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GENERAL

Chapter 1

11100 BACKGROUND

The Medicaid program, enacted in 1965 under title XIX of the Social Security Act (the Act), is a grant in aid Medical Assistance Program financed through joint Federal and State funding and administered by each State according to an approved State plan. Under this plan, a State reimburses providers of medical assistance to individuals found eligible under title XIX and various other titles of the Act.

In October 1972, Public Law 92-603 was enacted in which § 235 provided for 90-percent Federal financial participation (FFP) for design, development, or installation, and 75-percent FFP for operation of State mechanized claims processing and information retrieval systems approved by the Secretary. For Medicaid purposes, the mechanized claims processing and information retrieval system, which States are required to have, is the Medicaid Management Information System (MMIS). The objective of providing increased Federal financial support to MMIS acquisitions, or changes approved for enhanced funding, is to help States realize more efficient, effective, and economic administration of the Medicaid program. An implementing regulation, 45 CFR 250.90, was published May 20, 1974, and the supporting Part 7 of the Medical Assistance Manual, Program Regulation Guide (MSA-PRG-31) was published June 10, 1974. This regulation and guideline have provided the basis for Federal review and approval of State requests for 90- and 75-percent FFP under § 1903(a)(3) of the Act. A requirement of § 1903(a)(3) that all recipients of Medicaid services receive written notice regarding these services was amended (Public Law 95-142 on October 25, 1977) to allow such notices to be sent to a recipient sample rather than to all recipients. Subsequent reorganization and clarification of 45 CFR 250.90 have been made with the current regulation contained in 42 CFR 433, Subpart C. Section 901 of Public Law 96-398 added §1903(r) to title XIX of the Act, effective October 7, 1980. Section 1903(r) was amended by §9503(b) of Public Law 99-272 on April 7, 1988 and by §4753 of Public Law 105-33, effective January 1, 1998.

Section 1903(r) requires that all States with Medicaid programs have approved mechanized claims processing and information retrieval systems that are compatible with claims processing and information retrieval systems used in the administration of title XVIII of the Act. Section 4753 of Public Law 105-33 specifically states that compatibility requirements will include: 1) a uniform identification coding system for providers, other payees, and beneficiaries under titles XVIII and XIX; 2) provisions for liaison between States and carriers and intermediaries with agreements under title XVIII to facilitate timely exchange of appropriate data; and 3) provisions for exchange of data between the States and the Secretary with respect to persons sanctioned under titles XVIII or XIX. Also, §4753 of Public Law 105-33 requires that, effective for claims filed on or after January 1, 1999, the MMIS will provide electronic transmission of claims data in the format specified by the Secretary and consistent with the MSIS (Medicaid Statistical Information System) including detailed individual enrollee encounter data and other information that the Secretary may find necessary. The claims data format for MSIS electronic transmission is specified in part 2, § 2700. Furthermore, §4753 eliminates all references to development and application of performance standards used to conduct periodic standards-based reviews of previously certified MMISs. The SPR (standard performance review) serves as an evaluation instrument in determining the extent to which an MMIS performance is sustained after the initial certification. The effective date for elimination of the SPR under §4753 of Public Law 105-33 is January 1, 1998.

In addition, Subtitle F of Public Law 104-191 mandates that the Secretary of the Department of Health and Human Services adopt a wide range of national standards for the electronic exchange of health information. Standards are to be adopted for: 1) electronic transactions and data elements, 2) code sets, 3) unique health identifiers for individuals, providers, health plans, and employers, 4) security of health information, and 5) electronic signatures. The recommended standards for various types of standards mandated under Public Law 104-191 will be made available for public comment via a Notice of Proposed Rulemaking in the Federal Register. Once standards are published as a Final Rule in the Federal Register, States and all health related providers must implement standards within 2 years from the Federal Register publication date. The final standards will supersede any/all standards currently in place for electronic transactions and data elements.

11105 INTRODUCTION

An MMIS, once implemented and properly utilized by a State, becomes an important and comprehensive management tool for efficient, effective, and economical administration of a title XIX program. The MMIS referred to in this part is intended to identify successful automated program and administrative practices which increase the quality of services and reduce the costs of the State Medicaid program.

The systems approved for enhanced FFP have proven to be particularly effective tools in improving State management of its Medicaid program. They have enabled States to efficiently process claims, control program expenditures, monitor service utilization, and stay informed of program trends. These systems also provide data for Federal reporting needs.

The processes for approval of FFP at the 90- and 75-percent level have been established to encourage States to meet Federal MMIS system requirements. These processes and other applicable system requirements are described in this part.

11110 DEFINITIONS

Certain definitions common to multiple programs which are administered by the Department of Health and Human Services and which are found at 45 CFR 95.605 have been included to eliminate redundant and/or conflicting definitions from regulations governing the acquisition of automatic data processing systems, equipment, and services.

A. Advance Planning Document (APD).--A written plan of action to acquire the proposed automated data processing (ADP) services or equipment. Additional APD content requirements, for acquisitions for which the State is requesting enhanced funding from title XIX, are contained in 42 CFR 433, Subpart C.

o "Implementation APD".--Shall include:

- Results of the activities conducted under a Planning APD, if any;
- Statement of needs and objectives;
- Requirements analysis, feasibility study, and a statement of alternative considerations including, where appropriate, a transfer of an existing system and an explanation of why such a transfer is not feasible if another alternative is identified;
- Cost benefit analysis;
- Personnel resource statement indicating availability of qualified and adequate staff, including a project director, to accomplish the project objectives;
- Detailed description of the nature and scope of the activities to be undertaken and the methods to be used to accomplish the project;
- Proposed activity schedule for the project;
- Proposed budget for the project;
- Statement indicating the period of time the State expects to use the equipment or system;
- Estimate of prospective cost distribution to the various State and Federal funding sources and the proposed procedures for distributing costs and;
- Statement setting forth the security and interface requirements to be employed and the system failure and disaster recovery procedures available.

o "Planning APD" and "APD Update" are defined in 45 CFR 95, Subpart F, and are not required for an MMIS implementation.

B. "Automatic Data Processing (ADP)".--Data processing performed by a system of electronic or electrical machines so interconnected and interacting as to minimize the need for human assistance or intervention.

o "ADP Equipment" or "Hardware".--Automatic equipment that accepts and stores data, performs calculations and other processing steps, and produces information.

o "ADP Services".--

- Services to operate ADP equipment, either by private sources or by employees of the State agency, or by State or local organizations other than the State agency; and/or
- Services provided by private sources or by employees of the State agency or by State and local organizations other than the State agency to perform such tasks as feasibility studies, system studies, system design efforts, development of system specifications, system analysis, programming, and system implementation.

C. Certification Review.--The approval process by which HCFA determines if a State's system satisfies the approved APD, and/or if a State's title XIX mechanized claims processing and information retrieval system is operational and continuously meets requirements for FFP, as defined in §1903(a)(3) of the Act, 42 CFR 433, Subpart C, and this part of the manual.

D. Data Processing.--The preparation of source data or basic elements of information and their use according to precise rules or procedures to accomplish such operations as classifying, sorting, calculating, summarizing, recording, transmitting, information retrieval, and reporting.

E. Demonstrable Conceptual Equivalence.--A concept which permits States to illustrate that a system is technically different from the MMIS but still satisfies the objectives and functions of the MMIS, and is, therefore, its conceptual equivalent. (Note: A manual process does not meet this definition.)

F. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).--A type of medical service which provides early and periodic screening and diagnosis of eligible individuals under age 21 to ascertain their physical or mental defects. Health care, treatment, and other services are provided to correct or ameliorate defects and chronic conditions discovered, as provided in regulations. (See 42 CFR 441, Subpart B.)

G. Emergency Situation .--Is defined as a situation where:

o A State can demonstrate to the Department an immediate need to acquire ADP equipment or services in order to continue the operation of one or more of the Act programs covered by 45 CFR 95, Subpart F, and

o The State can clearly document that the need could not have been anticipated or planned for or that the State was prevented from following the prior approval requirements of 45 CFR 95.611.

The procedural requirements for requesting FFP in an emergency situation may be found in 45 CFR 95.624.

H. "Enhancement".--Modifications which change the functions of software and hardware beyond their original purposes, not just to correct errors or deficiencies which may have been present in the software or hardware, or to improve the operational performance of the software or hardware.

I. Feasibility Study.--A preliminary study to determine whether it is sufficiently probable that effective and efficient use of automated Medicaid systems including ADP equipment and operating systems can be made to warrant the substantial investment of staff, time, and money needed to acquire them.

o Requirements Analysis.--Determining and documenting the information needs and the functional and technical requirements the proposed computerized system must satisfy.

o Systems Analysis.--The examination of existing information flow and operational procedures within an organization. This analysis essentially consists of three basic phases: data gathering, or investigation of the present system and new information requirements; analysis of the data gathered in the investigation; and synthesis, or refitting of the parts and relationships uncovered through the analysis into an efficient system.

J. Financial Participation (FFP).--The Federal Government's share of a State's expenditures under the Medicaid program. Under §1903 of the Act, 90 and 75 percent FFP is provided as enhanced funding for MMIS expenditures, and 50 percent FFP for all general administrative expenditures.

o Enhanced Matching Rate.--The higher than regular rate of FFP authorized by title XIX of the Act for the acquisition of services and equipment that conform to specific requirements designed to improve administration of the Medicaid program.

o Regular Matching Rate.--The normal rate of FFP authorized by title XIX of the Act for State and local agency administration of the Medicaid program.

K. Fiscal Agent.--A private contractor to the State, normally selected through a competitive procurement process, who operates all or part of the State's approved MMIS.

L. "Implementation".--The design, development and installation, but not operation, of a system. The following definitions are part of implementation.

o "Design" or "System Design".--A combination of narrative and diagrams describing the structure of a new or more efficient automatic data processing system. This includes the use of hardware to the extent necessary for the design phase.

o "Development".--The definition of system requirements, detailing of system and program specifications, programming, and testing. This includes the use of hardware to the extent necessary for the development phase.

o "Installation".--The integrated testing of programs and subsystems, system conversion, and turnover to operation status. This includes the use of hardware to the extent necessary for the installation phase.

M. Maintenance or Systems Maintenance.--The routine operational exercising and functioning of the system to keep it ready and fit for performing at the standard and condition for which it was approved, including change of system operator. Those normal ongoing or cyclical ADP activities which insure that data, files, and programs of the State's approved system are kept up to date and/or that errors are reduced.

N. Medicaid Agency.--The single State Agency (SA) administering or supervising the administration of a State Medicaid plan under §1902(a)(5) of the Act.

O. "Medicaid Management Information System (MMIS)".--A commonly accepted term for "Mechanized Claim Processing and Information Retrieval System" identified in §1903(a)(3) of the Act and defined in 42 CFR 433.111.

The MMIS is conventionally organized into six core subsystems or functional areas. They are: Recipient; Provider; Claims Processing; Reference File; Surveillance and Utilization Review; and Management and Administrative Reporting.

P. "Medicaid Statistical Information System (MSIS)--Since 1972, HCFA has required annual submission of Form HCFA-2082 from all States and Territories that operate Medicaid programs under title XIX of the Social Security Act. In 1984, the Medicaid Statistical Information System (MSIS) was approved as a reporting option. Under this option, States can submit person-specific eligibility and paid claims files on magnetic tape instead of producing and submitting the printed (hard-copy) Form HCFA-2082. Participation in the MSIS was voluntary until the passage of the Balanced Budget Act of 1997. This Act requires that States participate in MSIS, effective January 1, 1999.

Q. "Operation".--The automated processing of data used in the administration of State plans for title XIX of the Act. Operation includes the use of supplies, software, hardware, and personnel directly attributable to the functioning of the mechanized system. (See 42 CFR 433.112 and 42 CFR 433.116 for specific requirements.)

R. "Project".--An automated systems effort undertaken by the State to improve the administration and/or operation of one or more of its public assistance programs. For example, a State may undertake a comprehensive, integrated initiative in support of its Food Stamp Program and Medicaid programs' intake, eligibility and case management functions. A project may also be a less comprehensive activity such as office automation, enhancements to an existing system or an upgrade of computer hardware, or it may also be initial implementation and/or operation or replacement of an MMIS.

S. Provider.--Any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency [as used in this Part, provisions to providers may apply to health plans].

T. Request for Proposal (RFP).--The document used for public solicitations of competitive proposals from qualified sources to supply ADP hardware, software, and other goods and services.

U. Replacement System.--An MMIS in which all six core subsystems are new and which has received prior HCFA approval because it is likely to be more efficient, economical, and effective in administering the State medical assistance plan than the system it replaces. It must meet all conditions of initial approval. (Note: Replacement of the operator of a system is not a replacement system in the MMIS context.)

V. Service Agreement.--The document signed by the State or local agency and the State or local Central Data Processing facility in accordance with which the latter agrees to provide data processing services to the former.

W. Shared On-Line System.--Data processing equipment, devices, programs, and stored data which may be accessed by two or more users utilizing either local or remote ability to interact with and under the control of a single central processing unit. Such a system can be used jointly between users within a State in the administration of such State's medical assistance plan.

X. "Software".--A set of computer programs, procedures, and associated documentation used to operate ADP hardware.

Y. State Plan.--The comprehensive written commitment by a Medicaid agency, submitted under §1902(a) of the Act and approved by HCFA, to administer or supervise administration of a Medicaid program in accordance with Federal and State requirements.

Z. Third Party Liability (TPL).--The term indicates the legal responsibility of other entities or individuals to pay the medical claims of Medicaid recipients before the Medicaid program pays these claims. Medicaid is the payer of last resort. Among the more common third parties are private health insurance, employment-related health insurance, and medical support from absent parents. Every Medicaid jurisdiction is required by §1902(a)(25) of the Act to pursue the legal liability of third party payers. In a systems context, TPL usually refers only to those automated, TPL-related activities which are contained in core parts of the MMIS.

AA. Total Acquisition Cost".--Means all anticipated expenditures (including State staff costs) for planning and implementation for the project. For purposes of regulation (see 45 CFR 95, Subpart F), total acquisition cost and project cost are synonymous.

11115 OBJECTIVES

For title XIX purposes, "systems mechanization" and "mechanized claims processing and information retrieval systems" refer to the Medicaid Management Information System. The objectives of this system and its enhancements are as follows:

A. Program

- o More accurate and timely claims processing;
- o Reduction in program and administrative costs through more effective claims processing, utilization control, and third party liability pursuit; and
- o Improved management of program and administrative costs.

B. Service

- o Improved service and information to recipients;
- o Reduced time to pay providers; and
- o Improved response time to inquiries.

C. Operations

- o Reduction in claims personnel requirements;
- o Increased utilization of computer capability;
- o Greater utilization of data base;
- o Improved operational control and audit trails;
- o Capability to handle increases in claims volume;
- o Reduction of systems audit exceptions; and
- o Compatibility with Medicare claim processing and information retrieval systems for the processing of Medicare claims.

D. Management

- Timely and effective reports for management planning and control;
- Improved analyses for decision making;
- Improved ability to respond to request for special analyses; and
- Improved capability to support Federal reporting requirements.

APPROVAL OF MMIS SYSTEMS

Section

11200 APPLICABLE FEDERAL APPROVAL REQUIREMENTS

The most current Public Laws and Federal regulatory requirements, as well as the system requirements and performance standards identified here, form the basis upon which the design, development, installation, operation, and enhancement of an MMIS is evaluated for approval of FFP. For approval of FFP for the design, development, installation, and enhancement of an MMIS, the requirements vary with the rate of FFP being requested. For the 90 percent funding rate, all requests are subject to prior approval. For 75 and 50 percent funding, a request other than a sole source procurement is subject to prior approval when the estimated costs exceed the threshold amount found in 45 CFR 95.611(a), currently $5,000,000. For sole source procurements at the 75 and 50 percent rates, the threshold amount is currently $1,000,000 of combined State and Federal funds. Failure to secure the requisite prior approval results in disapproval of your request and, if you claim funding for such a request, disallowance of your claim for FFP. Approval of operational funding at the 75 percent rate for an initial or replacement MMIS are subject to an initial certification review as described in §§11240 through 11243.

Whenever HCFA modifies the requirements for systems under 42 CFR 433.112 or 433.116, the notification provisions of 42 CFR 433.123 are followed.

11205 90 PERCENT FFP - GENERAL REGULATORY REQUIREMENTS

FFP is available at 90 percent for expenditures for design, development, installation, or enhancement of a mechanized claims processing and information retrieval system. To receive 90 percent FFP, a system proposal described in the APD must be approved by HCFA prior to your expenditure of funds. HCFA approves the system proposal if the following conditions are met (see 42 CFR 433.112):

- HCFA determines the system is likely to provide more efficient, economical, and effective administration of the State plan.

- The system meets the system requirements and performance standards in Part 11, as periodically revised.

- The system is compatible with the claims processing and information retrieval systems used in the administration of Medicare for prompt eligibility verification and for processing claims for persons eligible for both programs.

- The system supports the data requirements of the Peer Review 0rganizations (PROs) established under Part B of title XI of the Act.

- The State owns any software designed, developed, installed or enhanced with 90 percent FFP.

- The Department has a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use and authorize others to use for Federal Government purposes, software, modifications to software, and documentation that is designed, developed, installed or enhanced with 90 percent FFP.

- The costs of the system are determined in accordance with OMB Circular No. A-87 as referenced in 45 CFR 74.171.

- The Medicaid agency agrees in writing to use the system for the period of time specified in the APD approved by HCFA or for any shorter period of time that HCFA determines justifies Federal funds invested.

- The Medicaid agency agrees in writing that the information in the system is safeguarded in accordance with 42 CFR 431.

- The pertinent requirements of 45 CFR 95.612 on disallowance and of 45 CFR 95.621 on system security apply.

Eligibility determination systems are not part of mechanized claims processing and information retrieval systems, MMIS, or enhancements to those systems, and are not eligible for 90 percent FFP for any APD approved on or after November 14, 1989. This effective date was established by regulation BQC-59-FC published on October 13, 1989 in 54 FR 41966.

11210 75 PERCENT FFP - GENERAL REGULATORY REQUIREMENTS

The FFP is available at 75 percent of expenditures for operation of a mechanized claims processing and information retrieval system approved by HCFA. HCFA approves the system's operation if the following conditions are met (see 42 CFR 433.116):

o The applicable requirements of §11205 must be met.

o The complete system with all its component subsystems is and has been operating continuously, processing all claims types, during all periods for which 75 percent FFP is claimed.

o The system must provide individual notices, within 45 days of the payment of claims, to all or a sample group of the persons who received services under the plan. The notice "Explanation of Benefits (EOB)" must specify:

- The service(s) furnished;
- The names of the provider(s) furnishing the service(s);
- The date(s) on which the service(s) were furnished; and
- The amount of the payment(s) made under the plan for the service(s).

It must not specify confidential services (as defined by the State) and must not be sent if the only service furnished was confidential. The Department, while giving you flexibility in defining confidential services, expects that you exclude from EOBs only those particularly sensitive services for which disclosure violates a recipient's right to privacy, e.g., family planning services, venereal disease treatment.

o The system must provide both patient and provider profiles for program management and utilization review purposes.

o If you have a Medicaid fraud control unit certified under §1903(q) of the Act, the Medicaid agency must have procedures to assure that information on probable fraud and abuse that is obtained from, or developed by the system is made available to that unit.

o The pertinent requirements of 45 CFR 95.612 on disallowance and of 45 CFR 95.621 on system security apply.

o Eligibility determination is not part of the system operations approved for enhanced funding at 75 percent under 42 CFR 433, subpart C.

Automated eligibility determination systems approved or operating before November 14, 1989 do not qualify for FFP at 75 percent of expenditures on or after that date. Instead, these systems qualify for FFP at 50 percent of expenditures after that date.

11215 ACCESS FOR STATE AND FEDERAL INSPECTION

HCFA terminates FFP if the Medicaid agency fails to provide State and Federal representatives with full access to the system, including onsite inspection. HCFA may request such access at any time to determine whether conditions in 42 CFR 433, subpart C are being met.

11220 PROSPECTIVE APPROVAL OF ENHANCED FUNDING

In acquisitions where prior approval is required (see §11227), Departmental practice allows payment of FFP prospectively from the date of Departmental approval for implementation or operational costs of a system or enhancement when FFP for implementation or operation of the system or enhancement was not prior approved. FFP is allowed only for costs incurred after approval. The State must request approval of the system or enhancement and it must meet all requirements which it would have met if approved for implementation or operational FFP. (See §§11205 and 11210.) FFP at the 75 percent rate is also available for maintenance to an approved system. See §11200, §11238, and §11275 for the policy governing prior approval for this funding rate.

11225 CONSIDERATIONS AND OPTIONS

When you have determined the desirability of designing an MMIS or effecting system improvements which may lead to increased FFP, consider "demonstrable conceptual equivalence" and other options. The following are among options that may be considered:

o To claim the higher FFP under §1903(a)(3) of the Act, you need not have a single comprehensive claims processing and information retrieval system through which all claims for all types of service are processed. You may have multiple claims processing systems provided:

- They do not appreciably increase cost or detract from the primary benefits expressed in this part;

- Each system meets the established criteria in this part; and

- All systems feed into a single comprehensive utilization and management reporting system that meets the criteria established in this part. Under this approach, all of these components (subsystems) comprise the MMIS.

o Other mechanized information retrieval systems under title XIX, such as EPSDT, TPL, and Long Term Care, are eligible for the higher FFP allowed by §1903(a)(3) of the Act provided:

- You have an approved APD for the design, development, and installation of a mechanized claims processing and information retrieval system;

- The systems are used to store, retrieve, and produce utilization and management information about medical care and services which are required by the Medicaid agency and Federal Government for program administration and audit purposes;

- None of the design and operational aspects of such information retrieval system violate other statutory criteria, such as compatibility with information retrieval systems used by Medicare;

- HCFA determines that such systems are likely to provide more efficient, economical, and effective administration of the plan; and

- All procedures that are established in 42 CFR 433, subpart C are followed (i.e., the submission of an APD, prior HCFA approval is obtained before the expenditure of any funds for MMIS to qualify for enhanced matching in these expenditures, etc.)

These additional systems are not part of the required MMIS but qualify for enhanced FFP as optional integral components of the approved system.

o When requesting certification under §11240 you should also be prepared to submit results of successful acceptance testing (and a copy of your official acceptance letter to the developer where a contractor is involved). Your acceptance test plan must be submitted to HCFA at least 6 months prior to the planned operational date. Copies of any subsequent revisions to the plan must also be forwarded to HCFA in advance of the operational date.

