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*. (A) The Medicaid active universe consists of all active Medicaid cases funded through Title XIX for the sample month.

(B) The following types of cases are excluded from the Medicaid active universe:

(*1*) Cases for which the Social Security Administration, under section 1634 of the Act agreement with a State, determines Medicaid eligibility for Supplemental Security Income beneficiaries.

(*2*) All foster care and adoption assistance cases under Title IV–E of the Act are excluded from the universe in all States.

(*3*) Cases under active fraud investigation.

(*4*) Cases in which eligibility was determined under section 1902(e)(13) of the Act for States' Express Lane Eligibility option.

(C) If the State cannot identify cases that meet the exclusion criteria specified in paragraph (d)(1)(i)(B) of this section before sample selection, the State must drop these cases from review if they are selected in the sample and are later determined to meet the exclusion criteria specified in paragraph (d)(1)(i)(B) of this section.

(ii) *CHIP*. (A) The CHIP active universe consists of all active case CHIP and Title XXI Medicaid expansion cases that are funded through Title XXI for the sample month.

(B) The following types of cases are excluded from the CHIP active universe:

(*1*) Cases under active fraud investigation.

(*2*) Cases in which eligibility was determined under section 2107(e)(1) of the Act for States' Express Lane Eligibility option.

(C) If the State cannot identify cases that meet the exclusion criteria specified in paragraph (d)(1)(ii)(B) of this section before sample selection, the State must drop these cases from review if it is later determined that the cases meet the exclusion criteria specified in paragraph (d)(1)(ii)(B) of this section.

(2) *Eligibility universe—negative cases*. The Medicaid and CHIP negative universe consists of all negative cases for the sample month. The negative case universe is not stratified.

(3) *Stratifying the universe*. States have the option to stratify the active case universe.

(i) Each month, the State may stratify the Medicaid and CHIP active case universe into three strata:

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

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

(C) All other cases.

(ii) States that do not stratify the universe will sample from the entire active case universe each month.

(4) *Sample selection*. Each month, an equal number of cases are selected for review from one of the following:

(i) Each stratum as described in paragraph (d)(3)(i) of this section.

(ii) The entire active case universe if opting not to stratify cases under paragraph (d)(2)(ii) of this section.

(iii) Otherwise provided for in the State's sampling plan approved by CMS.

[71 FR 51081, Aug. 28, 2006, as amended at 72 FR 50513, Aug. 31, 2007; 75 FR 48849, Aug. 11, 2010]

§431.980 Eligibility review procedures.

(a) *Active case reviews*. The agency must verify eligibility for all selected active cases for Medicaid and CHIP 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 CHIP for the review month to determine whether the cases were properly denied or terminated.

(c) *Payment review.* The agency must identify all Medicaid and CHIP 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 review decision*—(1) *Active cases—Medicaid.* Unless the State has selected to substitute MEQC data for PERM data under paragraph (f) of this section, the agency must complete all of the following:

(i) Review the cases specified at §§ 431.978(d)(3)(i)(A) and 431.978(d)(3)(i)(B) of this subpart in accordance with the State's categorical and financial eligibility criteria and documented policies and procedures as of the review month and identify payments made on behalf of such beneficiary or family for services received in the first 30 days of eligibility.

(ii) For cases specified in § 431.978(d)(3)(i)(C) of this subpart, review the last action as follows:

(A) If the last action was not more than 12 months prior to the sample month, review in accordance with the State's categorical and financial eligibility criteria and documented policies and procedures as of the last action and identify payments made on behalf of such beneficiary or family in the first 30 days of eligibility.

(B) 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 and documented policies and procedures as of the sample month and identify payments made on behalf of the beneficiary or family for services received in the sample month.

(iii) For cases in States that do not stratify the universe, as specified in § 431.978(d)(3)(ii) of this subpart, review the last action as follows:

(A) If the last action was no more than 12 months prior to the sample month, review in accordance with the State's categorical and financial eligibility criteria and documented policies and procedures as of the last action and identify payments made on behalf of such beneficiary or family for services received in the sample month.

(B) 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, and documented policies and procedures, as of the sample month and identify payments made on behalf of the beneficiary or family for services received in the sample month.

(C) Cases that are not stratified must have the last action identified as either falling under the criteria of § 431.978(d)(3)(i)(A) or § 431.978(d)(3)(i)(B) of this subpart after the sample is selected.

(iv) 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, outdated (older than 12 months) and likely to change, or otherwise as needed, to verify eligibility.

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

(vi) Elements of eligibility in which State policy allows for self-declaration or self-certification are considered to be verified with a self-declaration or self-certification statement. The self-declaration or self-certification must be—

(A) Present in the record;

(B) Not outdated (more than 12 months old);

(C) Originating from the last case action that was not more than 12 months prior to the sample month;

(D) In a valid, State-approved format; and

(E) Consistent with other facts in the case record.

(vii) If a self-declaration or self-certification statement does not meet the provisions of paragraphs (e)(1)(vi)(A) through (D) of this section, eligibility may be verified through a new self-declaration or self-certification statement or other third party sources.

(A) If eligibility or ineligibility cannot be verified, cite a case as undetermined.

(ix) As a result of paragraphs (e)(1)(i) through (e)(1)(vii) of this section—

(A) 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 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—CHIP.* In addition to the procedures for active cases as set forth in paragraphs (e)(1)(i) through (e)(1)(vii) of this section, 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—

(e) *Negative cases—Medicaid and CHIP.* 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.

(f) *Substitution of MEQC data.* (1) A State in their PERM year may elect to substitute the random sample of selected cases, eligibility review findings, and payment review findings, as qualified by paragraphs (d)(2) and (d)(3) of this section, which are obtained through MEQC reviews conducted in accordance with section 1903(u) of the Act for data required in this section, as long as the State MEQC reviews meet the requirements of the MEQC Sampling Plan and Procedures at §431.814 of this part, and if the only exclusions are those set forth in section 1902(e)(13) of the Act, §431.814(c)(4), and §431.978(d)(1) of this part.

(2) MEQC samples must also meet PERM confidence and precision requirements.

(3) MEQC cases that are dropped due to the acceptable reasons listed in the State Medicaid Manual are included in the PERM error rate calculation.

[71 FR 51081, Aug. 28, 2006, as amended at 75 FR 48850, Aug. 11, 2010]

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

(a)(1) States must complete and report to CMS the findings, including total number of cases in the eligibility universe, the error causes for all 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.

(2) 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 data for active cases.

(2) Case error data for negative cases.

(3) Identify the last action on a case, either application or redetermination for States that do not stratify the eligibility sample in accordance with §431.978(d)(3)(i) of this subpart.

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

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

[71 FR 51081, Aug. 28, 2006, as amended at 75 FR 48851, Aug. 11, 2010]

§431.992 Corrective action plan.

(a) The State agency must develop a separate corrective action plan for Medicaid and CHIP, which is not required to be approved by CMS, designed to reduce improper payments in each program based on its analysis of the error causes in the FFS, managed care, and eligibility components.