(a) Take action to correct those errors identified through the claims processing assessment system review and, if cost effective, to recover those funds erroneously spent;

(b) Take administrative action to prevent and reduce the incidence of those errors; and

(c) By August 31 of each year, submit to HCFA a report of its error analysis and a corrective action plan on the reviews conducted since the cut-off-date of the previous corrective action plan.

FEDERAL FINANCIAL PARTICIPATION

§§ 431.861–431.864 [Reserved]

**§ 431.865 Disallowance of Federal financial participation for erroneous State payments (for annual assessment periods ending after July 1, 1990).**

(a) *Purpose and applicability*—

(1) *Purpose.* This section establishes rules and procedures for disallowing Federal financial participation (FFP) in erroneous medical assistance payments due to eligibility and beneficiary liability errors, as detected through the Medicaid eligibility quality control (MEQC) program required under § 431.806 in effect on and after July 1, 1990.

(2) *Applicability.* This section applies to all States except Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa beginning July 1, 1990.

(b) *Definitions.* For purposes of this section—

*Administrator* means the Administrator, Health Care Financing Administration or his or her designee.

*Annual assessment period* means the 12-month period October 1 through September 30 and includes two 6-month sample periods (October-March and April-September).

*Beneficiary liability* means—

(1) The amount of excess income that must be offset with incurred medical expenses to gain eligibility; or

(2) The amount of payment a recipient must make toward the cost of services.

*Erroneous payments* means the Medicaid payment that was made for an individual or family under review who—

(1) Was ineligible for the review month or, in full month coverage is not provided, at the time services were received;

(2) Was ineligible to receive a service provided during the review month; or

(3) Had not properly met beneficiary liability prior to receiving Medicaid services.

*National mean error rate* means the payment weighted average of the eligibility payment error rates for all States.

*National standard* means a 3-percent eligibility payment error rate.

*State payment error rate* means the ratio of erroneous payments for medical assistance to total expenditures for medical assistance (less payments to Supplemental Security Income beneficiaries in section 1634 contract States and payments for children eligible for foster care and adoption assistance under title IV-E of the Act) for cases under review under the MEQC system for each assessment period.

*Technical error* means an error in an eligibility condition that, if corrected, would not result in a difference in the amount of medical assistance paid. These errors include work incentive program requirements, assignment of social security numbers, the requirement for a separate Medicaid application, monthly reporting requirements, assignment of rights to third party benefits, and failure to apply for benefits for which the family or individual is not eligible. Errors other than those listed in this definition, identified by HCFA in subsequent instructions, or approved by HCFA are not technical errors.

(c) *Setting of State's payment error rate.*

(1) Each State must, for each annual assessment period, have a payment error rate no greater than 3 percent or be subject to a disallowance of FFP.

(2) A payment error rate for each State is determined by HCFA for each annual assessment period by computing the statistical estimate of the ratio of erroneous payments for medical assistance made on behalf of individuals or cases in the sample for services received during the review month to total expenditures for medical assistance for that State made on behalf of individuals or cases in the sample for services received during the review month. This ratio incorporates the findings of a federally re-reviewed subsample of the State's review findings and is projected to the universe of total medical assistance payments for calculating the amount of disallowance under paragraph (d)(6) of this section.

(3) The State's payment error rate does not include payments made on behalf of individuals whose eligibility determinations were made exclusively by the Social Security Administration under an agreement under section 1634 of the Act or children found eligible for