11227 ACQUISITION OF ADP EQUIPMENT AND SERVICES

Acquisitions of ADP equipment and services are governed by:

o For both competitive and/or non-competitive acquisitions to be funded at the 90 percent rate of reimbursement, the APD and the Detailed Implementation Schedule (DIS) describing the acquisition must receive prior approval by HCFA. Prior approval is also necessary for subsequent procurement instruments (RFP, contract, contract amendment, etc.) which exceed thresholds in 45 CFR 95.611(b). Failure to secure requisite approval by HCFA prior to the initiation of project activity and the State's expenditure of funds results in a disapproval of FFP for the acquisition. Additional FFP requested at the 90 percent rate, in excess of that originally estimated and approved for the acquisition or a schedule extension for major scheduled occurrences, requires submission of an amended APD and approval prior to the expenditure of the additional FFP. If prior approval was not received, §11220 may apply.

o For competitive acquisitions at the 75 and 50 percent rates of reimbursement, the rules are similar to those described above except that prior approval is <u>not</u> required for the APD and DIS if the total project cost is below the dollar thresholds set out in 45 CFR 95.611(a)(2) and (3). Currently, these thresholds are $5,000,000 in State and Federal funds. If cost of a project was originally below the threshold and later increases above the threshold, an APD must be submitted and approved for the excess cost over the threshold before the expenditure of those funds. Also, prior approval is not required for the RFP if the total project cost is below the thresholds set in 45 CFR 95.611(b)(1)and (2), currently $5,000,000 for acquisitions at the 50 percent rate and acquisitions at the 75 percent reimbursement rate. Amendment to a competed contract requires prior approval if above the threshold contained in 45 CFR 95.611(b), currently $1,000,000.

o For non-competitive acquisitions at the 75 and 50 percent rates, prior written approval is required if the total project cost is in excess of the dollar threshold found in 45 CFR 95.611(a)(4). Currently, the threshold amount is $1,000,000. Non-competitive acquisitions are only approved on an exception basis because the Federal Government's policy is to promote free and open competition.

- For a contract amendment for acquisitions at the 75 or 50 percent rates, prior approval is required whenever the amendment cost exceeds the threshold contained in 45 CFR 95.611(b), currently $1,000,000, or a contract time extension of more than 120 calendar days.

11230 APPROVAL PROCESS AND DOCUMENTATION SUBMISSIONS

The approval process for you to follow in obtaining enhanced FFP under 42 CFR 433, subpart C is outlined in §§11235 through 11243. A graphic display of the procedural steps is contained in §11275. Forward required submittals to the appropriate HCFA Regional Administrator (RA) when title XIX only requests are involved.

11235 90 PERCENT FFP

The approval process for 90 percent FFP requires submission of the following documents as appropriate:

- Advance Planning Document (see §11236);
- Detailed Implementation Schedule (see §11237); and
- Contracted Services Documents (see §§11265 thru 11267).

11236 IMPLEMENTATION ADVANCE PLANNING DOCUMENT (APD)

Your submission of the APD informs HCFA of your plan for system acquisition or enhancement and your intent to claim enhanced FFP for design, development, installation, or enhancement of an MMIS. It is also used to indicate whether work is to be performed by a contractor or by State personnel. The information content of this document is specified in the definition of an APD. (See §11110.) A Planning APD and APD Update are not required for MMIS systems.

In addition, the Medicaid program specific agreements (see 42 CFR 433 112(b)(5) through (9)) must also be furnished.

HCFA approvals, disapprovals, comments, and/or suggestions relating to title XIX only requests are sent to you in writing, from the RA or a designee.

Reimbursable costs for 90 percent are listed in §11276.11.

If work is to be performed under contract, see §§11265 through 11267.

11237 DETAILED IMPLEMENTATION SCHEDULE (DIS)

A State DIS is required for HCFA prior approval where it would be developed by both State and contractor staff. It must include a provision for identifying costs allocated to the design, development, and installation, or enhancement effort. In general, the DIS includes:

- Project Schedule and Deliverables,
- Project Resource Requirements,
- Project Organization and Staffing,
- Project Interface with the Affiliated Organizations and Systems,
- Project Reporting Requirements,
- Estimated Costs,
- System Acceptance Test Plan, and
- Conversion Plans, as required.

The DIS may be augmented by onsite reviews by authorized Federal or State program or audit personnel. The purposes of these onsite reviews are to assess:

- The current validity of the original plan developed in §11236;
- Progress against the DIS; and
- The validity of accounting and cost allocation records maintained.

Changes to your DIS are subject to prior approval.

11238 PROJECT REPORTING REQUIREMENTS

Periodic progress and status reports are essential to effective monitoring of your system development efforts as well as large scale ADP equipment acquisitions. Thus, at various points in the approval process, beginning with approval of your APD, you are put on notice as to the nature, extent, and timing of the reports you must submit. These reports may be augmented by onsite visits by Federal staff to verify the project's status and progress.

Given the diverse nature of the ADP projects involving title XIX, the degree of State reporting required for a specific ADP project is at the discretion of the HCFA approving component. At a bare minimum, advise the pertinent RO in writing that a project has been successfully completed, and if it has been completed on schedule and within the approved estimated cost.

You are also advised, at the time the project APD is approved, that change in the project's scope, duration, or cost requires submission of an amended APD for prior approval if thresholds of §11227 are exceeded.

11240 75 PERCENT FFP - FEDERAL CERTIFICATION REVIEW PROCESS

The Federal review process for FFP at 75 percent occurs in three phases:

- o Preliminary evaluation of State furnished information and system documentation;
- o A visit to the State for the purpose of onsite observation of ongoing system operations; and
- o A post-site visit evaluation report of findings and recommendations.

11241 PRELIMINARY EVALUATION

The Federal review process is initiated when you submit a written statement of intent to claim enhanced FFP for operations and supporting systems documentation. The statement of intent must assure HCFA that system operations meet requirements of §11210 and that access to State and Federal inspection is assured as required in §11215. System operations must meet the system requirements and performance standards specified in Chapter 3 including:

- o The date the complete system was officially accepted by the State as operational (include a copy of your official acceptance letter to the developer from the State on State letterhead);
- o The dates of operations covered by any claim;
- o Certification that requirements have been met for any and all periods of the claim; and
- o Certification that EOBs have been issued within 45 days of the payment of a claim to each individual who is furnished services covered by the State plan or to each individual in a sample group of individuals who was furnished such services on a regular basis for the entire period claimed.
- o To expedite the review, submit in advance of the certification review the following systems documentation:
  - A system diagram identifying overall logic flow, systems functions, and their associated files;
  - A narrative of each subsystem/functional area describing the incorporated functions;
  - A list of all error codes with explanations and procedures for corrective actions;
  - A list of reports by each subsystem/functional area (include a list that identifies the distribution of all systems generated reports);
  - A substantive and representative sample of all reports;
  - A system acceptance test plan; and
  - The outcome of the test.

The HCFA review team will initially evaluate your system documentation and information for completeness, equivalency to the system requirements contained in Chapter 3, and meeting the objectives and functions of the MMIS. If obvious deficiencies are noted, you may be requested to supply additional clarifying information. A minimum of 6 consecutive months of claims processing activity is required to adequately review the Surveillance and Utilization Review (SUR) reports.

NOTE: HCFA will not schedule a certification review unless all requirements of §11241 have been met. Of critical concern is the documented completion of successful acceptance testing and documented official acceptance of the system.

If, after preliminary review, your submittal is satisfactory, the HCFA review team, with input from the RO, will develop a response that specifies the date on which the onsite review of system operation will be accomplished, and the designation of the Federal team leader and members who will be the focal point for interface with your Medicaid agency.

A time schedule agenda will be identified which will enable you to make available those individuals involved with the subsystems of the State MMIS. The agenda will normally consist of an introductory meeting, a system overview presentation, a walk-through of the system operation, individual interviews of key Medicaid program staff, and selective validation of documents and controls associated with various functional areas of the MMIS operation. Your acceptance of the agenda will be obtained prior to on-site observation to insure availability of appropriate personnel and material.

Prior to the onsite certification review of your MMIS, you will be offered the opportunity to meet with the HCFA certification review team to discuss the certification review process and any areas of concern you may have.

11242 ONSITE OBSERVATION

The designated Federal team leader will conduct an entrance and exit conference with the designated State officials. In the entrance conference, the agenda and planned onsite activities will be reviewed to ensure that the planned schedule will be productive. Since the time of both Federal and State personnel is limited, the schedule may have to be revised before the review can begin.

The team leader will designate areas of responsibility to team members. Normally, assignments will be made with respect to the conventional organization of an MMIS into six core subsystems or functional areas; i.e., Recipient, Provider, Claims Processing, Reference File, SUR, and Management and Administrative Reporting.

You are expected to provide space for interviews and to designate key staff and/or contractor counterparts having particular expertise concerning specific system functions. Fiscal agents or contractors of your agency are approached only through the State Medicaid Program staff.

At the conclusion of the onsite review, the team leader will hold an exit conference with appropriate State officials. The team leader will discuss the activities that the HCFA review team has conducted and inform them of any additional information and/or documentation required.

The team leader will inform you that the team will develop a report of findings together with the recommended action for approval or disapproval of the State MMIS for the Administrator who will render a decision. No judgment as to approval or disapproval will be rendered at any time during the onsite review.

11243 POST-SITE EVALUATION

In the post-site evaluation, individual team members will independently analyze findings and, if necessary, conduct detailed studies prior to drafting an evaluation report covering their area of responsibility. These reports will be reviewed in conference, and the team leader will prepare a final report for signature by the Administrator or the Administrator's designee with a recommendation for approval or disapproval. The decision is forwarded to the appropriate HCFA RA who communicates the decision to your agency.

If HCFA disapproves the system or determines that the system met the requirements for initial approval on a date later than the date required under 42 CFR 433.116(a), the notice will include:

- The finding of fact upon which the determination was made; and

- The procedures for appeal of the determination in the context of a reconsideration of the resulting disallowance, in the event the full FFP rate is claimed, to the Departmental Appeals Board.

11250 REIMBURSABLE COSTS FOR STATE MMIS

Attributable costs reimbursable at the 90- and 75-percent FFP for State MMIS activities involving the design, development, installation, operation, and enhancement of an MMIS are found in §11276.11.

11255 TRANSITION FUNDING--90- AND 75-PERCENT FFP

Projects for designing, developing, installing, or enhancing an automated claims processing and information retrieval system will be funded during the transition between 90-percent FFP to 75-percent FFP as follows:

- The FFP at the 90-percent level is available for design, development, installation, or enhancement of each subsystem in an approved complete system meeting the requirements of §11205.

- The FFP at the 90 percent level for any subsystem terminates on the date the subsystem or enhancement to a subsystem is fully tested and subsequently you accept it.

- The FFP at the 50 percent level is available for operation of any subsystem or enhancement from that point that 90 percent FFP ceases until the complete system or enhancement is fully operational and meets the requirements of §11210.

- The FFP at the 75 percent level is available prospectively from the date the system or enhancement is approved and retroactively to the date that the complete approved system or enhancement is determined to be fully operational and meets all requirements of §11210. (See §11260 for the retroactive approval process.)

- The FFP at the 75 percent level is continuous if you replace the current operator of an approved system with a new operator of that same approved system provided no break in system operations occurs.

11260 RETROACTIVE 75 PERCENT FFP

A claim for retroactive enhanced FFP may be made for an approved period of systems operations. You can obtain increased operational FFP retroactive to the first quarter beginning after the date established by the Secretary that the system became operational. HCFA conducts a certification review prior to authorization of the retroactive FFP. In making a claim for retroactive 75 percent FFP, submit a written statement to the effect that your system operations have been reviewed by HCFA and meet all requirements in §§11210 and 11215, including the system requirements and performance standards of Chapter 3. Identify the reviewer and include the date of the review. Also include the following:

- The date the complete system was officially accepted as operational;
- The dates of the period of operations claimed;
- Certification that the requirements have been met for the entire period for which 75 percent is being claimed; and
- Certification that EOBs have been issued within 45 days of the payment of a claim to each individual who was furnished services covered by the State plan or to each individual in a sample group of individuals who furnished such services on a regular basis for the entire period claimed.

In all cases of retroactive FFP, you must agree in writing that the Federal Government has access to the system and associated documentation in all of its aspects including design, development, installation, and operations, regardless of source, including cost records of contractors and subcontractors as HCFA deems necessary.

11265 CONTRACTUAL SERVICES

Contractual services may be utilized to perform work for the design, development, installation, or enhancement of a mechanized claims processing and information retrieval system. An unsolicited proposal submitted by a reputable third party firm is not sufficient for obtaining FFP under §1903(a)(3) of the Act. Procurement of services must be open and competitive, unless one of the provisions found in §11.d(1)-(4) of Appendix G to 45 CFR Part 74 and/or the December 4, 1995 State Medicaid director letter is applicable to the procurement. Normally, a Request for Proposal (RFP) is prepared containing a specific scope of work and related requirements for solicitation of bids from responsible competing systems firms. (See §11266 and §2080.)

Work performed under contract to design, develop, install, or enhance an MMIS which meets all the provisions of §11205 is funded at the 90 percent FFP level; if not, the work is then funded at the 50 percent level. Subsequent operational costs of a certified approved MMIS are funded at the 75 percent FFP level.

Work performed under contract for operation and maintenance of an MMIS and meeting the provisions of §11210 is funded at the 75 percent FFP level. Such acquisitions must receive prior approval if required by §11227.

11266 REQUEST FOR PROPOSAL (RFP)

Your RFP must be approved by HCFA prior to its release to potential bidders if the pertinent provisions of §11227 apply. The RFP has a twofold purpose: to convey to prospective contractors the information needed to prepare a proposal, and to solicit information that procurement and technical personnel need to evaluate the proposals received. The RFP must include at a minimum:

- Statement of the purpose and scope of the specific work and/or services to be performed including a period of performance within which you expect to have the work performed;

- Listing and description of the reference material available to the contractor for use in preparation of proposals and/or in performance of the contract;

- Statement of contract termination procedures;

- Standard format and organization for the proposals including both work to be performed and cost statements;

- Explanation of the proposal evaluation criteria and the relative importance of cost or price, technical, and other factors for purposes of proposal evaluation and contract award;

- Description of the nature and extent of involvement of Medicaid agency personnel during the contract, including the name and title of the project officer;

- Description of the supplies, clerical support, computer time, work space, etc., that will be made available by the State, if applicable;

- Statement that the prime contractor is responsible for contract performance, whether or not subcontractors are used;

- Requirement that the contractor's personnel resources to be assigned to the contract are identified;

- Requirement for a schedule of proposed work (work statement), including well defined milestones;

- Requirement for a breakout of the total cost to perform the contract including the costs for individual phases or areas of the work statement;

- Requirement for a statement of corporate financial stability and/or for a performance bond; and

- Statement that the proposed contract will include provisions for retention of all ownership rights to the software by the State, if designed, developed, installed, or enhanced with FFP. (See 42 CFR 433.112 (b)(5) and (6), and 45 CFR 95.617(a)).

11267 REQUIRED ASSURANCES

For 90-percent, as well as for 75-percent funding and 50-percent FFP where the threshold amounts found at 95.611(a) are exceeded, give HCFA, with respect to each RFP and/or contract entered into for a system, assurance that:

- Procurements of ADP services and/or equipment for mechanized medical claims processing and information retrieval systems meet the provisions of 45 CFR 74, Administration of Grants;

- Fair competition and public advertising are within Federal and State procurement standards. The Federal procurement standards are in 45 CFR 74, Subpart P and the December 4, 1995 State Medicaid director letter;

- Copies of progress reports, as requested, will be delivered to HCFA; and,

- All deliverables, interim reports, data collection forms, questionnaires, and other working papers which support the final system acceptance will be made available on request to HCFA. This applies to the prime contractor, any subcontractors, and other State or local agencies supplying services.

11268 COST ALLOCATION PLAN

You must document costs in a cost allocation plan submitted in accordance with 45 CFR 95, and approved by HCFA to support your claim for FFP. You must be able to provide documentation to support wages, fringe benefits, and other expenditure items in accordance with Federal regulations in 42 CFR 433.34, Cost Allocation, and 45 CFR 95, Subpart E.

11269 REPLACEMENT SYSTEMS

The State may replace the operator of its system at any time; however, the process of changing operators does not constitute the installation of a replacement system and is not eligible for 90-percent funding. Enhanced FFP at the 75-percent rate will continue for an approved system regardless of who operates it. You must comply with the requirements of 45 CFR 74 and 45 CFR 95 when changing the operator of your system. (See §11227.)

A State may also discontinue the operation of an approved system and replace it with a new system that is likely to be more efficient, economical, and effective in administering the State plan. When all six core subsystems are new, this constitutes a replacement system as defined in §11110. The State agency must describe in its APD a plan for continuous systems operation so that there is no interruption between the end of one system and the beginning of another.

In order to receive enhanced FFP, a replacement system must meet all conditions of initial approval. A State must submit an APD that includes (42 CFR 433.117):

- The date the replacement will be in operation; and
- A plan for orderly transition from the system being replaced to the replacement system.

FFP at 90 percent is available for design, development, and installation if the State meets the provisions of 42 CFR 433.112 and follows the procedures of §§11215 through 11268. When a replacement system becomes operational, FFP will be available at 50 percent for operation of the replacement system until HCFA approves it. At that time, increased FFP will be available at 75 percent retroactively to the date HCFA determined the replacement system meet all conditions of approval.

It is the intent of HCFA to fund only one approved system in a State at any one time at the 75-percent rate of reimbursement. However, where fiscal agents are concerned, we recognize that in some instances because of contract overlap, system functions will be performed by two separate contractors with both being potentially reimbursed at 75 percent. Overlap can occur due to different circumstances, such as parallel systems testing. HCFA encourages the use of parallel systems testing as a means to validate the new system. HCFA anticipates that such a testing period would not exceed 30 days.

11270 RESERVED

11275 APPROVAL PROCESS AND DOCUMENTATION SUBMISSIONS

The title XIX only approvals process described here portrays a composite picture of the approval process. As such, do not interpret it as requiring that any State funding request needs to go through the entire process. The nature of a State's request determines what documents need to be submitted and what approvals need to be secured. For example, if you engage in the design, development, and installation of a replacement MMIS solely utilizing your staff, submit an APD, DIS, any requisite progress reports, and finally, notification that the new system is operational.

On the other hand, if you intend to change the operator of your current MMIS (a 75 percent activity estimated to cost above the threshold found in 45 CFR 95.611 (a)), submit an APD, RFP, contract, DIS, and any requisite progress or completion reports.

Matching Task or Event	FFP Prior Rate	HCFA Required Approval	Submittals
TO OBTAIN 90 PERCENT FFP			
1. Feasibility Study (Optional)	50%	1/	N/A
2. Planning, including preparation of an APD	90%	1/	N/A
3. Authority to proceed under §1903(a)(3) of the Act to design, develop, install, or enhance an MMIS	N/A	Yes 1/	APD
4. Preparation of an RFP for the design, development, installation, or enhancement of an MMIS	90%	No	N/A
5. Authority to release the RFP to the vendor community	N/A	Yes 1/	RFP
6. Preparation of proposal evaluation plan	90%	Yes	Proposal Evaluation Plan
7. Preparation of the DIS	90%	Yes	DIS

1/Prior approval is required if the thresholds in 45 CFR 95.611 are exceeded. The threshold for acquisitions (APD, RFP, or contract) at 50% FFP or 75% FFP is $5,000,000 for competitive and $1,000,000 for non-competitive. There is no threshold for acquisitions at 90% and prior approval is always required. All non-competitive acquisitions must receive prior approval.

Task or Event	FFP Matching Rate	HCFA Prior Approval	Required Submittals
TO OBTAIN 90 PERCENT FFP			
8. Preparation of project status progress reports	90%	No	Required report or document
9. Preparation of contracts for the design, development, installation, or enhancement of an MMIS	90%	No	N/A
10. Contract award	N/A	Yes 1/	Contract
11. Preparation of contract amendments	90%	Yes 1/	Amended APD
12. Execution of contract amendments	N/A	Yes 2/	Contract amendment
13. System acceptance	N/A	No	Letter and other documentation. See §11241.
TO OBTAIN 75 PERCENT FFP			
1. Initial operation of a new or replacement MMIS	75%	Yes 3/	Letter and other documentation. See §§11241-11269.
2. Continuing system operations	75%	Yes	Contract extension justification.
3. System maintenance	75%	Yes 1/ and 2/	Required Document

1/Prior approval is required if the thresholds in 45 CFR 95.611 are exceeded. The threshold for acquisitions (APD, RFP, or contract) at 50% FFP or 75% FFP is $5,000,000 for competitive and $1,000,000 for non-competitive. There is no threshold for acquisitions at 90% and prior approval is always required. All non-competitive acquisitions must receive prior approval.

2/The threshold for contract amendments is $1,000,000. All non-competitive acquisitions must receive prior approval and are only approved on an exception basis.

3/Prior approval of the operating system for 75% FFP is subject to the requirements of §§11240 through 11243 and 42 CFR 433.114 through 433.117.

11276 COSTS RELATED TO MMIS DESIGN, DEVELOPMENT, INSTALLATION, OPERATION, AND ENHANCEMENT

11276.1 Introduction.--FFP is available at either 90 percent or 75 percent, but may be paid only for those functions attributable to an MMIS. For example, with respect to provider enrollment, only the costs of entering data into the computer system and processing computer exceptions are reimbursed at 75 percent FFP. Other functions, even if performed by the same unit or individuals, are reimbursable at 50 percent FFP. Appropriate costs, including overhead directly attributable to the operation of the system are also reimbursable at 75 percent FFP. (See §11276.9.)

45 CFR 74.171 references OMB Circular No. A-87, which defines direct costs as "those that can be identified specifically with a particular cost objective. Indirect costs are those (a) incurred for a common or joint purpose benefiting more than one cost objective, and (b) not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the result achieved." As explained below, only direct costs identified specifically with the MMIS system may be claimed at the enhanced rate.

11276.2 Costs Reimbursable at 90 Percent FFP.--FFP at 90 percent is available for costs directly attributable to the Medicaid program for the design, development, installation, and enhancement of mechanized claims processing and information retrieval systems. Included are resources needed for systems requirements analysis, design definition, forms development, programming, unit testing, integrated test, conversion, the use of hardware to the extent necessary for design, development, and installation, and supplies for the above. These and other direct costs including personnel costs of the State project management team specifically assigned for the development and installation effort are included. Other administrative activities are matched at 50 percent.

11276.3 Costs Reimbursable at 75 Percent FFP.--FFP at 75 percent is available for MMIS operations and proprietary software.

