

fee-for-service (FFS) and managed care components of the Medicaid and CHIP programs and to determine whether eligibility was correctly determined. This subpart also requires providers to submit to the Secretary any medical records and other information necessary to disclose the extent of services provided to individuals receiving assistance, and to furnish information regarding any payments claimed by the provider for furnishing such services, as requested by the Secretary.

(2) All information must be furnished in accordance with section 1902(a)(7)(A) of the Act, regarding confidentiality.

(3) This subpart does not apply with respect to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands or American Samoa.

[71 FR 51081, Aug. 28, 2006, as amended at 75 FR 48847, Aug. 11, 2010]

#### § 431.958 Definitions and use of terms.

*Active case* means a case containing information on a beneficiary who is enrolled in the Medicaid or CHIP program in the month that eligibility is reviewed.

*Active fraud investigation* means a beneficiary or a provider has been referred to the State Medicaid Fraud Control Unit or similar Federal or State investigative entity including a Federal oversight agency and the unit is currently actively pursuing an investigation to determine whether the beneficiary or the provider committed health care fraud. This definition applies to both the claims and eligibility review for PERM.

*Adjudication date* means either the date on which money was obligated to pay a claim or the date the decision was made to deny a claim.

*Agency* means, for purposes of the PERM eligibility reviews under this part, the entity that performs the Medicaid and CHIP eligibility reviews under PERM and excludes the State Medicaid or CHIP agency as defined in the regulation.

*Annual sample size* means the number of fee-for-service claims, managed care payments, or eligibility cases necessary to meet precision requirements in a given PERM cycle.

*Application* means an application form for Medicaid or CHIP benefits

deemed complete by the State, with respect to which such State approved or denied eligibility.

*Beneficiary* means an applicant for, or beneficiary of, Medicaid or CHIP program benefits.

*Case* means an individual beneficiary or family enrolled in Medicaid or CHIP or who has been denied enrollment or has been terminated from Medicaid or CHIP. The case as a sampling unit only applies to the eligibility component.

*Case error rate* means an error rate that reflects the number of cases in error in the eligibility sample for the active cases plus the number of cases in error in the eligibility sample for the negative cases expressed as a percentage of the total number of cases examined in the sample.

*Case record* means either a hardcopy or electronic file that contains information on a beneficiary regarding program eligibility.

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

*Eligibility* means meeting the State's categorical and financial criteria for receipt of benefits under the Medicaid or CHIP programs.

*Improper payment* means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and includes any payment to an ineligible beneficiary, any duplicate payment, any payment for 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 CHIP beneficiary for which there is Medicaid or CHIP Federal financial participation. It may also mean a direct payment to a Medicaid or CHIP beneficiary in limited circumstances permitted by CMS regulation or policy.

*Payment error rate* means an annual estimate of improper payments made under Medicaid and CHIP 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 CHIP.

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

*Provider error* includes, but is not limited to, medical review errors as described in § 431.960(c) of this subpart, as determined in accordance with documented State or Federal policies or both.

*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 CHIP, as applicable, based on applications and redeterminations.

*State error* includes, but is not limited to, data processing errors and eligibility errors as described in § 431.960(b) and (d) of this subpart, as determined in accordance with documented State or Federal policies or both.

*States* means the 50 States and the District of Columbia.

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

[71 FR 51081, Aug. 28, 2006, as amended at 75 FR 48847, Aug. 11, 2010]

**§ 431.960 Types of payment errors.**

(a) *General rule.* State or provider errors identified for the Medicaid and CHIP improper payments measurement under the Improper Payments Information Act of 2002 must affect payment under applicable Federal policy or State policy or both.

(b) *Data processing errors.*

(1) A data processing error is an error resulting in an overpayment or underpayment that is determined from a review of the claim and other information available in the State's Medicaid Management Information System, related systems, or outside sources of provider verification.

(2) The difference in payment between what the State paid (as adjusted within improper payment measurement guidelines) and what the State should have paid, in accordance with the State's documented policies, is the dollar measure of the payment error.

(3) Data processing errors include, but are not limited to the following:

- (i) Payment for duplicate items.
- (ii) Payment for non-covered services.
- (iii) Payment for fee-for-service claims for managed care services.