A. MMIS Operations.--FFP at 75 percent is available for direct costs directly attributable to the Medicaid program for ongoing automated processing of claims, payments, and reports. Included are forms, use of system hardware and supplies, maintenance of software and documentation, and personnel costs of operations control clerks, suspense and/or exception claims processing clerks, data entry operators, microfilm operators, terminal operators, peripheral equipment operators, computer operators, and claims coding clerks if the coded data is used in the MMIS, and all direct costs specifically identified to these cost objectives. Report users, such as staff who perform follow-up investigations, are not considered part of the MMIS.

FFP at the 75 percent level for operations does not cover clerical processing operations, except as indicated. One of the aims of system improvements is the mechanization of front-end manual editing operations to achieve greater edit reliability and the reduction of clerical workload.

B. Proprietary Software.--FFP at 75 percent is available for the license fee associated with proprietary software being used to perform certain functions that are within the confines of an approved MMIS; e.g. information retrieval and report generation (See §11276.5 for Decision Support System policy).

Several regulatory factors govern such use, and are described in 45 CFR 95.617(c);

(1) Software packages sold or leased to the general public are not subject to the ownership provisions normally applied to software developed with FFP (45 CFR 95.617(a) and (b), and

(2) FFP is not available for proprietary application software developed specifically for the public assistance programs covered under this subpart, (in this case, the Medicaid Program).

Minimally, the proprietary application software must have an applicability to the medical environment/community at large, and be marketed/sold within that medical environment/community at large.

HCFA will approve the use of such proprietary software which;

(a) meets the above restrictions of 45 CFR 95.617(c), and,

(b) where the vendor of the proprietary software agrees, in writing, to grant the State a perpetual license for continued use of the software should the State award a contract for a subsequent take-over of the MMIS operations by another fiscal agent/contractor.

11276.4 Costs Reimbursable at 90 and 75 Percent FFP for Equipment and Supplies Rented or Purchased.--Purchase rather than rental of mechanized equipment must be justified by establishing that it is to the economic advantage of the State and Federal governments after consideration of the tangible and intangible factors involved. Included in this determination is consideration of the alternative to lease the equipment with option to purchase. Equipment cost for its use during the design, development, and installation or enhancement of an MMIS to assist in accomplishing these tasks is eligible for 90 percent FFP.

Equipment purchased for operational purposes is eligible only for FFP at 75 percent. Cost of equipment used during both implementation and operation of an MMIS is assigned by proration. Depreciation or use allowance for State charges for equipment cost is usual practice. (See 45 CFR 95, Subpart G.) Approval requirements for equipment acquisitions, when waiver is part of the APD, are found in 45 CFR 95.641.

The FFP percentage for purchase of supplies depends upon the life and use of the item. The portion of items consumed during design, development, and installation for system test such as cards, microfilm, and forms (limited quantity) may be charged at 90 percent FFP. The portion of items not consumed and partially used during design, development, and installation may be charged at 90 percent FFP, and the remaining portion at 75 percent FFP. These same items used during system operation must be charged at 75 percent FFP.

Supplies purchased, such as disk packs and magnetic tapes, must be charged at 75 percent FFP since the intent is for use in continuous operations. (See 45 CFR 95 for standards for depreciation and use allowances.)

Costs for site preparation are operational start-up costs and matched at the 75 percent FFP rate.

11276.5 Costs Reimbursable at 75 percent FFP for MAR and SUR Activities and Decision Support Systems.--Costs directly associated with personnel involved in MAR and SUR activities and the cost for operation of Decision Support Systems (DSS) generally qualify for 75 percent FFP.

A. MAR and SUR Activities.--In order for cost of personnel directly associated in the production of reports for MAR and SUR activities to qualify for 75 percent FFP the personnel must routinely perform these functions (and/or SUR parameter changes) as part of their assigned responsibilities. Costs associated with the use or follow-up action of these reports are not eligible for enhanced FFP.

B. Decision Support Systems.--MMIS was designed to meet operational needs through the processing and payment of claims and generation of pre-formatted management reports through the MAR and SUR functionalities. However, due to the information challenges in today's market, more flexible and timely means of obtaining and reporting information is necessary. A DSS is often a feasible means of managing data needs. DSS is a universal term describing a menu of hardware and software components which can be combined to facilitate access to data and data analysis to serve a wide range of end-users. A DSS provides a mechanism to process data in a manageable quantity and format which is easily accessed by users to manipulate data on-line. A DSS can enhance the MAR and SUR functionalities by giving States the ability to access large volumes of data to produce customized reports.

The funding levels applicable to acquisition, implementation, and operation of a DSS are listed below. These guidelines are predicated on the premise that the DSS is being procured by a State as a replacement for or a supplement to the current MAR and SUR reporting functionalities of the MMIS. A DSS procured for use with other than an MMIS would not be eligible for enhanced funding match, and depending on its relationship (or lack thereof) to the title XIX program, may (or may not) be eligible for only 50% match (or no match).

o	License fee for use of the proprietary software	75% FFP
o	Development of software to facilitate conversion of data format, including use of PCS, mainframe or mass storage	90% FFP
o	Initial conversion* of data, including use of PCS, mainframe, or mass storage (for testing)	90% FFP
o	Repetitive cyclic conversion* of data	75% FFP
	*If the design of the operation of the DSS requires a repetitive cyclic conversion of MMIS data then such subsequent conversion costs will be funded at a 75% FFP rate.	
o	Training of users	50% FFP
o	Operation of the DSS software, including use of PCS, mainframe, or mass storage	75% FFP
o	ADP professionals**	75% FFP
o	Users**	50% FFP

**When a State employs an ADP professional to create/key-in the necessary parameters which cause the DSS to generate user-requested reports, that ADP professional is matchable at 75% FFP. However, USERS who have been trained to enter/key-in the parameters necessary to generate their own reports from the DSS are only eligible for 50% FFP match.

11276.6 Costs Reimbursable at 75 Percent FFP for MMIS-Related Clerical or Manual Processing Activities.--Although it is an objective of the MMIS to reduce manual processing (see §11276.3), some manual intervention is necessary to make any computer system perform properly. However, only those manual functions which are directly attributable to the operation of the MMIS are funded at the enhanced FFP.

11276.7 Costs Reimbursable at 75 Percent FFP for Program Management, Prior Authorization of Services, and Audit Functions.--The 75 percent FFP for MMIS operations is available for claims processing and information retrieval functions performed by the State agency or the fiscal agent. This includes the actual processing of claims as well as the production of MMIS reports. As such, the following functions must be reviewed in terms of their relationship to claims processing and information retrieval.

A. Program Management.--Although required to operate a Medicaid program, this function is not reimbursable at the MMIS FFP rate unless directly related to claims processing or information retrieval. For example, making a program management decision on a specific suspended claim is allowable at 75 percent FFP. However, the development and issuance of overall policy is excluded. The development of an edit for the claims processing system to implement a program policy (e.g., a limitation of a service) is allowable at the 75 percent rate and includes the cost of designing and implementing the edit. The cost of the program management staff that developed the policy is allowable only at the regular 50 percent rate as part of ongoing program management.

B. Prior Authorization of Services.--A program management decision on a claim entered into the system and suspended is allowable. However, prior authorization of a service such as orthodontics or elective surgery before the service is delivered is not allowable. Such a decision is based on limitations in the State plan and not directly related to the mechanized claims processing system.

C. Audit.--All State and fiscal agent audit activity is not eligible for enhanced FFP as an MMIS activity. This includes cost report audits, provider audits, and follow up investigation of claims where fraud is suspected.

11276.8 Postage Costs.--The postage necessary to mail various products stemming from the operation of an MMIS, e.g., checks, remittance advices, is not considered part of the operation of an MMIS as defined in §11110. Consequently, all postage costs associated with the operation of an MMIS are matched at the 50 percent FFP rate.

11276.9 Reimbursement of Allocated Costs.--Only direct costs allocable to the development or operation of an MMIS are eligible for reimbursement at enhanced FFP rates. Such costs include utilities, rent, telephone service, etc., necessitated by either the development or operation of an MMIS.

Costs which cannot be specifically identified with the development or operation of an MMIS are matched at the 50 percent FFP rate. Such costs are usually indirect costs including the staff costs associated with agency-wide functions such as accounting, budgeting, legal affairs, general administration, etc.

This differentiation in the funding rates for these two types of costs is not applicable to the reimbursement of fiscal agent costs.

11276.10 Costs Reimbursable at 75 Percent FFP for Fiscal Agent MMIS Operations.-A fiscal agent may perform many additional functions (see §11276.7) for the State beyond those related to MMIS operations eligible for 75 percent FFP, yet bill the State at one all inclusive rate per claim processed. If this is the case, develop a cost allocation plan through which payments to the fiscal agent are broken out for matching at the appropriate FFP rates. (See §11276.9.)

11276.11 List of Reimbursable Costs for State Systems.--

A. Introduction.--This section identifies those activities associated with the design, development, installation, enhancement, and operation of an MMIS, and the appropriate FFP matching rate for which each qualifies. These costs must be specifically identified in the APD, RFP and contract if they are to be claimed at the 90 percent rate. Only items listed for 90 percent or 75 percent rate of funding qualify for enhanced FFP as expenditures for MMIS under §1903(a)(3)of the Act.

B. List of Reimbursable Costs.--

1. Design, Development, Installation, or Enhancement of an MMIS

Item	Rate of Funding	Text Reference(s)
Feasibility Study	50%	11275
Planning activities (e.g., preparation of an APD)	90%	11275
Preparation of an RFP for an initial or replacement MMIS	90%	11275 11269
Preparation of an RFP for an enhancement to an MMIS	90%	11275
Proposal evaluation and contractor selection	90%	11275
System and requirements analyses	90%	11110
System design, development, installation, and enhancement	90%	11275 11110
DIS	90%	11237 11275
Equipment costs only for use of such equipment in the design, development, installation, or enhancement of an MMIS	90%	11276.4

MMIS Operational Costs (Continued)

Item	Rate of Funding	Text Reference(s)
Direct personnel costs	90%	11276.2
Direct non-personnel costs	90%	11276.9
Indirect personnel and non-personnel costs	50%	11276.9
Acceptance testing	90%	11237
Supplies used during MMIS implementation	90%	11276.4
Design, development, installation, or enhancement of a proprietary system	0%	45 CFR 95.617(c)
Site preparation	75%	11276.4
Training of personnel engaged in the design, development, or installation of an MMIS	50%	42 CFR 432.50(b)
2. MMIS Operational Costs		
Preparation of an APD and/or RFP directed toward the potential change of operator for an approved MMIS	75%	11275
Proposal evaluation and contractor selection	75%	11275
Hardware used for MMIS operations	75%	11276.3
Supplies used in the operation of an MMIS	75%	11276.4
Claim forms (including encounter data)	75%	11276.3
Entry and maintenance of provider enrollment data	75%	11276.1
Direct costs of personnel directly associated with the operation of an approved MMIS including staff responsible for:	75%	11276.3
Data entry Operations control Exception and suspense processing (continued)		

MMIS Operational Costs (Continued)

Item	Rate of Payment	Text Reference(s)
Claims microfilming (continued from previous page): Peripheral equipment operations Computer operations Claims coding System documentation maintenance Software maintenance SURS parameter coding System management		
Entry and maintenance of data required under HIPAA for purpose of electronic data interchange	75%	11100
Direct non-personnel costs	75%	11276.9
Indirect personnel and non-personnel costs	50%	11276.9
Publications necessary for the operation of an MMIS, such as, required claim forms	75%	11276.3
Maintenance of the system necessary to support claims processing and information retrieval functions of an MMIS	75%	11276.1 11276.3
Postage	50%	11276.8
Provider relations directly related to MMIS claims processing, such as, entry and update of provider data	75%	11276.1
MMIS production of: Checks or warrants, Remittance advices EOBs, Medical assistance ID cards, MARS and SURS reports	75%	11276.3
Operational costs of an initial or replacement MMIS until the system has been approved	50%	11255
Training of personnel directly engaged in the operation of an MMIS	75%	42CFR432.50(b)(2)

MMIS Operational Costs (Continued)

Item	Rate of Payment	Text Reference(s)
3. Other System Costs		
Local ADP systems (not statewide in scope)	50%	11225
Automated administrative support systems (e.g., personnel, financial management, office automation)	50%	11276.1
Design, development, installation, enhancement, and operation of eligibility determination systems	50%	11280
Audit functions	50%	11276.7
Provider Manuals	50%	11276.9

11280 APPROVAL OF ELIGIBILITY DETERMINATION SYSTEMS

11280.1 Approval of the APD.--Your submission of the APD, preparation of which is funded by HCFA at 50-percent FFP, informs the Department of your plan for system acquisition or enhancement, and your intent to claim enhanced FFP for design, development, installation, (DDI), or enhancement of an eligibility determination system. It is also used to indicate whether work is to be performed by a contractor or by State personnel. The information content of this document is specified in the definition of an APD. (See §11110 and 45 CFR 95.605.)

The APD and following documents will be submitted to the Administration for Children and Families (ACF), Department of Health and Human Services, and will be distributed to the various funding programs for approval. Approvals, disapprovals, comments, and/or suggestions relating to multi-program requests will be coordinated by ACF.

Reimbursable costs will be submitted in accordance with an approved cost allocation plan. After November 13, 1989 HCFA will approve its share of costs for design, development, and installation or enhancements of eligibility determination systems at 50-percent FFP. An APD approved before that date will be funded at 90-percent FFP until completed. If work is to be performed under contract, see 45 CFR 95.611(b).

11280.2 Approval of Operations.--FFP at the 50-percent rate of reimbursement for the title XIX share of the operational costs of eligibility determination systems is available provided the following requirements for such systems are met. (See 45 CFR 95.621(b).)

A. Retroactive Funding.--For operational cost of a system, approved for a period of operation before November 14, 1989, HCFA will approve its share of costs of an eligibility determination system at the 75-percent rate. From that date forward the rate is 50-percent.

B. Request for HCFA Approval.--Within 30 days of the system becoming fully operational, provide the Director, Center for Medicaid and State Operations (CMSO), HCFA, with:

- o Certification that all Medicaid specific functions and objectives identified in the federally approved advance planning document for the system and modification thereto are being performed and have been met.

- o A list of all Medicaid specific functions performed by the system.

- o A summary of the DDI total costs, the DDI costs allocated to HCFA, and an estimate of the share of the operational costs allocated to HCFA. The methodology used to arrive at this allocation of operational costs should also be submitted.

C. HCFA Determination Process.--After acknowledging receipt of this material, HCFA determines which review process it will employ in formally approving the title XIX portion of the eligibility determination system. The two review methodologies are:

1. A review in HCFA central office (CO) of the system's documentation in conjunction with an analysis of the outcome of the ACF certification review; or

2. A review in HCFA CO of the system's documentation followed by a HCFA post-installation, onsite review of the system.

Which of these methodologies HCFA employs depends on an analysis of these factors as they relate to the eligibility determination system:

- o The magnitude of the title XIX financial investment in the development and operation of the system.

- o Whether the State has a medically needy program and/or is a 209(b) State.

- o The judgment of the HCFA RO as to the operational effectiveness of the system.

- o The judgment of the other operating divisions (ACF and the Food and Nutrition Service) as to the capabilities of the system.

- o The findings of the ACF certification review.

D. Required System Documentation for Onsite Review.--In the event an on-site review is required by HCFA, submit the additional system documentation to HCFA CO:

- o A narrative description of the system architecture.

- o An overall system flow chart identifying the computer programs, files, process flow, and external interfaces which highlights the Medicaid specific aspects of the system.

- o A narrative description of each Medicaid specific computer program, module, routine, and file within the system.

- o A data element dictionary with each Medicaid data element identified.
- o A list of all Medicaid specific reports and outputs produced by the system.
- o The results of the acceptance testing of the Medicaid portions of the system.
- o Written evidence of MSIS acceptance/compliance with HCFA requirements.

This list is not an all-inclusive list of system documentation. You may submit other types of system documentation to demonstrate how your eligibility determination system supports the Medicaid program

E. Outcome.--Within 6 months of the operational date of the system (assuming you have submitted the required documentation within the timeframe specified in subsection B), HCFA will officially inform you whether the eligibility determination system is approved; i.e., whether you may continue to claim FFP for the title XIX share of the operational costs of the system.

11281. ELIGIBILITY VERIFICATION SYSTEMS (EVS), SWITCHING COMPANIES, ELECTRONIC CLAIMS CAPTURE (ECC), AND ELECTRONIC CLAIMS MANAGEMENT (ECM) SYSTEMS -OVERVIEW

EVSs are any State systems through which providers of medical services are furnished Medicaid eligibility status for those individuals seeking services. This function, when performed through the MMIS and subject to the criteria contained in §11281.1, may qualify for enhanced FFP. EVSs that qualify for enhanced funding are addressed in §11281.1.

An EVS may be performed through an agent of the State who disseminates eligibility information to the providers and charges these providers for this information. (Agent as used in this context does not apply to the FA or its subcontractors.) Typically, these transactions occur from the agent directly to the providers. Rules governing this type of EVS are contained in §2080.18. This section deals with an EVS that may be operated by you or your FA as a component of the MMIS using the services of a switching company. (See §11281.1.C.) Eligibility information can also be disseminated from the eligibility determination system in the State. These systems are not considered part of the MMIS and do not qualify for enhanced FFP. (See §11280.)

ECC is the system which facilitates the submission of claims from the providers through a direct link over telephone lines to the MMIS. No other medium such as claims forms, magnetic tape, floppy disks, etc., is necessary to transmit the claims to the MMIS. You may choose to furnish equipment to providers to make these transactions possible and this equipment is eligible for 75-percent FFP provided that the conditions contained in §11281.2 are met. ECC systems must be for the dual purpose of verifying eligibility **and** electronic claims capture. Equipment furnished to providers for purposes of performing only one of these two functions does not qualify for any FFP.

An ECM system not only captures claims over telephone lines, facilitated by networks, but also adjudicates the claims submitted by the provider on-line and in real time. The term ECM was created by §4401(h) of OBRA 1990. OBRA 1990 contemplated the use of ECM for adjudicating outpatient drug claims. Guidelines for ECM are contained in §11281.3.

EVSs, ECCs, and ECMs must meet the requirements for an MMIS in order to qualify for enhanced funding.

NOTE: Subtitle F of Public Law 104-191 mandates that the Secretary of the Department of Health and Human Services adopt a wide range of national standards for the electronic exchange of health information. Standards are to be adopted for: 1) electronic transactions and data elements, 2) code sets, 3) unique health identifiers for individuals, providers, health plans, and employers, 4) security of health information, and 5) electronic signatures. The recommended standards for various types of standards mandated under Public Law 104-191 will be made available for public comment via Notices of Proposed Rulemaking in the Federal Register. Once standards are published as Final Rules in the Federal Register, States and all health related providers must implement standards within 2 years from the Federal Register publication date. The final standards will supersede any/all standards currently in place for electronic transactions and data elements.

11281.1 EVS as Component Of MMIS - Funding Policy and Operational Requirements.-

A. Funding.--EVSs are subject to all prior approval and other approval requirements to be funded with FFP. Additionally, the following rules apply for the funding of EVSs.

o Your cost to design, develop, and install an EVS that accesses an approved MMIS is funded at the 90-percent rate of FFP subject to §11205.

o Your telecommunications equipment and other hardware (both telecommunications and non-telecommunications hardware) necessary to perform this function and which directly accesses your MMIS files is funded at the 75-percent rate of FFP subject to §11210.

o Your telecommunications equipment and other hardware or software that accesses a non-MMIS system or file, including a contractor system outside of the approved MMIS, is funded at the 50-percent rate of FFP.

o Operational costs of an EVS which accesses an approved MMIS and conforms to the operational requirements contained in subsection B are funded at the 75-percent rate of FFP.

o Telecommunications equipment which you furnish to a provider, such as modems, point of sales terminals, etc., is not eligible for **any** funding with FFP if this equipment is for the sole purpose of EVS. This equipment is eligible for FFP at the enhanced rate of 75 percent if it **also** serves to facilitate ECC or ECM.

o Your toll-free telephone line is funded at the 50-percent rate of FFP for purposes of answering eligibility inquiries outside of the MMIS. A toll-free line which accesses the MMIS for purposes of eligibility verification is funded at the 75-percent rate of FFP.

o Staff costs, either yours or your FA's, to respond to provider queries are funded at the 75-percent rate of FFP if the staff is accessing the MMIS.

o Staff costs for personnel who access non-MMIS systems or files for purposes of verifying eligibility, e.g., county workers interacting with an eligibility determination system, are funded at the 50-percent rate.

B. Operational Requirements.--In order to qualify for any FFP, the EVS must communicate all of the following information to providers:

o Eligibility status for the date queried;

o Third party payers who must be billed prior to Medicaid;

o Recipient participation in a managed care program; and

o Program and service restrictions (e.g., lock-in, lockout).

C. Transmitting Operational Requirements Using Switching Companies.--The information concerning the operational requirements listed in subsection B may be transmitted via on-line real time transactions using switching companies (switches). A switch is an entity which uses telecommunications to act as a conduit or pass-through of data to facilitate a provider's access to that data. The function of a switch is limited to acting as a conduit of real time on-line transaction data, i.e., it receives and transmits to or from SAs, Medicaid FAs, and providers without altering or retaining the data in route. A switch may serve as a billing agent for providers only if it meets the requirements for both the switch and billing agent functions defined in §2080.18E and ensures that both of those functions are maintained as separate and distinct operations.

D. Safeguards.--You must insure that appropriate safeguards are in place to protect the confidentiality of eligibility information. The use or disclosure of this information is restricted to purposes directly connected with the administration of the Medicaid program. It is recommended, but not required, that the EVS maintain records of all inquiries made, the information conveyed, and to whom the information is conveyed. HCFA recommends retaining these records for at least 1 year.

At no time is it permissible for data to be released for a mass number of recipients unless specific identification of each recipient is made. For example, it is not appropriate to release information to a provider asking for a listing of all recipients in a geographic area. It is appropriate to release information to a provider (e.g., a hospital) inquiring about the eligibility status of all inpatients when they can identify a patient by his/her Medicaid identification number, or by two or more of the following: patient's full name, including middle initial; patient's date of birth; or patient's social security number.

11281.2 ECC - Funding Policy and Operational Guidelines.--

A. Funding.--ECC systems are subject to all prior approval and other approval requirements to be funded with FFP.

Additionally, the following rules apply for the funding of ECC:

o Your cost to design, develop, and install an ECC that interacts with an approved MMIS is funded at the 90-percent rate of FFP subject to §11205.

o Your telecommunications equipment and other equipment which directly accesses your MMIS files is funded at the 75-percent rate of FFP subject to §11210.

o Your operational costs, including telecommunications network costs, of an ECC system which conforms to the operational requirements contained in subsection B are funded at the 75-percent rate.

o Telecommunications equipment which you furnish to a provider, such as modems, point of sales terminals, etc., is not eligible for **any** funding with FFP if this equipment is for the sole purpose of ECC. This equipment is eligible for FFP at the enhanced rate of 75 percent if it **also** serves to facilitate EVS. (See §11281.1.)

o You **must** retain ownership of any equipment furnished to providers over its useful life cycle (as specified in your approved APD) if purchased with your own and/or Federal funds.

o Other entities, either State or private, may wish to make use of the equipment furnished to providers. This is permissible provided that:

- No additional costs are borne by the Medicaid agency to modify the equipment;

- HCFA is credited with its share of any usage or rental fee charged by the State agency according to the provisions contained in 45 CFR 74.42 (c)(1); and

- Any APD involving a joint venture for purposes of purchasing equipment contain an allocation of costs for non-Medicaid uses.

B. Operational Requirements.--In order to qualify for enhanced FFP, the ECC must perform all of the following functions:

- o All EVS functions detailed in §11281.1.B and D;
- o Transmit claims to the MMIS;
- o Accept claims only from providers eligible for the Medicaid program;
- o Certain logic/consistency editing that screens the claim prior to transmission to the MMIS. At a minimum, the following editing must be included:
  - Dates of service entered are logical (e.g., February 30 is not accepted);
  - Service rendered is consistent with the place of service/type of service; and
  - Number of services performed is consistent with the span of time (e.g., 20 physician hospital visits in a 2-day span of time is a potential inconsistency).
- o Notify the provider shortly after transmission if the claim(s) submitted is acceptable for further processing and if services are covered under the State Plan; and
- o Interact with personal computers owned by the providers, i.e., perform all the operational functions in this section in conjunction with personal computers already owned by providers. If any equipment or software is furnished to these providers, it must be compatible with the personal computer.

11281.3 ECM - Funding Policy and Operational Guidelines.--

A. Funding.--An ECM system is limited to processing covered outpatient drugs and performs all the functions of both the EVS and ECC system. However, the ECM system not only captures the claim but also adjudicates the claims on-line in a real time environment. The funding policy for the ECM system is the same as that of the ECC system.

B. Operational Requirements.--In order to qualify for enhanced FFP, the ECM system must perform all of the following functions:

- o All EVS functions detailed in §11281.1.B;
- o All ECC functions detailed in §11281.2.B;
- o Claims adjudication, which includes screening against all edits and audits contained in your MMIS applicable to the claim type billed, and taking all steps up to but not including payment of claims; and
- o Claims data processed through the ECM system must be integrated into a single comprehensive utilization and management reporting system. (See §11225.)

11282. ELECTRONIC FUND TRANSFER (EFT) AND ELECTRONIC REMITTANCE ADVICES (ERA)

Technology which permits ECC also makes possible other kinds of electronic transferrals. You may choose to transfer funds directly to the accounts of your providers rather than issue a check to the provider. You may also utilize the ECC to convey an ERA to the provider, instead of mailing a hard copy remittance advice (RA) to the provider. You may also have RAs print at the provider location through printers attached to the devices used for ECC. All EFT and ERA activities are eligible for enhanced rates of FFP, subject to all prior approval requirements. You may also wish to have RAs listed on an electronic bulletin board which can only be accessed by that provider. Safeguards must be in place to insure that only the provider who rendered the services, or his/her designated agent, can access this information. This may be accomplished by password protecting files, hierarchical security structure, etc.

NOTE: Subtitle F of Public Law 104-191 mandates that the Secretary of the Department of Health and Human Services adopt a wide range of national standards for the electronic exchange of health information. Standards are to be adopted for: 1) electronic transactions and data elements, 2) code sets, 3) unique health identifiers for individuals, providers, health plans, and employers, 4) security of health information, and 5) electronic signatures. The recommended standards for various types of standards mandated under Public Law 104-191 will be made available for public comment via Notices of Proposed Rulemaking in the Federal Register. Once standards are published as Final Rules in the Federal Register, States and all health related providers must implement standards within 2 years from the Federal Register publication date. The final standards will supersede any/all standards currently in place for electronic transactions and data elements.

11282.1 Signature Requirements For ECC/EFT.--42 CFR 455.18 and 455.19 require that either the claim submitted or the check or warrant payable to the provider contain language acknowledging that the provider is aware that payment is from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws. States that employ both ECC and EFT, in order to comply with these regulations, are to obtain a signed statement from the provider which certifies that the provider is aware that payment is from Federal and State funds and that anyone who misrepresents or falsifies essential Medicaid claims information may be prosecuted under Federal and State laws. This statement must be resubmitted upon a change in provider representative and updated as needed.

If a State employs either ECC or EFT but not both, you must continue to comply with the requirements of 42 CFR 455.18 and 455.19. However, as an option, these States may elect to make use of the statement signed by the provider described in the preceding paragraph.

It is recommended that States confer with their State Attorney General's office to ascertain if any other safeguards peculiar to your State are needed to insure that cases of fraud and abuse may be prosecuted to the fullest extent possible.

SYSTEM REQUIREMENTS

Chapter 3

11300 GENERAL REQUIREMENTS

The system requirements in §§11300 through 11375 form a basis for the improvement of title XIX programs through the mechanization of claims processing and information retrieval systems. They will be used with other requirements by HCFA as a basis for determining whether the system qualifies for 90-percent or 75-percent Federal funding. Federal MMIS requirements are to be considered minimal, not exclusive requirements.

The intent of §1903(a)(3) is the improvement of title XIX programs through Federal assistance in the mechanization of approved Medicaid claims processing and information retrieval systems. To accomplish this and still allow for necessary variations among the States, HCFA has developed functional system requirements of §1903(a)(3) and (r). These system requirements can be used as a model for new systems and a measure of existing systems. Accordingly, HCFA will use system requirements contained in this chapter as its standard for evaluation and approval of systems for which funding is requested under §1903(a)(3). Recognizing that variations in the expression and/or implementation of identical concepts are not necessarily detrimental, HCFA is guided by a policy of "demonstrable conceptual equivalence" when evaluating systems. This concept is defined in §11110.

HCFA is further guided by the principle of avoiding duplicate systems design and development costs whenever possible by requiring the transfer of existing approved systems in situations where the feasibility of a successful transfer is assured.

To receive HCFA approval for funding under 42 CFR 433, an existing or proposed system must:

- o Be mechanized;
- o Include or encompass all subsystems/functionalities;
- o Conform in concept with each subsystem describe herein;
- o Provide security from anticipated threats or hazards to its data.

NOTE: Due to the Privacy Act and the requirements of §1902(a)(7), any system changes that propose to transmit data via the Internet, must contain adequate security measures, as determined by preapproval from HCFA;

- o Maintain a record of every query directed against an individual's record, including the identity of the person or organization originating that query;
- o Be able to eliminate from the system data which are no longer timely;
- o Contain and utilize the data elements described in §11375;
- o Provide and apply the following minimum edits to all input data regardless of how such data enters the system;
  - Proper field content,
  - Accuracy of data, and
  - Reasonableness of data

o Produce and disseminate in a timely and accurate manner all systems reports using identification coding systems for providers, other payees, and beneficiaries that are used under title XVIII.

o Accept and use the HCFA Common Procedures Coding System (HCPCS);

o Accept and use a common hospital billing form (i.e., the Uniform Bill (UB-82), (Standard Form HCFA-1450));

o Accept the same provider electronic billing data set required by the Medicare program; and

o Accept and use the common claim form, Health Insurance Claim Form, HCFA-1500, for noninstitutional providers (physicians, durable medical equipment suppliers, laboratories, chiropractors, and podiatrists).

o Effective January 1, 1999, provide for electronic transmission of claims data in the format specified by the Secretary and consistent with the MSIS (Medicaid Statistical Information System), including enrollee encounter data and other necessary data. (Refer to §2700.)

NOTE: Subtitle F of Public Law 104-191 mandates that the Secretary of the Department of Health and Human Services adopt a wide range of national standards for the electronic exchange of health information. Standards are to be adopted for: 1) electronic transactions and data elements, 2) code sets, 3) unique health identifiers for individuals, providers, health plans, and employers, 4) security of health information, and 5) electronic signatures. The recommended standards for various types of standards mandated under Public Law 104-191 will be made available for public comment via Notices of Proposed Rulemaking in the Federal Register. Once standards are published as Final Rules in the Federal Register, States and all health related providers must implement standards within 2 years from the Federal Register publication date. The final standards will supersede any/all standards currently in place for electronic transactions and data elements.

11301 FUTURE ADDITIONAL SYSTEM REQUIREMENTS

When HCFA determines that additions or changes will improve the Medicaid claims processing and information retrieval system, it will publish these changes by notice in the Federal Register making the proposed change available for public comment. After allowing an appropriate period, HCFA will respond to the comments received in a subsequent notice. When the final notice is published, HCFA will issue the new or modified standards or conditions in the SMM. Based upon the requirement's complexity, HCFA will allow the States an appropriate time period to meet the new requirement.

For Example: Subtitle F of Public Law 104-191 mandates that the Secretary of the Department of Health and Human Services adopt a wide range of national standards for the electronic exchange of health information. Standards are to be adopted for: 1) electronic transactions and data elements, 2) code sets, 3) unique health identifiers for individuals, providers, health plans, and employers, 4) security of health

information, and 5) electronic signatures. The recommended standards for various types of standards mandated under Public Law 104-191 will be made available for public comment via Notices of Proposed Rulemaking in the Federal Register. Once standards are published as Final Rules in the Federal Register, States and all health related providers must implement standards within 2 years from the Federal Register publication date. The final standards will supersede any/all standards currently in place for electronic transactions and data elements.

11310 MMIS FUNCTIONAL REQUIREMENTS

The federally required MMIS presently consists of the following six core subsystems (Eligibility determination systems are not part of MMIS or enhancements to MMIS):

- Recipient
- Provider
- Claims Processing
- Reference File
- Surveillance and Utilization Review
- Management and Administrative Reporting

11315 RECIPIENT SUBSYSTEM

A. Basic Functions and Objectives.--Your recipient subsystem must:

- Maintain identification of all applicants eligible for Medicaid benefits.

- Allow for timely updating of the subsystem's data base to include new recipients and all changes to existing recipient records.

- Maintain positive (active as opposed to passive) control over all data pertaining to Medicaid recipient eligibility.

- Build and maintain a computer file of recipient data to be used for claims processing, administrative reporting, and surveillance and utilization review.

- Distribute eligibility data to other processing agencies, if such a requirement exists.

- Maintain control over the Medicare Part B Buy-In processing for eligible recipients.

- Receive appropriate Medicaid recipient eligibility data from all sources of eligibility determination.

- Provide file space for, and record whenever available, the Social Security Number of each eligible recipient.

- Contain and use the data necessary to support third party liability recovery activities. (See §3900.)

B. Ancillary Functions and Objectives.--

o A shared on-line recipient subsystem must provide Medicaid data and reports as required by the Medicaid Agency.

o If the EPSDT system is integrated into the MMIS, then case identification, tracking, and referral functions will be performed as part of the recipient subsystem.

11320 PROVIDER SUBSYSTEM

Your provider subsystem must accomplish the following functions and objectives:

o Facilitate the participation of qualified providers in the Medicaid program.

o Enroll providers in the Medicaid program after they agree to abide by the rules and regulations of the State Medicaid program.

o Ensure that providers are qualified to render specific services under the Medicaid program by screening applicants for State license and certification, by Specialty Board certification if appropriate, and by visit to the provider by a review team if necessary.

o Process provider applications and changes in a timely manner and maintain control over all data pertaining to provider enrollment.

o Build and maintain a computerized file of provider data for claims processing, administrative reporting, and surveillance and utilization review.

o Review enrolled providers on a continuing basis to ensure that they continue to meet provider eligibility requirements.

11325 CLAIMS PROCESSING SUBSYSTEM

A. Basic Functions and Objectives.--Your claims processing system must:

o Ensure that all input into the subsystem is captured at the earliest possible time and in an accurate manner.

o Establish control over all transactions during their entire processing cycle, including claims in pending status.

o Verify that all providers submitting input are properly enrolled.

o Ensure that all recipients for whom input is submitted were eligible for the type of service at the time the service was rendered.

o Ensure that all input submitted to the subsystem is processed completely.

o Verify that charges submitted by providers are reasonable and within acceptable limits.

o Ensure that reimbursements to providers are rendered promptly and correctly.

o Maintain accurate and complete registers and audit trails of all processing.

o Maintain all processed data necessary to satisfy legal requirements and the needs of other subsystems.

o Respond to queries concerning recipient eligibility and benefit status.

o Process approved prior authorization requests.

o Process provider credits and adjustments.

o Identify uniquely and be able to locate any provider claim.

o Automatically suspend all transactions in error until corrections are made.

o Check each claim prior to payment against all current and previously paid claims for which a duplicate payment could exist.

o Provide a prompt response to all inquiries regarding the status of any claim.

o Issue remittance statements to providers detailing claims and services covered by a given payment at the same time as the payment.

o Provide EOB individual notices, within 45 days of the payment of claims, to all or a sample group of the persons who received services under the plan as described in §11210. To assist MMIS States in implementing the option to send EOBs on a sample basis, the following sampling methods are recommended:

-- Sampling instructions are the Medicaid fraud guidelines on Verification of Services to Recipients. They provide for a sample of claims from high-volume providers and a sample of claims from low-volume providers. Sample sizes may be increased or decreased each month at your discretion. Note that each sample only represents each set of providers, not all claims paid.

-- One random sample from all claims you pay each month is large enough to obtain some overall representation of the population, at a minimum, a monthly sample ranging from 500 claims up to 100 percent of the State population. The distribution of claims in such a sample will tend to mirror that of the population, including many drug and doctor claims and relatively few hospital and nursing home claims.

-- A random sample of providers, then a sample of claims from each of the sampled providers. The sample of providers can be structured several ways, e.g., a specified number of each type of provider, or a random sample from all providers. A minimum sample of 100 providers each month, with at least five claims sampled from each provider, is suggested.

-- A random sample of recipients (or cases) with all claims paid in a month for each. This method would provide the most comprehensive list of services for each sampled recipient (or case). A sample of at least 400 recipients each month is suggested. Structure the recipient sample according to your needs -- either a random sample of recipients, or a specified number of each type of recipient (AFDC, SSI, medically needy, etc.)

-- Other sampling methods if approved by the HCFA RA.

B. Ancillary Functions and Objectives.--Your claims processing subsystem must also:

o Assure adjudication for payment within 30 days after:

-- Receipt of any properly submitted correct claim which passes all required edits and checks; or

-- Correction of any error condition(s) preventing payment which are attributable to the provider; or

-- Correction of any error condition(s) preventing payment which are attributable to the agency or its system or its data; or

-- Correction of any condition(s) preventing payment which are beyond the agency's control.

o Identify claims paid for all services covered by the State plan, including:

-- Early and Periodic Screening, Diagnosis, and Treatment

-- Family Planning Services

o Record Medicare deductibles and coinsurance paid by Medicaid on crossover claims.

o Ensure that the payment for services is consistent with 42 CFR Part 447 -Payments for Services.

o Have the capability to identify, by recipient, the screening and related diagnosis and treatment services.

o Have the ability to identify TPL and assure that the title XIX program is the payor of last resort in accordance with the State plan. (See §3900.)

o Have the ability to identify enrollee encounter data. Encounter data and other data for electronic transmissions must be reported in a format consistent with the MSIS (Medicaid Statistical Information System), effective January 1, 1999. (See §2700.) Encounter data will also be subject to encounter data transaction standards when such standards are established under HIPAA.

11330 REFERENCE FILE SUBSYSTEM

Your reference file subsystem must:

o Provide an updating facility for the MMIS Procedure, Diagnosis, and Formulary File.

o Provide a means of obtaining various listings of the Procedure, Diagnosis, and Formulary File.

o Provide a reasonable and customary charge file for Medicaid charges, Medicare charges, or both.

- Enable the reasonable and customary charge file to be updated.

- Provide a means of transferring history records used for duplicate claims detection from an active file to a file used only periodically.

- Generate various listings of the claims processing suspense file.

- Maintain the data necessary to support the claims processing subsystem in ensuring that claims are paid in accordance with 42 CFR 447 - Payment for Services.

11335 SURVEILLANCE AND UTILIZATION REVIEW (SUR) SUBSYSTEM

A. Basic Functions and Objectives.--Your SUR subsystem must:

- Develop a comprehensive statistical profile of health care delivery and utilization patterns established by provider and recipient participants in various categories of services authorized under the Medicaid program.

- Investigate and reveal misutilization of the State's Medicaid program by individual participants and promote correction.

- Provide information which reveals and facilitates investigation of potential defects in the level of care and quality of service provided under the Medicaid program.

- Accomplish the above objectives utilizing a minimum level of manual clerical effort and a maximum level of flexibility with respect to management objectives of the State's Medicaid program.

- By means of computerized exception processing techniques, provide the ability to perform analyses and produce reports responsive to the changing needs of title XIX managers, PROs, and State Medicaid fraud control units.

- Be capable of developing provider, physician, and patient profiles sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

B. Ancillary Functions and Objectives.--Your SUR subsystem must also have:

- The capability to perform exception processing.

- At least 9 months of adjudicated claims data in the SUR History file, of which a full 6 months or more must be used for exception processing.

- The capability to separate federally-assisted program participants from any others in the claims data.

- A technical and user training program.

- The capability to generate SUR reports and special reports as needed; including, a required annual run of all reports for all participants.

- o The flexibility to produce claim detail and special reports by provider and recipient.
- o The capability to perform focused review.
- o The capability to profile group practices and to profile each individual within the group practice.
- o The capability to suppress (i.e., not generate or print) processing on individuals within a category of service or class group on a run-to-run basis.
- o Capability to access all data elements required by this chapter.

11340. MANAGEMENT AND ADMINISTRATIVE REPORTING (MAR) SUBSYSTEM

A. Basic Functions and Objectives.--Your MAR subsystem must:

- o Report information to assist management in fiscal planning and control.
- o Provide information required in the review and development of medical assistance policy and regulations.
- o Monitor the progress of claims processing activity and provide summary reports which reflect the current status of payments.
- o Review provider performance to determine the adequacy and extent of participation and service delivery.
- o Report recipient participation in order to analyze usage and develop more effective programs.
- o Be kept responsive to State users requests for information according to State defined time frames and priorities.
- o Produce program data necessary to satisfy Federal Medicaid reporting requirements, e.g., those contained in §2700.

B. Ancillary Functions and Objectives.--Your MAR subsystem must also:

- o Prepare budget allocations for various categories of service for the fiscal year.
- o Project the cost of program services for future periods from past experience.
- o Compare current cost with previous period cost to analyze current cashflow.
- o Compare expenditures with budget to control financial position.

- o Analyze areas of program expenditure to determine relative cost benefit.
- o Review services used by recipient categories for participation and relative cost.
- o Analyze progress in accreting eligible Medicare Buy-In recipient data and the break-even point between Medicare and Medicaid payments.
- o Review provider participation and analyze provider service capacity in terms of recipient access to health care.
- o Present claims processing and payment information for an analysis of timely reimbursement.
- o Analyze the frequency, extent, and type of provider and other claims processing errors.
- o Monitor third party avoidances and collections in accordance with State plan requirements.
- o Provide information needed for institutional and capitation rate setting.
- o Analyze provider claim filing for timeliness, fiscal controls, and ranking.
- o Analyze drug use by individual and by eligibility category for cost and potential abuse.
- o Present geographic analysis of expenditures and recipient participation.
- o Provide information to support State and Federal program initiatives and reporting requirements.

11350 MARS AND SURS REPORTS

You may accomplish the functions and objectives of both MARS and SURS through the timely and accurate production of reports focused on the specific functions of both subsystems. Whether these reports are produced in a regular, recurring pattern or are ad hoc reports is left to your discretion. In the final analysis, it is your responsibility to demonstrate that these two subsystems meet their objectives and perform their functions in an unambiguous fashion.

11375 DATA REQUIREMENTS

The minimum data element file requirements for systems approval derive from State plan requirements and Federal reporting requirements. Data elements related to services not covered in the State plan need not be included.

Claim format and content varies depending upon the type of provider that submits a claim and individual State plan requirements.

NOTE: Subtitle F of Public Law 104-191 mandates that the Secretary of the Department of Health and Human Services adopt a wide range of national standards for the electronic exchange of health information. Standards are to be adopted for: 1) electronic transactions and data elements, 2) code sets, 3) unique health identifiers for individuals, providers, health plans, and employers, 4) security of health information, and 5) electronic signatures. The recommended standards for various types of standards mandated under Public Law 104-191 will be made available for public comment via Notices of Proposed Rulemaking in the Federal Register. Once standards are published as Final Rules in the Federal Register, States and all health related providers must implement standards within 2 years from the Federal Register publication date. The final standards will supersede any/all standards currently in place for electronic transactions and data elements.

The Uniform Hospital Discharge Data Set (UHDDS), developed through the National Committee on Vital and Health Statistics (NCVHS) and required by HHS departmental policy, effective January 1, 1975, and which meets current PRO requirements of §11205, contains, for hospital service only, discharge data as a file requirement and is identified in this section as:

* UHDDS as well as MMIS requirement
** UHDDS requirement only

The following data elements contained in the systems files are minimal and not exclusive requirements for source and use within the MMIS.

1. Recipient Identification Number:
   A number that uniquely identifies an individual eligible for Medicaid benefits.

*2. Recipient Social Security Number (SSN):
   The number used by SSA throughout a wage earner's lifetime to identify earnings under the Social Security program.

   For newborns and children not having a SSN but covered under Medicaid use No. 1 above to identify these eligibles.

3. Recipient Social Security Claim Number:
   The number assigned to an individual by the SSA under which monthly cash benefits (and Medicare benefits) are paid or eligibility is established.

4. Recipient's Name:
   The name of the recipient.

*5. Recipient's Address:
The address of the recipient.

*6. Recipient's Date of Birth:
The date of birth of the recipient.

7. Recipient's Race Code:
   a. The racial origin of the recipient
** b. Race/Ethnic
   White, Black, Hispanic, Asian/Pacific Islander, American/Indian/Alaska Native, and other

*8. Recipient's Sex Code:
The sex of the recipient.

9. Recipient's Aid Category:
The statutory category of public assistance, SSI or State supplementary payment under which a recipient is eligible for Medicaid benefits.

10. Gross Family Income:
The monthly gross income for the family of which this recipient is a member.

11. Family Size:
The number of persons in the family of which this recipient is a member.

12. Eligibility Beginning Date:
A date that begins a period in which a recipient was certified as eligible to receive Medicaid benefits.

13. Eligibility Ending Date:
A date concluding a period in which a recipient is eligible to receive Medicaid benefits.

14. Third Party Liability Code:
   a. A code indicating availability to a recipient of potential third party resources.
** b. Expected Principal Source of Payment
   (1) Self-pay
   (2) Workmen's Compensation
   (3) Medicare
   (4) Medicaid
   (5) Maternal and Child Health
   (6) Other Government Payments
   (7) Blue Cross
   (8) Insurance Companies
   (9) No charge (free, charity, special research, or teaching)
   (10) Other

15. Buy-In Status Code:
The code indicating a recipient's status with respect to the Medicare Buy- In Program.

16. Recipient Exception Indicator:
A code indicating that all claims for a given recipient are to be manually reviewed prior to payment.

17. Money Payment Code:
A code indicating whether or not the recipient is currently receiving cash assistance.

18. Medicare Type Code:
A code indicating whether the recipient is covered by Medicare, and, if so, whether he/she has Hospital Insurance Benefits (Part A) and/or Supplementary Medical Insurance Benefits (Part B).

19. Buy-In Eligibility Date:
The date from which the recipient is eligible for the Medicare Buy-In Program.

20. Buy-In Premium Date:
The date associated with a Buy-In premium amount.

21. Buy-In Premium Amount:
The amount of money the State pays to HCFA each month per recipient for Buy-In coverage.

22. SSA-Information Exchange Code:
A code scheme consisting of various numerical codes which describe situations that can occur at SSA or at the State level.

23. Recipient's Eligibility Certification Date:
Date recipient was certified as eligible for public assistance, supplemental security income or State supplemental benefits.

24. Recipient's Location Code:
The geographic or geopolitical subdivision of a State in which the recipient resides.

25. Medicaid Premium Amount:
A recurring premium paid by medically needy individuals before they can receive Medicaid services. The amount of the fee is based upon the number of persons in the family and the gross family income.

26. Medicaid Enrollment Fee Amount:
A one-time enrollment fee paid by medically needy individuals before they can receive Medicaid services. The amount of the fee is based on the number of persons in the family and the gross family income.

27. Medicaid Deductible Amount:
The annual (or other period) amount which the recipient must pay toward the cost of medical services before Medicaid will begin to pay.

28. Date of Death:
The date of a recipient's death as indicated in the Social Services or SSI file after an official notice of death has been received.

29. Provider Number (State):
A unique number assigned by the State to each participating provider of services.

30. Provider Name:
The name of the provider of Medicaid services as used on official State records.

31. Provider Address:
The mailing address of the provider.

32. Provider Pay to Address:
The address to which Medicaid payments to a provider are sent.

33. Provider Type:
A code indicating the classification of the provider rendering health and medical services as approved under the State Medicaid plan.

34. Provider Beginning Date of Service:
A date beginning a period in which the provider was authorized to receive Medicaid payments.

35. Provider Ending Date of Service:
A date concluding a period in which the provider is authorized Medicaid payments for services rendered.

36. Provider Group Number:
The number assigned to the group practice of which an individual provider is a member.

37. Provider Type of Practice Organization:
A code identifying the organizational structure of a provider's practice.

38. Provider Employer Identification Number:
The number assigned to an employer by the Internal Revenue Service for tax reporting purposes.

39. Provider Social Security Number:
The number assigned to an individual by SSA.

*40. Medicare Provider Number:
The identification number assigned to a Medicare provider by HCFA (provider means any individual or entity furnishing Medicaid services under a provider agreement with the Medicaid agency (Reference 42 CFR 430.l).

41. Provider Year End Date:
The calendar date on which the provider's fiscal year ends.

42. Provider Specialty Code:
    A code used to indicate the medical specialty of a physician.

43. Provider Exception Indicator:
    A code indicating that all claims from a given provider are to be manually reviewed prior to payment.

44. Provider Credit Balance Amount:
    The amount of money the Medicaid program owes a provider.

45. Provider Credit Balance Date:
    The processing date on which the last amount was entered in the Provider Credit Balance amount.

46. Out-of-State Provider Code:
    A code indicating that the provider is located out of State.

47. Per Diem Rate:
    The payment amount for each day of care in an institution reimbursed on a per diem basis.

48. Percent-of-Charges Factor:
    The percent of a provider's charges that constitutes payment for certain categories of service.

49. Rate Effective Date:
    The effective date of the accompanying per diem rate or percent-of-charges factor.

50. Provider Location Code:
    The geographic or geopolitical subdivision in which the provider's place of business is located.

51. Provider Enrollment Status Code:
    A code indicating a provider's certification status with respect to the Medicaid program.

52. Provider Enrollment Status Date:
    The effective date of the accompanying provider enrollment status code.

53. Provider Group Name and Address:
    The name and mailing address of the provider group.

54. Transaction Control Number:
    A unique number identifying each claim transaction received.

55. Category of Service:
    A code defining the category of service rendered (e.g., general inpatient, pharmacy, physician, home health).

56. Laboratory, Medicare Certified Indicator:
    A code indicating that a laboratory is approved as meeting the requirements for participation in Medicare.

57. Laboratory Service Authorized Code:
A code indicating the services/procedures that a laboratory which meets the requirements for participation in Medicare is authorized to perform.

*58. Physician Identification:
a. Attending Physician Number
The provider number of the physician attending an inpatient in a hospital, nursing home, or other institution.

This is the physician primarily responsible for the care of the patient from the beginning of this institutional episode.

**b. Operating Physician
This is the physician who performed the principal procedure. See Data Element No. 87 below, for definition of principal procedure.

59. Referring Physician Number:
The provider number of the physician referring a recipient to another practitioner or provider.

60. Prescribing Physician Number:
The provider number of the physician issuing a prescription.

*61. Principal Diagnosis Code:
a. The diagnosis code for the principal condition requiring medical attention.

**b. The condition established after study to be chiefly responsible for causing the patient's admission to the hospital for care for the current hospital stay. (HCFA requires the acceptance of ICD-9-CM coding.)

62. Other Diagnosis Code:
a. The diagnosis code of any condition other than the principal condition which requires supplementary medical treatment.

**b. Conditions (up to four) other than the principal condition that coexisted at the time of admission, or developed subsequently, which affected the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on this hospital stay. (HCFA requires the acceptance of ICD-9-CM coding.)

*63. Admission Date:
The date a recipient was admitted to a medical institution.

64. Beginning Date of Service:
The date upon which the first service covered by a claim was rendered. If a claim is for one service only (e.g., a prescription), this is the only service date.

65. Ending Date of Service:
The date upon which the last service covered by a claim was rendered.

*66. Discharge Date:
The formal release of an inpatient from a hospital.

67. Place of Service:
A code indicating where a service was rendered by a provider.

*68. Patient Number:
Any number assigned by a provider to a recipient or claim for reference purposes, such as a medical record number.

69. Patient Status:
A code indicating the patient's status on the last date of service covered by an institutional claim.

70. Total Claim Charge:
The sum of all charges associated with an individual claim.

71. Units of Service:
A quantitative measure of the services rendered to, or for, a recipient (e.g., days, visits, miles, injections).

72. Third Party Payment Amount:
The amount of payment applied toward a claim by third party sources.

73. Medicare Cash Deductible Amount:
The unmet Medicare deductible subject to payment by Medicaid.

74. Medicare Blood Deductible Amount:
The unmet Medicare deductible for blood subject to payment by Medicaid.

75. Medicare Coinsurance Charge:
The Medicare coinsurance amount subject to payment by Medicaid.

76. Medicare Reasonable Charge:
Payment amount recognized as the reasonable charge for Medicare.

77. Medicaid Co-Payment Amount:
The portion of the claim charge which the recipient must pay, called coinsurance when expressed as a percentage of the payment amount.

78. Prior Authorization Control Number:
A number that uniquely identifies a particular instance of prior authorization.

79. Payment Amount:
The computed amount of payment due a provider for a claim transaction.

80. Date of Adjudication:
The date a claim is approved (or partially approved) or disallowed.

81. Error Code:
A code indicating the nature of an error condition associated with that claim transaction.

82. Date Entered Suspense:
The date a claim transaction was initially suspended.

83. Payment Date:
The date a payment instrument was generated for a claim transaction.

84. Allowable Procedure Payment:
The maximum allowed amount payable for a particular medical procedure, treatment, or service item.

85. Professional Fee:
The amount allowed to a dispenser of drugs as compensation for his professional services.

86. Prescription Number:
The number assigned by a pharmacist to a prescription at the time it is filled.

87. Procedure Codes:
Codes identifying medical procedures (i.e. accept and use exclusively the HCPCS in a physician or outpatient setting). (For an inpatient setting, ICD-9-CM Volume 3 is recommended).

**a. Principal Significant Procedures:
When more than one procedure is reported, designate the principal procedure. In determining which of several procedures is the principal, apply the following criteria:

(1) The principal procedure is the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes, or was necessary to take care of a complication.

(2) The principal procedure is that procedure most closely related to the principal diagnosis.

**b. Other Significant Procedures:

(1) One which carries an operative or anesthetic risk, requires highly trained personnel, or requires special facilities or equipment.

(2) Up to four significant procedures can be reported.

(HCFA requires the acceptance of ICD-9-CM coding.)

88. Drug Code:
Codes identifying particular drugs; e.g., National Drug Code, drug tables.

89. Diagnosis Code:
A table of codes identifying medical conditions; i.e., ICD-9-CM.

90. Drug Name:
The generally accepted nomenclature for a particular drug.

91. Drug Classification:
The therapeutic group in to which a drug is categorized.

92. Minimum Days Supply of Drugs:
The minimum units of a drug prescription eligible for payment.

93. Maximum Days Supply of Drug:
The maximum units of a drug prescription eligible for a particular drug.

94. Procedures Names:
The generally accepted nomenclature for medical, surgical, dental, etc., procedure.

95. Diagnosis Name:
The generally accepted nomenclature for a diagnosis. Name is required only if not encoded by provider. (See Data Element No. 6l.)

96. Unit of Measure:
The unit in which a drug is dispensed (e.g., cc, capsule, tablet).

97. Drug Cancellation Date:
The date after which a particular drug is no longer covered under the State Medicaid program.

98. Medicaid Reasonable Charge:
Payment amount recognized as the reasonable charge for Medicaid.

*99. Discharged Patient's Destination:
A code indicating a recipient's destination upon discharge from a medical institution.

a. Discharged to home (routine discharge).
b. Left against medical advice.
c. Discharged to another short term hospital.
d. Discharged to a long term care institution.
e. Died.
f. Other.

100. Billing Date:
The date a provider indicates a claim was prepared.

101. Procedure Charge:
The charge for an individual procedure, treatment, or service item as submitted by the provider.

102. Drug Charge:
The charge submitted by a provider for a given drug prescription.

103. Adjustment Amount:
The amount (plus or minus) by which a provider's account is to be changed.

104. Date Claim Received:
The date on which a claim transaction is received by the claims processing agency.

105. Date of Surgery:
The date on which a surgical procedure(s) was performed on an inpatient.

106. Drug Wholesale Cost:
The generally accepted wholesale cost of a drug.

107. Maximum Allowed Price:
The maximum amount that will be paid for a procedure, treatment, or service item.

108. Valid Sex Indicator:
A code which indicates when a procedure or diagnosis is limited to one sex only.

109. Age Range Indicator:
A code which specifies an age range when a procedure or diagnosis is limited to a particular age group.

110. Budgeted Amount:
The planned expenditures for various Medicaid services over a given period of time.

111. Screening Results Code:
A code indicating the outcome of the various screening tests rendered.

112. Screening Referral Code:
A code indicating the nature of any referrals made as a result of screening.

113. Screening Related Treatment:
A code identifying procedures or services received as a result of screening.

114. Family Planning Code:
A code indicating whether any diagnosis, treatment, drugs, supplies, and devices, counseling service, or other billed services or materials are for the purposes of family planning.

115. Certification Review Indicator:
Indicator showing that review was made of certification of a recipient who has been admitted to institutional care including approval status.

116. Certification/Recertification Date:
The date of certification/recertification of a recipient who has been admitted to institutional care.

117. Certification Status:
An indication of initial certification status of a patient in an institution.

118. Number of Requests for Extension:
The number of times an extension of certification of stay was requested for a patient in an institution.

119. Days Certified Initially:
The number of days stay certified initially for a patient in an institution.

120. Total Days Certified:
The total number of days stay certified for a patient in an institution.

121. Date of Application:
The date that a recipient applied for eligibility status in the Medicaid program.

122. SSN of an Absent Parent:
See 42 CFR 433.138 for the conditions under which this piece of information must be captured.

MMIS SYSTEM PERFORMANCE REVIEW (SPR)

CHAPTER 4

Chapter 4, previously entitled "MMIS System Performance Review (SPR)", is deleted in its entirety pursuant to Public Law 105-33. More specifically, §4753 of Public Law 105-33 eliminates all references to development and application of performance standards used to conduct periodic standards-based reviews of previously certified MMISs. The SPR (standard performance review) serves as an evaluation instrument in determining the extent to which an MMIS performance is sustained after the initial certification. The effective date for elimination of the SPR stated under §4753 of Public Law 105-33 is January 1, 1998.

CPAS REVIEW PROCESS

CHAPTER 6

11600. BACKGROUND

Claims processing (CP) procedures begin when a provider's claim is received by the State Medicaid agency or its fiscal agent. Decisions are made as to whether or not payment will be authorized and, if so, the dollar amount of the payment. In order to make these decisions, the claim is processed in accordance with established State CP procedures and requirements. Although different from State to State, some basic procedures are common to all States.

The claim is examined to insure that:

1. It contains all the required information;

2. the information is internally consistent;

3. the recipient who received the service and the provider who submitted the claim were certified as eligible to participate in the program on the date(s) of service;

4. the service provided is covered under the program;

5. the service does not exceed frequency limitations;

6. any required prior authorizations or certifications were obtained.

If the claim conforms to these requirements, a decision is made as to the dollar amount to be paid. This amount is determined by appropriate fee schedules and fiscal policies.

The Claims Processing Assessment System (CPAS) is a State administered Medicaid Quality Control program which serves as a management tool for examining and evaluating the accuracy of claims processing and payments. Federal monitoring of State CPAS activities is accomplished through management reviews in either the System Performance Review (SPR) for certified MMIS States, the State assessment for non-MMIS States, or other Federal review. These reviews are used as the mechanism to determine which CPAS; (i.e., alternate or mandatory/superior) a State must operate subsequent to the review period.

11601. OVERVIEW OF CPAS

A. General.--All States are required to operate claims processing assessment systems that have the capability to perform the following functions:

1. Identify deficiencies in the claims processing operations;

2. measure the cost of deficiencies;

3. provide data to determine appropriate corrective action;

4. provide an overall assessment of the State's claims processing or that of its fiscal agent;

5. provide for a claim-by-claim review where justifiable by data; and

6. produce an audit trail that can be reviewed by HCFA or an outside auditor.

The above functions have been shown by demonstrations to be essential to an efficient CPAS plan. States with demonstrated superior performance may establish alternate claims processing assessment programs, subject to HCFA approval based on effectiveness, efficiency and economy.

B. Alternate System.--States whose claims processing systems are not affected by C below are allowed to operate an alternate claims processing assessment system using the methods of their choice subject to Federal criteria and approval. The alternate system could be an in-house independent audit, or an alternate quality control system. Any such system is subject to Federal approval prior to implementation. The required reporting for these States is minimal. States are not required to submit detailed samples. However, these States will be required to provide a report of the results of such assessments. (See §11606.)

C. Mandatory System.--A mandatory system, or a system that is judged superior, would be required of those States that:

1. Exceed a claims processing performance threshold. The threshold has been established as a payment error rate exceeding 1 percent and where misspent Federal funds annually exceed $1 million;

2. Make significant system changes (MMIS States only). A significant system change is defined as the replacement by an MMIS State of an approved claims processing subsystem, which must meet the conditions for initial approval of the MMIS; or,

3. Change system operators or fiscal agents and HCFA review determines that the performance of the CPAS in use does not adequately monitor the quality of the claims processing system during the transition.

The scope of the review process, documentation, development, and reporting requirements for the mandatory system are more comprehensive than for an alternate system. (See §11604.)

D. Superior System.--A State required to operate the mandatory CPAS must use this system or a system determined by HCFA to be superior. A superior system provides better data, more data, or comparable data at greater efficiency or economy. States could, for example, use additional strata, review denied claims, conduct special studies in problem areas, or increase automation.

E. Definitions.--The following definitions are for use within the context of the CPAS.

Certified Provider Listing.--An official State registry of providers and facilities authorized to receive reimbursement for services provided to State Medicaid recipients.

CFR.--Code of Federal Regulations.

Correct Payment Authorization.--The lesser of either the amount billed by a provider for a covered service or the amount specified for that service in the appropriate payment fee schedule (fee schedules, reasonable charge profiles, etc.).

Dollar Error.--An error that resulted in an erroneous payment authorization; i.e., an overpayment, underpayment, or total dollar error.

Medicare Crossover Payment.--Payment authorization by the State Medicaid agency for the Medicare deductible and coinsurance amounts.

Overpayment.--A dollar error in which the payment authorization amount is in excess of the correct payment authorization.

Payment Authorization.--The amount adjudicated for payment by the CP operational unit regardless of the amount of the check subsequently issued to the provider.

Payment Fee Schedule.--A listing of the maximum payment rates for specified services covered under the State's Medicaid program.

Permissible State Practice.--Written procedures, provider guides, office instructions, and policy manuals and issuances that are consistent with the State plan or with approvable State plan amendments which have been submitted to but not yet acted upon by the HCFA RO.

Prior Authorization.--Prior approval by the State agency to reimburse a provider for a specific service, if rendered.

Procedural Error.--An error that occurred during claims processing which may or may not result in a dollar error.

Recipient Paid Claim History File.--A listing, over a period of time, of medical services received by a recipient for which Medicaid reimbursement was provided.

The listing should provide the information necessary to conduct the QC review; e.g., the service rendered, units of service, date of service, provider of the service, date and amount of payment authorization, third party payment data.

Sample Unit.--A line item(s) representing the lowest level of payment adjudication for claims authorized for payment or adjustment. The most detailed claim breakdown for which a payment/adjustment determination is made and authorized. For purposes of the CPAS Manual, a sample unit is referred to as a "claim" in narrative discussions.

Total Dollar Error.--An error in which the full amount or part of the claim should have been disallowed; i.e., no portion of the payment/adjustment should have been authorized.

Underpayment.--A dollar error in which the payment authorization is below the correct payment authorization amount.

11604. MANDATORY SYSTEM

The mandatory system sample universe consists of all claims authorized for payment or adjustment by the State agency or its fiscal intermediary. Claims are subject to sample selection for the month in which payment is authorized rather than in the month in which the service was provided or in the month in which payment was actually made to the provider. Adjustments that increase or decrease previous payment authorizations are also subject to sample selection and review. However, claims for which no payment was authorized; i.e., denied claims, are not subject to sample selection.

The mandatory system provides data on the incidence of claims processing errors and the resulting cost of the errors in program dollars. Once a claim is selected, it is reviewed to determine (1) if it was processed in accordance with the State's CP procedures and (2) if the payment/adjustment amount authorized is correct. A CPAS Review Schedule is completed for each claim selected for review and is used to record information regarding the types and sources of errors found. The CPAS Review Schedule demonstrates a cause and effect relationship between occurrence errors and resulting dollar errors in the payment/adjustment authorization.

The mandatory system review is conducted in two major phases and produces two types of findings. In the first phase, the claim is reviewed to determine if it was processed correctly; that is, was all the necessary documentation present, were all the required procedures followed, were coding or data entry errors made, etc.? If processing errors were made, a procedural error is recorded on the CPAS Review Schedule. Procedural

errors are described by nature codes and may or may not result in an incorrect payment/adjustment authorization. (The CP operational unit may make errors in processing the claim but the payment authorization may still be correct.)

In the second phase the reviewer must develop any procedural errors found to determine whether they caused the payment authorization to be incorrect. Development means that the CP reviewer must obtain missing documentation, rework payment computations, or perform other activities necessary to determine if the payment authorization was correct. If incorrect, a dollar error is cited on the CPAS Review Schedule. Dollar errors are described in terms of the nature of the error, type of the error (underpayment, overpayment, etc.), and amount of the error. A dollar error finding is recorded on the CPAS Review Schedule with the procedural error which was most responsible for the dollar error. As a result, statistical data is generated which describes the relationship between procedural and dollar errors in States' CP systems.

The mandatory system review is conducted in consecutive 6-month cycles. Each sample period represents one-half of the Federal fiscal year (from October 1 through March 31 and from April 1 through September 30). Based upon the State agency's completed CPAS reviews, HCFA-CO generates statistical reports and tables for each 6-month review period.

11604.1 Scope.--Claim payment authorizations and adjustments subject to sample selection are grouped by provider type. The claims selected for payments include the following groups:

- Inpatient hospital services (other than services for tuberculosis or mental diseases);
- long-term care services;
- other individual practitioners and clinics; and
- separately billed prescribed drugs.

The mandatory system review is concerned with the most detailed claim breakdown for which a payment amount was determined and authorized for payment or adjustment; i.e., the lowest level of payment adjudication by the CP operational unit. In many instances the claim under review (sample unit) will be a single service (office visit, drug, etc.) listed as a separate line item on the provider's invoice. (Other line items appearing on the same invoice not in the sample unit are subject to separate sample selection and review.) In other instances the sample unit may be several services listed separately on the provider's invoice but grouped together for payment determination purposes, or an inclusive rate payment made for an individual beneficiary (such as some hospital services, nursing home rates, etc.).

For CPAS purposes, claims processing is considered complete when an authorization for payment has been made. The claim is reviewed for correctness based on the amount authorized. Adjustments (increases and decreases) made subsequent to the payment authorization are considered separate CP actions and are subject to separate sample selection and review. Adjustments may be in the form of a supplemental payment authorization, a debit or credit to the provider's account, or a new payment authorization after a credit to the provider's account for the amount of the original claim.

The review is not limited to the provider invoice information but includes examination of supporting documentation, recipient paid claim history files, payment fee schedules, and other source documents required to reach a definitive review finding. The review is conducted in accordance with State plans, State practice (provided there is no conflict with the State plan), and the review instructions contained in this manual.

A .

Permissible State Practice and the State Plan.--The review is conducted in accordance with permissible State practice; i.e., written provider guidelines, office instructions, and policy manuals and issuances that are consistent with the State plan or with approvable plan amendments which have been submitted to but not yet acted upon by HCFA.

In all instances where State practice conflicts with the State plan (or approvable amendments) State practice is not permissible and the review is conducted in accordance with the provisions of the State plan. Although the State plan preprint is a simplified document, it is designed to be consistent with Federal regulations. Where the State plan does not specifically address an issue and State practice conflicts with Federal regulations, the review is conducted against the CFR. If, however, the approved State plan specifically addresses an issue but is in conflict with Federal regulations, the review is conducted in accordance with the approved State plan.

State plan amendments submitted to HCFA for approval but not yet acted upon are considered in effect for review purposes if the amendments are approvable. Plan amendments are approvable so long as they do not conflict with the CFR. Plan amendments which conflict with Federal regulations are not approvable and cannot be honored for review purposes. The effective date of an approvable amendment may be prospective or retroactive, but may not be retroactive beyond the beginning of the calendar quarter in which the amendment was submitted. If the effective date of the amendment is not specified, the date it is submitted to HCFA is the effective date for review purposes. Once submitted, an approvable plan amendment remains in effect unless it is formally disapproved by HCFA.

B. Parameters of the Review.--Although payments and adjustments are subject to selection in the month of authorization, the review is conducted in accordance with policies, procedures, fee schedules, etc., in effect on the date(s) the service was provided or the date of payment authorization, as specified by permissible State practice. In instances where the service was provided over a period of days, particularly from one month to the next, it may be necessary to apply separate policies or fee schedules to the review when the dates of service span the effective date of a policy or fee schedule change. For example, one fee schedule may have been in effect for some of the services performed, but a different fee schedule became effective for the remaining services provided.

11604.2 Claims Not to be Reviewed.--Certain types of claims are not to be included in the mandatory CPAS sample universe. These will normally be eliminated in the sample selection process. Claims not to be included in the sample universe and considered listed in error if selected are:

1. Claims in which the payment authorization date is not within the sample month;

2. claims for which no Federal matching is claimed; i.e., are paid with State funds only;

3. claims that are an end-of-year institutional cost settlement;

4. claims that are 100 percent federally funded; and

5. claims listed under the incorrect provider type. (Claims included in the sample universe are stratified by provider type prior to sample selection options; i.e., hospitals, long-term care, individual practitioners and clinics, and prescription drugs.)

Due to the nature of the CP review and its documentation requirements, there are few valid reasons for not completing a correctly sampled case. For example, the absence of documentation is not a valid reason for an incomplete review. Reviews may be incomplete, however, when the State corrects for excessive oversampling in accordance with §11608.3.

11604.3. Review Completion and Reporting Requirements.--

A. Review Completions.-- Submit to the HCFA RO, on a weekly basis, a copy of the Review Schedule for each review completed during the week. As a guideline, complete a minimum of 90 percent of the monthly sample selection within 60 days after the close of

the sample month. All CP reviews must be completed and submitted to the HCFA-RO by the end of the ninth month of the review cycle; e.g., June 30 for the October-March period and December 31 for the April-September period.

As a rule, State review findings are considered final when submitted to the HCFA-RO and may not be changed.

B. Reports.--States are required to submit monthly reports to the HCFA RO which contain sample selection data and disposition lists. Monthly reports are due to the HCFA RO within 5 working days after the end of the review month.

Using copies of the review schedules and the monthly reports, HCFA CO will generate status reports to monitor State completions and the 6-month statistical reports and tables.

States must also report claims and dollar universe figures by strata within 30 days after the end of the sampling period.

11604.4 Review Procedures.--The following sections outline the review steps, data needs and source documents, development, and error determination instructions for the claims reviews.

A. Steps in the Review.--As previously noted, the claim is reviewed in accordance with the State plan. In order to adequately meet the review requirements, the reviewer must have a thorough understanding of permissible State practice, the State plan, and a familiarity with the CFR. The reviewer must use this knowledge to:

1. Determine the policies and fee schedules in effect for the date(s) of service and/or the payment authorization date, whichever is applicable under permissible State practice;

2. determine the documentation required to process the claim;

3. determine if the unit followed the correct processing procedures; and

4. develop the review to determine if a correct payment authorization was made.

B. Below is a list of some of the specific steps which must be considered for each claim selected for review.

1. Payment for Services.--Check the invoice or paid claims file to determine:

a. If the claim was properly selected for review; i.e., was not listed in error;

b. the line item(s) under review;

c. the review parameters established by the date(s) of service and/or payment authorization date; and

d. the amount of payment/adjustment authorization.

2. Provider Eligibility.--Compare the date(s) of service with the provider eligibility file to determine if the provider was, in fact, certified to participate in the program for the day(s) the service was rendered.

3. Recipient Eligibility.--Determine who the recipient was and establish that the recipient appeared on the Medicaid eligibility file for the month(s) covered by the date(s) of service.

4. Covered Services.--Compare the type of service provided with the services covered under permissible State practice to determine if the claim under review was for a covered service.

5. Required Invoice Information.--Determine if all required information was provided on the invoice. If not, develop missing information required to complete the review.

6. Appropriate Billing Procedures.--Determine if the provider followed the correct billing procedures when submitting the claim. Areas of consideration include, but are not limited to, compatibility of diagnosis and procedures, and inclusion of required support documentation (i.e., operative reports).

7. Prior Authorization.--Providers must obtain approval from the State prior to delivery of certain services if reimbursement is to be provided. Establish if prior authorization was required, if prior authorization was obtained and documented, and that the service provided was not in excess of any limitation set by prior authorization requirements.

Where the State provides for a waiver of prior authorization under certain circumstances, such as an emergency, verify that the waiver and subsequent authorization were granted or can be granted in accordance with permissible State practice. If a payment was approved without prior authorization, or waiver if provided for, a procedural error is cited. If prior authorization was not obtained and a waiver of prior authorization can not be granted, both a procedural and a dollar error must be cited.

8. Level of Care Certification.--Where the State plan, or if not specified, permissible State practice requires evidence of certification prior to payment authorization, verify that the required certification was obtained. If not obtained prior to payment authorization, a procedural error is cited. Then determine if certification existed at the time of payment authorization. If certification at the time of payment authorization cannot be documented, a dollar error must be cited.

9. Duplication of Payment Frequency Restrictions.--Ascertain that a separate payment was not authorized for the service under review; i.e., the payment authorization under review does not duplicate a previous authorization. (Where a duplicate billing on a single invoice results in a duplicate authorization, the claim(s) appearing after the first claim on the invoice is considered a duplicate.) To determine if the sample unit is a duplicate payment authorization, compare the claim against a paid claims history which covers the period of time in which a claim can be submitted for payment as defined by permissible State practice.

In addition, determine whether a service was provided more frequently than allowed under permissible State practice. To accomplish this consider both the limitation on the number of times a service may be performed and any differences in the rate of payment for initial and subsequent services. Compare the claim against the claims history for the entire period of time the service under review is subject to frequency limitations under permissible State practice.

10. Authorized Payment Amount.--Verify the correctness of the claim amount authorized by consulting fee schedules, reasonable charge profiles, or by recalculating relative value based payments.

11604.5 Data Needs and Source Documents.--The reviewer is responsible for utilizing all documents and references necessary to determine if the claim was processed in accordance with required procedures and if the payment authorization was correct.

Source documents vary from State to State. For example, the original invoice, a photocopy of the original, or microfilm/microfiche may be utilized. Where the original invoice was submitted via electronic data transfer, a printout produced from the original transmission and containing all data relevant to the review is acceptable. Invoices are often annotated by State personnel during the various processing steps. The reviewer must ascertain if changes made to an invoice after submission by the provider could affect the error determination. Where the invoice has been altered during processing or where microfilming is not done prior to processing, it may be necessary to obtain the original hard copy invoice or verify key information via the provider's records.

The following are examples of data needs necessary for review. Also listed are some of the source documents from which to extract the information.

	DATA NEEDS	SOURCE DOCUMENTS
1.	Sample selection data; provider stratum and sample month.	Listing of sample units selected for review and the State's sampling plan.
2.	Invoices containing the line items sampled.	Microfilm/microfiche files; original or copy of invoice; electronic data transfer printout.
3.	Payment Data.	Recipient paid claim history file; authorization for payment.
4.	Provider Eligibility Status for Month(s) of Service.	Computer generated or other listing of eligible providers for month(s) of service.
5.	Recipient Eligibility Status for Month(s) of Service.	Computer generated or other listing of eligible recipients for month(s) of service.
6.	Service Frequency Limitations.	Permissible State practice; recipient paid claim history file; fee schedules; screens and edits used in claims processing.

	DATA NEEDS	SOURCE DOCUMENTS
7.	Allowable Payments for Services During the Service Date(s) or Payment Authorization Date.	Specified fee schedules by area; listing of payment screens or edits used in claims processing; relative value scales (RVSs) for services and conversion factors (RVS multiplied by conversion factor yields fee); listing of "usual and customary" charges by provider group; hospital and nursing home reimbursement guides or manuals.
8.	Services Covered by the State Medicaid Program.	Permissible State practice; drug guides; fee schedules; provider reimbursement manuals.
9.	Prior Authorization Requirements.	Permissible State practice; fee schedules.
10.	Requirements for Physician Certification.	Permissible State practice.

11604.6 Development and Error Determination.--

A. Development refers to the process of determining whether a procedural error resulted in a dollar error. All procedural errors are subject to development to the point necessary to determine the effect of the error on the payment authorization. Although all procedural errors are cited on the CPAS Review Schedule, development to determine dollar errors ceases at the point a total dollar error is found; i.e., the full amount of the claim should have been disallowed. Therefore, develop first those procedural errors found which could result in a total dollar error.

When development requires that the reviewer obtain documentation that was required, but missing when the claim was processed, the quality control unit will first contact the State operational unit to obtain the missing documentation. Examples of required documentation are:

1. The invoice containing the line item under review;

2. prior authorization forms;

3. physician certification when the operational unit is required to verify certification prior to payment authorization.

If the State CPAS unit is able to supply existing documentation, and demonstrate that it was available when the claim was processed, no error will be cited. If the State CPAS unit must obtain new documentation; e.g., contact the provider, a procedural error is cited because the claim was processed without the required documentation. The correctness of the payment authorization is then reviewed based upon the new documentation.

If the operational unit fails to secure the required documentation, the State CPAS unit should obtain the missing documentation if possible. However, the ultimate responsibility and burden of proof rests with the State operational unit to demonstrate that the payment authorization was appropriate. If the required documentation cannot be obtained or is unacceptable, a dollar error must be cited. For example, if evidence of prior authorization cannot be obtained, it must be assumed that prior authorization was not granted.

Although the operational unit may obtain the necessary documentation, the CPAS unit must determine if the documentation is acceptable. Documentation which is acceptable in place of the original is:

1. A copy of the documentation from the provider's records;

2. a signed and dated statement from the provider containing the required data; or

3. a quality control reviewer's narrative of a telephone contact with the provider supplying the necessary documentation.

B. Error Determination.--The review measures the correctness of payment authorizations/adjustments by identifying claims processing errors and resulting dollar errors. Procedural errors occur during the processing of a claim and may or may not cause a dollar error. Dollar errors result in the payment authorization being in error, either a total dollar error, overpayment, or underpayment. A major objective of the CP review is to identify procedural errors and their effect on the correctness of the payment authorization. As a result, the nature of error codes for procedural errors are different than the nature of error codes for dollar errors.

In making an error determination, first record all procedural errors found using the error code which best describes the nature of the procedural error. Then determine if the procedural error(s) resulted in a dollar error(s). If so, record an error code which best describes the nature of the dollar error.

Although the review is designed to establish a cause and effect relationship between procedural and dollar errors, the relationship is not always one-to-one. For example, the reviewer may determine that three procedural errors occurred during the processing of the claim, but that only one dollar error resulted. All three procedural errors are coded on the review schedule, but the resulting dollar error is only recorded once. In such instances, determine which procedural error most directly caused the dollar error.

11604.7 Error Category Profile

A. Nature Codes.--Nature codes are divided into seven categories under two major headings: procedural and dollar errors. Each category is divided into numerical subcategories describing the specific nature of the error. The specific nature of an error to be coded on the review schedule is the number of the error category and the number of the error subcategory which best describes the specific error. For example, a documentation procedural error cited because of no evidence of a claim would have the nature code 01.

B. Procedural Error Heading.--Procedural errors are divided into three categories: (1) Documentation, (2) Coding/Data Entry, and (3) Other Errors. Errors found in these three categories are recorded under the Procedural heading of the CPAS Review Schedule only and cannot appear under the Dollar heading.

Permissible State practice determines which subcategories of the Error Category Profile are applicable to the claim under review. When making the determination note that non-line item requirements associated with the adequacy of the invoice information; e.g., appropriate I.D. numbers, signature, are within the scope of the review and are associated with the appropriate procedural error category in the profile. Each procedural error found is to be recorded on the review schedule and is subject to development to determine if a dollar error also occurred. Since further development stops when a total dollar error is found, development should be completed first on those procedural errors most likely to result in a total dollar error.

1. Documentation.--Cite when a payment/adjustment is authorized without the information or verification required by permissible State practice. Each documentation error found is to be recorded and subject to development.

CODE	DESCRIPTION
01.	No evidence of claim submittal (no invoice).
02.	Physician/provider signature omitted or questionable.
03.	Recipient signature omitted or questionable.
04.	Required recipient identification missing or questionable.
05.	Required physician/provider identification missing or questionable.
06.	Referring physician identification missing or unclear.
07.	Prior authorization missing or unclear.
08.	Level of care certification missing or unclear.
09.	Date(s) of service missing or questionable.
10.	Diagnosis, procedure codes, and/or narrative description missing or questionable.
11.	Number of services missing or unclear.
12.	Drug type not specified or questionable.
14.	Dollar amount of claim missing, unclear, or questionable.
15.	Unauthorized force coding to bypass reasonable charge, fee schedule, or other edits.
19.	Other required information/documentation missing, incomplete, or unclear. Use the reverse side of the CP Review Schedule to explain this error more fully.

2. Coding/Data Entry.--Cite when an error is made by the State agency in coding invoice or payment data, or in entering computer data. Each coding/data entry error found is to be recorded and is subject to development.

CODE	DESCRIPTION
20.	State entered incorrect code to identify noncoded recipient invoice data; e.g., recipient identification, sex type,
21.	State entered incorrect code to identify noncoded provider invoice data; e.g., provider code,
22.	State entered incorrect code to describe noncoded service data; e.g., procedure codes, drug type, billing codes,
23.	State made keypunch error when transcribing coded data.
29.	Other coding/data entry error not identified above. Describe on reverse side of review schedule.

3. Other.--Each of the following procedural errors found are to be recorded and are subject to development.

CODE	DESCRIPTION
30.	Nonpermissible State practice - Written claims processing policy or procedure not in conformance with the approved State plan. (See §11604.1.)
39.	Other procedural errors not cited above. This code is also used when a dollar error cannot be identified with a specific procedural error described above. Explain error fully on reverse side of the review schedule.

C. Dollar Error Heading.--Dollar errors are divided into four categories, (1) Eligibility, (2) Coverage, (3) Payment, and (4) Reasonable Charge. Errors found in these four categories are recorded under the Dollar heading of the CP Review Schedule. Since the review ends with the identification of a total dollar error, first develop those procedural errors which may result in a determination that the full amount of the payment authorization should have been disallowed. To assist the reviewer, probable total dollar errors are indicated on the Error Category Profile by an asterisk. Permissible State plans determine which subcategories of the profile are applicable to the claim under review.

1. Eligibility.--Cited when the provider or the recipient was not certified as eligible to participate in the Medicaid program during part or all of the service date(s).

	CODE	DESCRIPTION
*	40.	The provider was not certified as eligible.
*	41.	The recipient was not certified as eligible.

2. Coverage.--Cite when permissible State practice prohibits reimbursement for the service(s) under review.

	CODE	DESCRIPTION
*	50.	Service not covered under the permissible State practice.
*	51.	Service exceeded the frequency limitation. This code is used when the frequency limitation has been exceeded by the authorization for the payment under review.
*	52.	No required physician certification. Level of care certification requirements not met on service date(s).
*	53.	No required prior authorization. The State agency has not met required prior authorization requirements.
*	54.	Claim processed although the filing deadline had expired.

*	55.	Additional EPSDT screening within prohibited time period.
*	56.	EPSDT screening service for a recipient age 21 or over.
*	57.	Inpatient charge includes both day of admission and day of discharge.
*	58.	Setup charges allowed although surgery was cancelled.
*	69.	Other coverage errors not specified above. Explain on reverse side of review schedule.

3. Payment.--Cite when a computation or payment determination error resulted in an incorrect payment authorization.

	CODE	DESCRIPTION
*	70.	Unable to verify that service was rendered.
*	71.	Duplicate payment authorized.
*	72.	Incorrect provider paid.
	73.	Copayment amount incorrectly applied.
	74.	Mathematical error resulted in incorrect payment authorization amount.
	79.	Other payment errors not specified above. Explain on reverse side of review schedule.

4. Reasonable Charge.--Cite when errors were made in applying reasonable charge rates, fee schedules, etc.

CODE	DESCRIPTION
80.	Incorrect reimbursement rate (fee schedule) applied.
81.	New patient code used although claims history shows previous patient charge by the same provider.
82.	Billed services improperly combined into service coverage package.
83.	Payment authorized for more than one dispensing fee when a prescription was split by the pharmacist.
84.	Payment authorized for drugs where the quantity prescribed is greater than the maximum quantity allowed by permissible State practice.
85.	Payment authorized for a maintenance drug where the quantity prescribed is less than the minimum allowed by permissible State practice.
89.	Other reasonable charge errors not specified above. Explain on reverse side of review schedule.

D. Type Codes.--In addition to being described by nature codes, errors are also described by type. There are five error type categories:

1. No Dollar Error.--Procedural errors which, when developed, did not result in a dollar error. For example, the claim may have been processed without required documentation, but when the documentation was obtained it was determined that the payment authorization was in the correct amount.

2. Total Dollar Error.--Dollar errors in which the full amount of the payment authorization under review should have been disallowed; i.e., an overpayment in the full amount of the payment authorization. Development is ended after a total dollar error is identified.

3. Overpayment Error.--Dollar errors in which the payment authorization was in excess of the correct payment authorization amount.

EXAMPLE 1:

Dollar Amount Billed	$15.00
Appropriate Reimbursement Rate	$10.00
Dollar Amount Authorized	$15.00

The overpayment error is the difference between the reimbursement rate and the amount authorized. The error amount is $5.00.

EXAMPLE 2:

Dollar Amount Billed	$15.00
Appropriate Reimbursement Rate	$25.00
Dollar Amount Authorized	$25.00

In example 2 the overpayment is the difference between the dollar amount billed and the dollar amount authorized. Here the error amount is $10.00.

4. Underpayment Error.--Dollar errors in which the payment authorized is less than the correct payment authorization amount.

EXAMPLE 1:

Dollar Amount Billed	$15.00
Appropriate Reimbursement Rate	$10.00
Dollar Amount Authorized	$ 5.00

In example 1 the underpayment error is the difference between the reimbursement rate and the dollar amount authorized. In this example it is $5.00.

EXAMPLE 2:

Dollar Amount Billed	$20.00
Appropriate Reimbursement Rate	$25.00
Dollar Amount Authorized	$10.00

In example 2 the underpayment error is the difference between the dollar amount billed and the dollar amount authorized. It is $10.00.

5. Nondeveloped Procedural Error.--Procedural errors which were: a) not developed to determine if they resulted in a dollar error, or b) resulted in a dollar error but the dollar error is assigned to another procedural error.

Code 5 is used to designate procedural errors which were not developed because the review was completed after identifying a Total Dollar Error or when several procedural errors resulted in the same dollar error. (Since the dollar error is coded with the procedural error most responsible, other procedural errors are coded as type 5 -Nondeveloped.)

11604.8 Special Review Circumstances.--

A. Third Party Liability.--Since TPL dollar errors are not within the scope of the CP review, no development of procedural errors is necessary.

B. Adjustments.--

1. Amount.--Only the net amount of the adjustment is under review. In most instances the adjustment amount is the full amount of the supplemental authorization, credit or debit. In other instances, if the initial payment was cancelled and a new payment authorized to the same provider, the adjustment is the difference between the original amount authorized and the new amount authorized; i.e., the net amount. For example, the original authorization in the amount of $20 was cancelled and a new payment authorized in the amount of $15. Although the $15 authorization must be reviewed for correctness, the amount of the adjustment reported on the CPAS Review Schedule is a $5 decrease.

In instances where the original payment is cancelled and a new payment authorized to a different provider, the amount of the adjustment is the amount of the cancellation. The new payment authorization to a different provider is not considered part of the adjustment and is to be subject to separate sample selection.

2. Correctness.--In order to determine the correctness of adjustments, they must be reviewed in relation to the correctness of the original payment authorization and any prior adjustments. To be correct, the adjustment must be based upon an accurate assumption. For example, an adjustment may be authorized to increase an original payment. This assumes that the original authorization was less than can be allowed under permissible State practice. If, however, a review of the original authorization revealed it to be an overpayment, the assumption, and consequently, the adjustment are in error.

The original authorization must be examined as if it were the claim selected. That is, procedural errors are identified and developed in order to determine the correctness of the original payment authorization. The adjustment is then reviewed to determine if any original errors found, both procedural and dollar, were corrected or otherwise compensated for by the adjustment. If not, the errors carry forward to the adjustment and are coded on the CPAS Review Schedule. If, for example, a claim was originally processed without required documentation and the adjustment was processed without obtaining the documentation, a documentation procedural error is charged to the adjustment (unless, of course, the adjustment was to cancel the original payment authorization due to a lack of required documentation). Likewise, any dollar errors occurring in the original payment authorization, if not corrected in the adjustment process, may contribute to an adjustment dollar error.

The following outlines the types of adjustment dollar error findings which may result depending upon the correctness of the original payment authorization.

1. Original Authorization Correct and Paid in the Amount Specified in the Appropriate Fee Schedule.--

a. Adjustment to Increase.--Net amount of increase reported as total dollar error.

b. Adjustment to Decrease.--Net amount of decrease reported as underpayment.

2. Original Authorization Correct but Provider Billed Less Than Specified in Appropriate Fee Schedule.--

a. Adjustment to Increase.--Can be correct only if provider requests adjustment.

(1) Net amount of increase correct if in amount of adjustment request or amount specified in the appropriate fee schedule, whichever is the lesser amount.

(2) Underpayment coded if net amount of increase is less than the correct adjustment amount as specified in (1) above.

(3) Overpayment coded if net amount of increase is more than the correct adjustment amount as specified in (1) above.

b. Adjustment to Decrease.--Net amount of adjustment reported as underpayment.

3. Original Authorization a Total Dollar Error.--

a. Adjustment to Increase.--Net amount of increase reported as total dollar error.

b. Adjustment to Decrease.--

(1) Any amount of decrease correct up to the amount of original payment authorization.

(2) Any amount of decrease beyond original payment authorization reported as an underpayment.

4. Original Authorization an Overpayment.--

a. Adjustment to Increase.--Net amount of increase reported as a total dollar error.

b. Adjustment to Decrease.--

(1) Any amount of decrease correct up to the amount of the original overpayment.

(2) Any amount of decrease beyond original overpayment amount reported as underpayment.

5. Original Authorization an Underpayment.--

a. Adjustment to Increase.--

(1) Any amount of increase correct up to the amount of original underpayment.

(2) Any amount of increase beyond original underpayment reported as overpayment.

b. Adjustment to Decrease.--

(1) Net amount of decrease reported as an underpayment.

11604.9 Review Schedule Instructions.--

Complete a HCFA 331 CPAS Review Schedule for each sample unit selected for review.

SECTION I - CLAIM INFORMATION

Complete this section for each sample unit selected for review.

1-4. Optional State Use.--Enter claim or review information if desired. For example, recipient identification, reviewer identification, date assigned, date completed,

5. Local Code.--Enter the code, if applicable, that identifies the county or local agency that certified the recipient as eligible for Medicaid, or the fiscal intermediary that authorized the payment.

6. Sample Unit Number.--Enter the number (invoice - line item number) which identifies the sample unit selected for review.

7. State Code.--Enter the two-digit code for the State in which the review was selected. (See appendix A for State codes.)

8. Sample Month/Year.--Enter the month and year that corresponds to the specified sample month from which the sample unit was selected. States may specify a sample month other than a calendar month if their payment procedures operate on a fixed fiscal month basis. The sample month is specified in the approved State sampling plan.

9. Review Number.--Enter the number, alpha and/or numeric, assigned to the review. Enter zeros in any unused data positions.

10. Date(s) of Service.--Enter the date(s) of service covered by the payment authorization under review.

FROM: Enter the first day of service (month/day/year) covered by the payment authorization under review.

TO : Enter the last day of service (month/day/year) covered by the payment authorization under review.

Where the service was provided during a single day, the "from" and "to" dates will be the same.

11. Date Payment Authorized.--Enter the date (month/day/year) the claim was authorized for payment.

If the date the claim was authorized for payment is not within the sample month, calendar or fiscal, the claim is listed in error.

12. Service Type.--Enter the code that identifies the type of service under review. (See appendix A for type of service codes.)

Service codes are divided into series 100-500 by provider type. Series 200, 300, and 500 are subdivided by types of service.

13. Claim Type.--Enter the number that corresponds to the type of claim selected for review. For adjustments it will be necessary to conduct the review before the appropriate adjustment code can be determined. (See §11604.8-Adjustments.)

(1) Original.--Enter the number one if the claim selected for review is the first adjudicated claim payment determination; i.e., the initial payment determination for an invoice prior to any adjustments.

(2) Adjustment to Increase/Original Authorization Correct.--Enter the number two if the claim selected for review is an adjustment to increase the amount of a previous correct payment authorization.

(3) Adjustment to Increase/Original Authorization Incorrect.--Enter the number three if the claim selected for review is an adjustment to increase the amount of a previous incorrect (over- or underpayment) payment authorization.

(4) Adjustment to Decrease/Original Authorization Correct.--Enter the number four if the claim selected for review is an adjustment to decrease the amount of a previous correct payment authorization.

(5) Adjustment to Decrease/Original Authorization Incorrect.--Enter the number five if the claim selected for review is an adjustment to decrease the amount of a previous incorrect (over- or underpayment) payment authorization.

14. Amount Authorized.--Enter the amount authorized for payment or adjustment for the sample unit selected for review without regard to any subsequent adjustments to the payment amount. For adjustments, see section for explanation of amount authorized.

SECTION II - REVIEW DISPOSITION

Complete this section for each sample unit selected for review. Enter the number that corresponds to the disposition of the review.

1. Review Completed.--Enter the number one if a review finding is reached; i.e., item 15, is coded.

2. Listed in Error.--Enter the number two if the claim selected for review is listed in error. Use the space provided to explain the reason the claim is listed in error. The claim is listed in error if:

a. The date of payment authorization, item 11, is not within the specified sample month from which the claim was selected, item 8; or

b. the claim selected for review was denied; i.e., not authorized for payment;

c. the sample unit selected was listed on the wrong provider type sample listing prior to sample selection;

d. the sample unit selected is not a federally matched Medicaid claim; i.e., is paid with State funds only;

e. the sample unit selected for review is an end-of-year institutional cost settlement; or

f. the sample unit selected was 100 percent federally funded.

Incomplete.--Enter the number three if the claim was not listed in error but the review was not completed. (See §11604.2 - Claims Not To Be Reviewed.)

SECTION III - REVIEW FINDINGS

Complete this section for each sample unit selected for review that was not listed in error.

15. Findings Status.--Enter the number that corresponds to the findings status of the sample unit selected for review.

a. Correct.--Enter the number one if no procedural or dollar errors were found during the review.

b. Procedural Error.--Enter the number two if only procedural errors were found during the review.

c. Procedural and Dollar Error.--Enter the number three if procedural errors resulting in dollar errors were found during the review.

16. Error Data.--Complete this item for each sample unit determined to contain a procedural or dollar error; i.e., number 2 or 3 was entered in item 15.

A. Procedural Errors - Nature. Enter the code from the Error Category Profile which best describes the nature of the procedural error found.

Record all procedural errors, working from the top to the bottom, identified during the review. If more than five procedural errors are identified, attach an additional review schedule in order to capture all procedural errors identified.

Develop each procedural error recorded to determine if it resulted in a dollar error.

Exceptions: TPL procedural errors are not developed. Secondly, if the development of a procedural error results in a Total Dollar Error (the full amount of the paid claim being overpaid), the review ends without the development of the remaining procedural errors. An overpayment or underpayment, however, does not end the review because subsequent errors may offset or compound the first error found.

B. Type.--Enter the number that corresponds to the type of the dollar error determination; i.e., no error, total dollar, overpayment, underpayment, TPL procedural, or nondeveloped procedural error.

1. No Dollar Error.--Enter the number one if the procedural error, when developed, did not result in a dollar error.

2. Total Dollar Error.--Enter the number two if the procedural error resulted in an overpayment in the full amount of the payment; i.e., the amount entered in item 14 should have been totally disallowed.

3. Overpayment.--Enter the number three if the procedural error resulted in an overpayment (the amount authorized was more than the correct authorization amount) but not in a total dollar error.

4. Underpayment.--Enter the number four if the procedural error resulted in an underpayment; i.e., the amount authorized was less than the correct authorization amount.

5. TPL Procedural Error.--Enter the number five if the procedural error was a TPL error (code 13 or 31).

6. Nondeveloped Procedural Error.--Enter the number six if the procedural error was not developed (because a total dollar error was found) or although resulting in a dollar error, the dollar error was assigned to another procedural error.

C. Dollar Errors--Nature.--If the procedural error results in a dollar error, enter the code from the Error Category Profile which best describes the nature of the dollar error. If the procedural error is not developed, if development does not result in a dollar error, or if the dollar error has been reported (associated) with another procedural error, leave item C, Dollar Errors--Nature, blank.

After development of a procedural error, enter the dollar error data directly across from the procedural error; i.e., in line with the procedural error nature code.

Example -

Procedural Errors		Dollar Errors	
A. Nature	B. Type	C. Nature	D. Amount
23	2	71	$ 000134 00

D. Amount.--If a 2, 3, or 4 is entered under item B, Type, enter the amount, in dollars and cents, of the error. If the number 1, 5, or 6 is entered in item B, item D is left blank.

The amount of a total dollar error is the full amount of the payment authorization under review. The amount of an overpayment or underpayment is the difference between the amount authorized and the correct payment authorization amount. The correct payment authorization amount is the amount specified in fee schedules or the amount billed, whichever is smaller.

17. Net Dollar Error Findings.--Complete this section if more than one dollar error was recorded in item 16-B.

A. Net Dollar Error Amount.--Enter the net dollar amount of all dollar errors combined. The net dollar error amount is determined by adding all overpayments together and subtracting all underpayments, and is the difference between the amount authorized and the correct payment authorization amount.

B. Type.--Enter the number which corresponds to the type of the net dollar error finding.

1. No Net Dollar Error.--Enter the number one if overpayments and underpayments cancelled each other to result in no dollars being authorized in error.

2. Total Dollar Error.--Enter the number two if the net amount of all dollar errors results in an overpayment in the full amount of the payment authorization (item 16).

3. Overpayment.--Enter the number three if the net amount of all dollar errors results in an overpayment but not in a total dollar error.

4. Underpayment.--Enter the number four if the net amount of all dollar errors results in an underpayment.

SECTION IV - OPTIONAL USE CODES

This section is provided for optional State use.

SECTION V - RE-REVIEW FINDINGS

Do not complete this section. It is for Federal regional office re-review purposes only.

THIS PAGE RESERVED FOR

CLAIMS PROCESSING ASSESSMENT SYSTEM REVIEW SCHEDULE

11606. ALTERNATE SYSTEM

The purpose of the alternate system is to allow States not required to perform a mandatory system to determine the type of claims processing quality control system they feel will best serve their needs.

Alternate systems may take many forms. These systems may involve computerized reviews of the entire claims file, reviews which focus upon certain claims strata or aspects of the claims processing, and other subsystems, etc.

Alternate systems must be able to:

1. Identify deficiencies in the claims processing,
2. measure the cost of deficiencies,
3. provide data to determine appropriate corrective action,
4. provide an overall assessment of the State's claims or that of its fiscal agent,
5. provide for a claim-by-claim review where justifiable by data, and
6. produce an audit trail that can be reviewed by HCFA or an outside auditor.

Each State which qualifies to operate an alternate system must submit a plan to the HCFA regional office detailing how their system will operate and what data is to be generated from their system. No specific format is required for the submission of this plan. States must receive prior approval before implementing an alternate system.

Reporting Requirements.--States operating alternate systems must provide an annual report of the results of their CP assessment to the HCFA-RO no later than August 31. Detail the methodology employed in determining errors and include descriptions of errors. Deficiencies discovered in the CP system and actions taken to correct deficiencies must also be detailed.

Deficiencies in claims processing operations are:

1. Payment for incorrect, inconsistent, or incomplete claims;
2. errors which result in incorrect, inconsistent or incomplete data entries;
3. payment to a provider not eligible to participate in the program;
4. payment for a service furnished to an ineligible individual;
5. payment for services not authorized by regulation or policy;
6. payment above allowable charges or costs;
7. payment for which an individual was responsible; and
8. duplicate payment.

11607. CPAS PLAN

The CPAS plan is utilized by all States participating in the Medicaid program. The plan includes varying types of information depending upon the type of claims processing review system the State operates. Each plan will be subject to prior HCFA approval before implementation.

For States required to implement a mandatory system, the plan is a sampling plan detailing the type of statistical sampling methodology and types of claims that are sampled. States that elect to operate a superior system or States operating an alternate system are required to submit a plan which details the type of CPAS that they operate. At a minimum, each superior system must meet the criteria outlined in §11604. Each State operating an alternate system must meet the criteria outlined in §11606.

States are required to submit its CPAS plan to the HCFA-RO at least 60 days prior to the beginning of the fiscal year or prior to the implementation date if their CPAS is being changed. Extensions of up to 30 days may be approved by the HCFA-RO if the State cannot complete the plan timely. If the State obtains an extension, the HCFA-RO may require the State to make changes to its CPAS plan with 90 days after it is submitted, even if it is made after the CPAS implementation date.

11608. GENERAL REQUIREMENTS FOR MANDATORY SYSTEM SAMPLE SELECTION

The CP review involves a sample review of all Medicaid line items authorized for payment conducted over two 6-month cycles. Each sample period represents one-half of a fiscal year, from October 1 through March 31 and April 1 through September 30. The line item sample is comprised of monthly sample selections from each month's universe of authorized line items. Review of the selected line items is conducted according to the instructions outlined in §11606. Note that the CP sample is not stratified by eligibility category as is the eligibility sample.

A. Sample Unit.--The sample unit for the CP quality control (QC) sample is an individual line item on an invoice for which the State has authorized payment within the specified payment sample month. Payment authorization is the final act of approval for payment, subsequent to all editing and prior to, or coincident with, the actual associated check issuance. A line item is defined as the most detailed claim breakdown at which payment adjudication is determined. For example, for hospitals which bill on a per diem rate, the line item is the total for an individual's services even if dollar amounts are shown for each service. If the State allows ancillary charges to a per diem-based bill, each ancillary service is a separate line item and subject to sample selection. The only exception to the basic line item definition is where billing covers more than one

individual. In this instance, sampling must always be specific by individual. Line items which cover services over more than one month are subject to selection in the month they are authorized for payment. Adjustments are subject to sampling the month they are authorized for payment. Adjustments are sampled as units authorized for payment but are reviewed for their net amount. Line item adjustments made by cancelling a previous payment authorization (or debiting a provider's account) and then repaying in the adjusted total amount to the same provider are sampled as one net adjustment. Adjustments resulting in negative payment amounts are also included in the sampling frame.

Note that the above definition does not differentiate between hard copy, tape to tape, and other automated billing formats. All claims, once authorized for payment, are included in the appropriate sampling frame regardless of their original form.

B. Sample Sizes.--Minimum numbers of line items for which reviews must be completed have been established for each State. These requirements are the basis for determining the actual number of selected line items. The actual number of sample line items to be selected depends on the expected number of noncompleted reviews.

For States with exceptionally small universes of line items, HCFA will consider reducing the minimum sample size. This reduction will be limited to the effect of the finite population correction factor. States must request this reduction in their initial sampling plan submittal.

C. Populations To Be Sampled.--The line item universe is comprised of all Medicaid line items authorized for payment by the State agency during a month. The CP line item sample may be stratified based on different provider types. This stratification allows for an improved allocation of review effort based on the dollars at risk in that stratum. These line items are sampled from the following stratified sampling frames, but States may elect to not utilize all of these types in their system.

1. Billings for Inpatient Hospital Services.
2. Billings for Long-Term Care Services.
3. Billings From Other Individual Practitioners, Clinics/Separate Billings for Services and Supplies.
4. Separately Billed Prescribed Drugs.

States must divide their claims population into at least two strata, one of which must be comprised of all claims types not included in the other strata. Claims should be stratified by dollar amount; i.e., high dollar claims in one strata, low dollar claims in the other.

D. Sampling Frames.--The sampling frames for the prescribed sample universe are all Medicaid line items authorized for payment. This universe of line items may contain line items which relate to non-Medicaid programs. Exclude these line items from the

sample results. This may be accomplished by dropping the review of the non-Medicaid line items or by removing these line items from the sampling frame prior to sampling. If line items are removed from the sampling frame based on specific State provider or service codes, take care to ensure that ALL line items bearing that coded designation are not in the population of interest.

Where there is any doubt about the exclusion of a specific code, leave it in the sampling frame, and drop inappropriately sampled line items during the review process.

The line item universe is stratified prior to sampling, and stratification may be based solely on the type of provider which submits the bill. For example, a line item for a lab fee billed by an inpatient hospital is sampled in the inpatient hospital stratum. A lab fee billed by an independent lab is included in the other individual practitioner's stratum. States for which the prescribed strata are inefficient or involve sampling hardships may restructure the strata to suit the State's needs. The criteria the proposed alternative stratification must meet are a minimum of two strata structured to group homogeneous line item payment amounts and a satisfactory stratification rationale is given in the sampling plan. The specific line item provider type strata are defined to be the following. The number following the provider type description is the CFR reference.

E. Provider Type Strata.

100 Series - Hospital Services:

101. Billings for Inpatient Hospital Services Other Than Services for TB or Mental Diseases-440.10.

200 Series - Long-Term Care Services

201. Skilled nursing facility for individuals age 21 or older other than services in an institution for TB or mental diseases-440.40(a);

202. inpatient hospital services for individuals age 65 or older in institutions for TB or mental diseases-440.140(a);

203. skilled nursing facility services for individuals age 65 or older in institution for TB or mental diseases-440.140(b);

204. intermediate care facility services for individuals age 65 or older in institutions for TB or mental diseases-440.140(c);

205. intermediate care facility services other than in an institution for TB or mental diseases-440.150;

206. inpatient psychiatric services for individuals under age 21-440.160;

207. services in Christian Science sanatoriums-440.170(c);

208. skilled nursing facility services for individuals under age 21-440.170(d); and

209. services furnished during the month admitted to a public institution or an institution for TB or mental diseases-435.1008(b).

300 Series - Other Individual Practitioners, Clinics/Separate Services and Supplies:

301. Outpatient hospital services-440.20(a);

302. rural health clinic services-440.20(b);

303. physicians' services-440.50;

304. medical or other remedial care provided by licensed practitioners-440.60;

305. clinic services-440.90;

306. EPSDT-440.40(b);

307. other laboratory and X-ray services-440.30;

308. home health services-440.70;

309. private duty nursing services 440.80;

310. dentures, prosthetic devices, and eyeglasses-440.120(b), (c), and (d);

311. diagnostic services-440.130(a);

312. screening services-440.130(b);

313. preventive services-440.130(c);

314. rehabilitation services-440.130(d);

315. transportation-440.170(a);

316. services of Christian Science nurses-440.170(b);

317. personal care services in a recipient's home-440.170(f);

318. PT, OT, and other individual services-440.110;

319. dental services-440.100;

320. emergency hospital services-440.170(e); and

321. other care-440.170.

400 Series - Prescribed Drugs:

401. Separately Billed Prescribed Drugs-440.120(a).

The above strata are consistent with the reporting strata for the HCFA-120 report. The correspondence between the above strata and the HCFA-120 service type codes in the appendix of the report instructions are:

1. Inpatient hospital - HCFA-120 service type 1;
2. long-term care - HCFA-120 service types 2 through 7;
3. other - HCFA-120 service types 8 through 15 and 17 through 20; and
4. prescribed drugs - HCFA-120 service type 16.

It is assumed that for those States stratifying by provider type most States will choose to partition the line item universe into provider type strata based on provider type codes contained in the line item records. Where this is done, the State must document that the provider type codes on the sampling frame records accurately reflect the correct provider stratum. To demonstrate this, the State must conduct a sample study the first time a sampling frame is used, and submit summarized results to the HCFA RO for review. To demonstrate the accuracy of the provider codes the State must select a random sample of 750 line items authorized for payment from the total authorized line item file. For each line item the State must match the provider type code on the authorized line item file to the provider type on the original source document; e.g., hard copy, tape to tape facsimile. In order for States to use the provider type codes in partitioning the sampling frame, 735 of the 750 sample line items must be coded within the proper stratum. For States which fail to meet this tolerance, the HCFA-RO in consultation with HCFA-CO will negotiate with the State to determine an acceptable sampling plan.

F. Summary of Line Items Excluded From the Sample.--The line item CP QC sample is restricted to the universe of Medicaid line items authorized for payment. Examples of line items excluded from the sampling frame are:

1. Line items authorized for payment by non-Medicaid or nonmatched programs; e.g., payments for individuals eligible only for programs fully funded by the State;

2. non-Medicaid payments for noncovered services;

3. payments for 100 percent federally funded programs; and

4. end-of-year institutional cost settlements.

G. Sample Selection.--Systematic or simple random sampling is recommended for selection of the CP QC sample. The individual stratum line item samples are selected from the stratified sampling frames. It may be advantageous to the State to use different sampling methodologies in the various strata. This is acceptable provided that the methodologies are clearly outlined in the sampling plan for each stratum.

Sample selection must be performed on a complete sampling frame. It is essential that all updates to the line item files for the sample month are incorporated to ensure inclusion in the sampling frame of all line items authorized for payment in the State's specified sample month. Sampling may be conducted on complete lists at the end of the sample month or during the month as CP runs are made.

The State must submit a list of all sampled line items to the HCFA-RO prior to the assignment of those line items to review staff. This list must include all sampled items,

their claims identification numbers, their State-specified QC review numbers, and the authorized payment amount. For sampled adjustments, the listed amount may be either the gross or net amount of the adjustment. However, the net amount is subjected to review.

11608.1 Requirements for Sampling Plan Documentation.--Each State's CP QC sample must be selected in accordance with a sampling plan approved by the HCFA-RO. This sampling plan is separate from that submitted for the eligibility case sample. Before implementation of a sampling methodology the State must submit for HCFA-RO approval specific documentation of the sampling plan to be employed. It must describe each of the following proposed sample characteristics:

1. The universe of line items to be sampled;

2. the list(s) from which the sample is selected;

3. the sample sizes; and

4. the sample selection procedures.

Each of the above characteristics must be described in detail for each stratum in the line item sample. Declarations of compliance with sections of this manual in the sampling plan are not acceptable.

Any proposed revisions to the sample design must be documented in a revised sampling plan. The revised plan must be submitted to the HCFA-RO for review and approval prior to its implementation. Approved sampling plans remain in effect for the entire 6-month period unless circumstances beyond the State's QC unit control make this impossible. Any such situation must be documented by the State and the necessary changes approved by both the HCFA-RO and HCFA-CO.

Basic sampling plans must be submitted to the HCFA-RO 60 days prior to the corresponding review period. Detailed universe estimates and sampling intervals must be submitted at least 2 weeks prior to the first sample selection of the period. States must submit a basic sampling plan only when a revision to the most recent approved plan is proposed. Detailed universe estimates and interval calculations must be resubmitted for each sample period. The HCFA-RO determines the adequacy of the sample size. The claims processing and eligibility sampling plans are reviewed and approved by the HCFA-RO independently of each other.

A. Line Item Universe To Be Sampled.--The sampling plan must describe in detail the lists from which the CP QC sample is selected. It is expected that the sampling

frame lists will be partitioned subsets of the file of all line items authorized for payment. The sampling frame lists for line items may consist of a subset from a processed line item list or any other appropriate source. Regardless of the source of each sampling frame, the sampling plan must explicitly describe the following characteristics of the sample selection lists for each line item stratum:

1. Source;

2. the types of line items on the lists;

3. the accuracy and completeness of the lists in regard to the particular stratum;

4. whether the list is complete or is formed by merging a number of lists;

5. the physical form of the lists (e.g., computerized master file, local computer files, hard copy);

6. the frequency of and length of delay in updating the sample frame lists of line items;

7. the number of line items authorized for payment on the lists and an estimate of the proportion of listed-in-error items;

8. methods used to delete unwanted items from the lists; and

9. whether the lists are made up of line items or invoices and the method employed to create a line item list, if applicable.

States are permitted to specify a sample month other than the calendar month if their recording and payment procedures operate on another fixed monthly cycle. This sample month must be specified in the sampling plan and can vary by no more than 15 days from the calendar month. It must be documented that this revised sample month is based on an existing State reporting or processing cycle. A desire to begin sample reviews at an earlier date is not an acceptable justification.

B. Sample Size.--The basic sample sizes (i.e., the minimum number of reviews to be completed) for the 6-month review period are specified in appendix B for each State. States may reallocate the required total sample size among strata based on desired areas of concentration. The plan must specify for each stratum and substratum the expected number of claims selected, listed in error, and completed, and must include a justification of non-prescribed sample sizes or allocations.

States with exceptionally small universes may request a reduction in the minimum required sample size due to the effect of the Finite Population Correction (FPC) factor. This request must include documentation of universe estimates by stratum. The final decision on reducing a required minimum sample size will be made by HCFA-CO based on a verification of the FPC effect.

C. Sample Selection Procedures.--The procedures used in selecting the sample line items must be described in detail in the sampling plan for each (sub)stratum. These procedures must conform to the guidelines and procedures in §11608.2. If the sampling frame for a stratum is comprised of more than one list, the sampling methodology for each list must be defined. Different sampling methodologies may be used in different strata providing they are all documented properly and approved by HCFA-CO.

Alternative sampling plans which provide a valid statistical sample will be considered for approval. The major criteria that nonprescribed methodologies must meet is that the methodology provides precision of estimates equivalent to a simple random sample. The variance equivalence which must be demonstrated applies to the payment CP error rate across all strata. The variance equivalence of a nonstandard methodology must be demonstrated in the sampling plan submittal.

Although it is recognized that the prescribed systematic sample is technically a cluster sample with a potentially larger variance than a random sample, the increase in variance is in standard practice assumed to be negligible. The benefit of any alternative sampling method should be to gain information or to make sampling more practical. Therefore, the intent of the variance equivalence requirement is to preclude the acceptance of alternate sampling plans which produce unreliable estimates.

11608.2 Selection of Systematic and Simple Random Samples.--It is recommended that States use either systematic or simple random sampling for selecting sample line items from the stratum sampling frames. Systematic sampling is the preferred method for CP QC purposes. It provides a pattern of selection of individual line items from the sampling frame list at equally spaced intervals, with the starting point being determined by random selection.

A systematic sample is self-weighing across months if the same sampling interval is used throughout a review period. It is important that line items with similar probabilities of error are not placed at equally spaced intervals. Otherwise, a systematic sample will not yield a truly random sample. The pattern of line items on the sampling frame list must be random with respect to error likelihood.

Simple random sampling, or other more complex sampling methodologies, will in most cases be more difficult to administer than a systematic sample. In simple random

sampling each line item on the sample selection list is assigned a unique identifying number. Numbers are then selected by some random process and the corresponding line item on the sampling frame list included in the sample.

The following steps in sections A and B describe the steps involved in selecting a systematic line item sample. These steps are applied independently to the sampling frame lists for each (sub)stratum. Note that the steps in section A relate to calculation of a sampling interval and are performed only at the beginning of each period. The steps in section B outline the sample selection procedures for authorized line items and are performed monthly.

A. Calculation of the Sampling Interval.--Employ the following steps to calculate the systematic sampling interval at the beginning of each period. This step sequence is followed separately for each (sub)stratum.

Step A - Estimate the Average Monthly Sample Frame Size

The average monthly sample frame size is an estimate of the average number of line items contained on the list which is subject to sampling during each month of the 6-month review period. The monthly sampling frame size may be expected to vary. In estimating the average monthly sampling frame size, consider any known circumstances, such as policy changes, that would appreciably affect the size.

Step B - Determine the Number of Required Completed Line Item Reviews

Appendix B contains the minimum number of completed reviews required for each 6-month review period. If a State wishes, it may increase the number of completed reviews.

Step C - Estimate the Average Number of Reviews To Be Completed Monthly

The average number of reviews to be completed monthly is calculated by dividing the number of required completed line item reviews for the 6-month review period (step B) by six.

Step D - Estimate the Proportion of Line Items Listed in Error

Listed-in-error line items are line items included in the sample selection list which are not in the population of interest (e.g., line items for totally State-funded programs). The estimate reflects the true proportion for the entire 6-month period.

Step E - Calculate the sampling interval using the following formula where:

X - average monthly sample frame size (step A);

Y - average number of reviews to be completed monthly (step C);

Z - proportion of line items listed in error (step D);
sampling interval (I) = X x (1-Z) /Y.

Unless a correction for undersampling or excessive oversampling is necessary (refer to §11608.3), the same sampling interval must be applied in each month of the 6-month review period. This sampling interval is always rounded down to the next lower integer (e.g., 25.67 becomes 25).

As an example assume that:

1. The average monthly sample frame size (X) is 11,000;

2. the average number of reviews to be completed monthly (Y) is 100; and

3. the proportion of line items listed in error (Z) is 5/100 (or .05).

The sampling interval (I) is:

I = 11,000 X .95/100 = 104.5;
rounded down to 104.

The number of line items selected for a review month must exceed the number of sample line items required in order to compensate for dropped reviews due to selected line items which are not in the population of interest (listed in error). The sample of line items reviewed includes only the line items selected that are in the population of interest.

B. Selection of Line Items for the Review Month.--The selection of line items for the review month consists of three steps. These are repeated for each month of the review period using the same sampling interval. These steps are performed independently for each (sub)stratum.

Step F - Make Any Necessary Adjustment in the Sampling Interval for Undersampling or Excessive Oversampling

Undersampling (or excessive oversampling) exists when the actual number of completed line item reviews is below (or significantly above) the required number. Undersampling must be corrected to achieve the minimum sample size. Excessive oversampling may be reduced at State option so that actual sample sizes will be closer to the minimum required sample sizes. Detailed procedures for correction are in §11608.3. The new sampling interval calculated as part of these procedures is used in selecting sample line items for the review month.

Step G - Select a Random Start

The random start, j, is an integer between one and the sampling interval, I, inclusive. This number is selected randomly (usually using a table of random numbers).

Step H - Select Sample Line Items

The first line item selected is the j'th line item (random start number) on the sample selection list. Every I'th (sampling interval) entry following the j'th line item on the sample selection list is chosen as part of the monthly sample. Thus, if the random start is 28 and the sampling interval is 104, the 28'th, 132'nd, 236'th, 340'th, etc., entries on the sample selection list are selected for the sample. (Note that only the line items selected must be reviewed in the sample. If line item 132 is selected, reviewing line item 131 or 133 is not acceptable.) The process of selection continues in this fashion until the end of the list is reached.

11608.3 Procedures for Correcting the Monthly Sample for Excessive Oversampling and Undersampling.--Note that undersampling (completion of fewer line items than required) must be corrected using the procedures outlined. Correcting for oversampling is a State option. Alternative methods, most of which will result in excessively stratified estimates, must be approved by both the HCFA regional and central offices. Adoption of even the prescribed procedures must be approved by the HCFA RO prior to implementation. The correction procedures adopted must be applied independently to the over/undersampled stratum/substratum.

A. Correcting for Excessive Oversampling.--Oversampling is a normal part of the sampling operation which compensates for unidentifiable but anticipated "not reviewed" line items. However, the State may find that it has oversampled more than necessary. This can be due to such factors as a larger allowance made for anticipated "not reviewed" line items than were found, or to an underestimated line item universe size for the reporting period resulting in the use of a smaller than necessary sampling interval.

If a State wishes to reduce this sample, the recommended method to correct for oversampling to produce unbiased estimates without resorting to complex weighing procedures is:

1. Using the methods described in §11608.2 A, recompute the sampling interval for the reporting period using revised estimates of the sample frame size and/or the fraction of reviews to be dropped.

For each month in which sample line items have already been selected:

2. Compute a revised estimate of the number of sample line items which should have been selected in the preceding months of the sampling period as follows:

Revised estimate of the number of sample line items for the month	=	(Monthly Sample) Selection List Size/Revised Sampling Interval

3. Subtract the number of line items obtained in step 2 from the number of sample line items that have been selected. This is the number of line items to be eliminated (regardless of whether the review has been initiated or not).

4. Divide the number of sample line items that have already been selected by the number of line items to be eliminated (obtained in step 3) to obtain the secondary sampling interval to be used in identifying the specific line items to be eliminated.

5. Use a random start and apply the secondary sampling interval obtained in step 4 to select line items from the list of sample line items already selected. Eliminate the line items identified.

For months for which sample line items have not yet been selected:

6. Use the corrected sampling interval for the reporting period obtained in step 1 to select sample line items from the monthly frames.

B. Correcting for Undersampling.--Undersampling generally occurs if the number of "not reviewed" line items is greater than expected or the estimate of the line item universe for the reporting period is too high. When such misestimation occurs, a larger sampling interval than appropriate is used, resulting in a sample which does not meet minimum requirements.

The recommended method for correcting undersampling in order to produce unbiased estimates without resorting to complex weighing procedures is:

1. Using the methods described in §11608.3A, recompute the correct sampling interval for the entire reporting period using revised estimates of the sample frame size and/or the fraction of reviews to be dropped.

For each month in which sample line items have already been selected:

2. Compute a revised estimate of the number of sample line items which should have been selected in the month as follows:

Revised estimate of the number of sample line items for the month	=	Monthly Sample Selection List Size/Revised Sampling Interval

3. Subtract the number of line items that have already been selected from the number obtained in step 2. This is the number of additional line items to be selected from the monthly frame.

4. Divide the total monthly sampling frame size by the number identified in step 3 to obtain the secondary sampling interval to be used in identifying the additional line items to be selected from the monthly sampling frame.

5. Use a random start and apply the secondary sampling interval calculated in step 4 to the monthly sampling frame from which line items have already been selected. Add the specific line items identified to the line items selected and reviewed for the same month as the month of the sampling frame from which it was selected. (If a line item that has been previously selected in the sample is identified, select an alternate line item by using a table of random numbers.) This procedure oversamples for line items that are listed in error. Discard line items that are selected which are listed in error.

For months for which sample line items have not yet been selected:

6. Use the corrected sampling interval for the reporting period obtained in step 1 to select sample line items from the monthly frames.

C. Guidelines for Expanded and Substratified Samples.--A State may choose to modify the basic sample requirements by expanding the size of the sample (i.e., increasing the number of line items to be reviewed) or by further dividing the sample into strata representing homogeneous subgroups of the population at interest. Note that the basic CP QC sample design for the line item sample is already stratified. The following sections presents guidelines that a State must use if it chooses to substratify the CP QC sample.

D. Guidelines for Expanding the Sample Size.--States may choose to increase the number of completed reviews beyond the minimum numbers specified; however, the following guidelines must be adhered to:

1. If additional line items are selected across the entire spectrum of one of the State CP QC strata in accordance with the State sampling plan, the additional line items are to be considered as part of the CP QC sample. All reports submitted are to include these line items and associated review information.

2. If the additional line items come only from a particular segment of one of the populations (e.g., a specific provider or specific counties) they may, at State option, not be considered as part of the CP QC sample and may be excluded from reports to HCFA-CO. However, the sampling plan submitted to the HCFA-RO must identify this segment of line items and when the sample from the segment is selected, appropriate controls must be applied to separate those line items from the rest of the line items included in the CP QC process. If these line items are included in reports to HCFA, they must be weighted in accordance with the rules specified by HCFA. If these additional line items are selected with a different sampling methodology, they are to be excluded from reports to HCFA.

Note that any planned expansions in the sample size must be explained in detail in the sampling plan documentation submitted to HCFA-RO for approval.

E. Guidelines for Further Stratifications.--The basic CP QC sample design suggests that the Medicaid population in a State be sampled in groups stratified as follows:

1. CP QC sample strata:

   a. - inpatient hospital;

   b. - long-term care;

   c. - other individual practitioners, clinics/services, and supplies; and

   d. - drugs.

A State may choose to further stratify into substrata. The State is encouraged to substratify the sample to best suit the State's needs. For example, a State may divide its inpatient hospital strata into drugs and other. Other beneficial stratification may include specific geographic breakdowns of providers.

In substratifying the sample, a State must comply with the following:

1. There can be no more than three substrata in each stratum; and

2. there cannot be fewer than 50 completed line item reviews per substratum for the 6-month review period.

11609. DOCUMENTATION SOURCE SHEET

A documentation source sheet is optional but recommended for all errors recorded. This sheet provides for the recording of information related to procedural errors, development, and whether procedural errors found resulted in a dollar error.

A. Nature Code.--Nature error code is the applicable code(s) selected from the Error Category Profile. More than one error code may be entered on the documentation source sheet.

B. Support Document.--The descriptive title of each supporting document should be entered in this data element. If more than one support document is required to substantiate the error code entered, each support document should be entered on a separate line. The following are examples of supporting documents:

1. Recipient Eligibility Listing
2. Provider Eligibility Listing
3. Procedure Fee Schedule
4. Prior Authorization Form
5. Exception Processing Log
6. Provider Billing Manual
7. Manual Citation

C. Document Location.--This data element should contain the name of the agency which is custodian of the document as well as the document's physical location. The location should include any specific retrieval file, page, or other reference number.

D. Effective Date.--Provide the date that identifies the supporting document's applicability to the adjudication process.

E. Remarks.--Enter explanatory notes that support the error cited.

THIS PAGE RESERVED FOR

CP DOCUMENTATION SOURCE SHEET

11610. CONTENTS OF THE STATE CPAS FILE

The State must supply or make available all the information and documentation necessary to conduct the Federal re-review of State CP findings. Each completed State review file should contain the following documentation:

1. Documentation of the claims payment authorization amount;
2. a copy of the provider invoice or provider invoice information;
3. provider certification documentation;
4. recipient eligibility certification documentation;
5. paid claim history information pertinent to the review findings;
6. documentation of any required medical judgment certifications;
7. a documentation source sheet if utilized;
8. permissible State practice references which bear on the review findings and which the reviewer deems necessary for clarification;
9. CPAS Review Schedule; and
10. explanation and documentation required to support review findings.

In addition, the State must have, or have available:

11. Certified provider listing and recipient eligibility files;
12. permissible State practice which defines allowed services, frequency limitations, and any other pertinent program requirements;
13. fee schedules, reimbursement tables, and other information on allowable payments to groups and individual providers; and
14. listing of covered services.

11611. CPAS CORRECTIVE ACTION

CPAS corrective action (CA) involves a full range of State initiated activities designed to eliminate errors in State claims processing and misspent Federal funds resulting from these errors.

All State agencies are required to submit a comprehensive corrective action plan to the HCFA-RO which provides an analysis of CPAS findings and detail State efforts to remedy deficiencies discovered in its claims processing. Each plan must address CP errors discovered subsequent to the period covered by the previous corrective action plan. The plan is to be submitted to the HCFA-RO by August 31 of each year as a part of the State's annual CPAS report.

The State agency must prepare the CA plan in three major steps.

A. Identification of Errors and Causes.--This section summarizes State CPAS data and analyzes the major concentrations of errors. It also reports the results of any special studies used to obtain additional information on the identification of errors and related causes. Finally it includes a statement of the cause of each major concentration of errors.

B. Planned Corrective Action.--Section two details CA planned or implemented. This includes a description of CA selected for each identified cause of error and the overall implementation schedule for each action showing the major task to be conducted. In addition, list the specific dates for the completion of key tasks, along with all tasks and milestones for all affected agency and administrative components. Identify all anticipated results, costs, and time schedule of the CA.

C. Evaluation of Results of Planned CA Previously Reported.--This section describes the proposed method of evaluating the CA effectiveness and source and method of evaluation and assembling data.

STATE CODES

ALABAMA	AL	01
ALASKA	AK	02
ARIZONA	AZ	04
ARKANSAS	AR	05
CALIFORNIA	CA	06
COLORADO	CO	08
CONNECTICUT	CT	09
DELAWARE	DE	10
DIST. OF COLUMBIA	DC	11
FLORIDA	FL	12
GEORGIA	GA	13
HAWAII	HI	15
IDAHO	ID	16
ILLINOIS	IL	17
INDIANA	IN	18
IOWA	IA	19
KANSAS	KS	20
KENTUCKY	KY	21
LOUISIANA	LA	22
MAINE	ME	23
MARYLAND	MD	24
MASSACHUSETTS	MA	25
MICHIGAN	MI	26
MINNESOTA	MN	27
MISSISSIPPI	MS	28
MISSOURI	MO	29
MONTANA	MT	30
NEBRASKA	NE	31
NEVADA	NV	32
NEW HAMPSHIRE	NH	33
NEW JERSEY	NJ	34
NEW MEXICO	NM	35
NEW YORK	NY	36
NORTH CAROLINA	NC	37
NORTH DAKOTA	ND	38
OHIO	OH	39
OKLAHOMA	OK	40
OREGON	OR	41
PENNSYLVANIA	PA	42
PUERTO RICO	PR	72
RHODE ISLAND	RI	44
SOUTH CAROLINA	SC	45
SOUTH DAKOTA	SD	46
TENNESSEE	TN	47
TEXAS	TX	48
UTAH	UT	49
VERMONT	VT	50
VIRGINIA	VA	51
VIRGIN ISLANDS	VI	78
WASHINGTON	WA	53
WEST VIRGINIA	WV	54
WISCONSIN	WI	55
WYOMING	WY	56
GUAM	GU	66

ANNUAL SAMPLE SIZES
(USE 1/2 for 6-Month Period.)

Region I

Connecticut	6,000
Maine	4,200
Massachusetts	10,400
New Hampshire	2,600
Rhode Island	4,200
Vermont	2,600

Region II

New Jersey	10,400
New York	10,400
Puerto Rico	4,200
Virgin Islands	2,600

Region III

Delaware	2,600
District of Columbia	4,200
Maryland	8,100
Pennsylvania	10,400
Virginia	8,100
West Virginia	4,200

Region IV

Alabama	6,000
Florida	8,100
Georgia	8,100
Kentucky	6,000
Mississippi	4,200
North Carolina	8,100
South Carolina	6,000
Tennessee	8,100

Region V

Illinois	10,400
Indiana	8,100
Michigan	10,400
Minnesota	8,100
Ohio	10,400
Wisconsin	10,400

ANNUAL SAMPLE SIZES
(USE 1/2 for 6-Month Period.)

Region VI	
Arkansas	6,000
Louisiana	8,100
New Mexico	4,200
Oklahoma	6,000
Texas	10,400
Region VII	
Iowa	6,000
Kansas	6,000
Missouri	6,000
Nebraska	4,200
Region VIII	
Colorado	4,200
Montana	2,600
North Dakota	2,600
South Dakota	2,600
Utah	2,600
Wyoming	2,600
Region IX	
Arizona	--------
California	10,400
Guam	2,600
Hawaii	4,200
Nevada	2,600
Region X	
Alaska	2,600
Idaho	2,600
Oregon	6,000
Washington	8,100

LEGAL BACKGROUND AND AUTHORITY

Title XIX of the Social Security Act, specifically Section 1903(a)(3) as provided by Section 235 of Public Law 92-603, enacted October 30, 1972, and amended by Section 10 of Public Law 95-142, enacted October 25, 1977 and Section 1903(r) as provided by Section 901 of Public Law 96-398, enacted October 7, 1980, and amended by section 9503 (b) of Public Law 99-272, enacted April 7, 1986.

TITLE XIX--GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

Payment to States

Sec. 1903(a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966 -

(3) an amount equal to

(A)

(i) 90 percentum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of Title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title, and

(B) 75 percentum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; plus 1/

(C) 75 percentum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of medical and utilization review by a Utilization Review and Quality Control Peer Review Organization under a contract entered into under 1902(d); plus 2/

1/ Subparagraph (B) was amended by sec. 10 of P.L. 95-142.

2/ Subparagraph (C) was added by 1981 OBRA and amended by PL 97-248 1982 TEFRA

TITLE IX - MECHANIZED CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

MECHANIZED CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

Section 1903 of the Social Security Act was amended, by Public Law 96-398, section 901, by adding the following new subsection:

(r)

(1)

(A) In order to receive payments under paragraphs (2) and (7) of subsection (a) without being subject to percentum reductions set forth in subparagraph (C) of this paragraph, a State must provide that mechanized claims processing and information retrieval systems of the type described in subsection (a)(3)(B) and detailed in an advance planning document approved by the Secretary are operational on or before the deadline established under subparagraph (B).

(B) The deadline for operation of such systems for a State is September 30, 1985.

(C) If a State fails to meet the deadline established under subparagraph (B), the percentums specified in paragraphs (2) and (7) of subsection (a) with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning on or after such deadline, and shall be further reduced by an additional 5 percentage points after each period consisting of two quarters during which the Secretary determines the State fails to meet the requirements of subparagraph (A); except that --

(i) neither such percentum may be reduced by more than 25 percentage points by reason of this paragraph; and

(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State meets the requirements of subparagraph (A).

(2)

(A) In order to receive payments under paragraphs (2) and (7) of subsection (a) without being subject to the percentum reductions set forth in subparagraph (C) of this paragraph, a State must have its mechanized claims processing and information retrieval systems, of the type required to be operational under paragraph (1), initially approved by the Secretary in accordance with paragraph (5)(A) on or before the deadline established under subparagraph (B).

(B) The deadline for approval of such systems for a State is the last day of the fourth quarter that begins after the date on which the Secretary determines that such systems became operational as required under paragraph (1).

(C) If a State fails to meet the deadline established under subparagraph (B), the percentum specified in paragraphs (2) and (7) of subsection (a) with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning after such deadline, and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters during which the State fails to meet the requirements of subparagraph (A); except that --

(i) neither such percentum may be reduced by more than 25 percentage points by reason of this paragraph; and

(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State's systems are approved by the Secretary as provided in subparagraph (A).

(D) Any State's systems which are approved by the Secretary for purposes of subsection (a)(3)(B) on or before the date of the enactment of this subsection shall be deemed to be initially approved for purposes of this subsection.

(3)

(A) When a State's systems are initially approved, the 75 percentum Federal matching provided in subsection (a)(3)(B) shall become effective with respect to such systems, retroactive to the first quarter beginning after the date on which such systems became operational as required under paragraph (1), except as provided in subparagraph (B).

(B) In the case of any State which was subject to a percentum reduction under paragraph (2), the percentum specified in subsection (a)(3)(B) shall be reduced by 5 percentage points for the first two quarters beginning after the deadline established under paragraph (2)(B), and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters beginning after such deadline and before the date on which such systems are initially approved, except that no reduction shall be made under this paragraph for any quarter following the quarter during which the State's systems are initially approved by the Secretary.

(4)

(A) The Secretary shall review all approved systems not less often than once every three years, and shall reapprove or disapprove any such systems. Systems which fail to meet the current performance standards, system requirements, and any other conditions for approval developed by

the Secretary under paragraph (6) shall be disapproved. Any State having systems which are so disapproved shall be subject to a percentum reduction under subparagraph (B). The Secretary shall make the determination of reapproval or disapproval and so notify the States not later than the end of the first quarter following the review period. Reviews may, at the Secretary's discretion, constitute reviews of the entire system or of only those standards, system requirements, and other conditions which have demonstrated weakness in previous reviews.

(B) If the Secretary disapproves a State's systems under subparagraph (A), the Secretary shall, with respect to such State for quarters beginning after the determination of disapproval and before the first quarter beginning after such systems are reapproved, reduce the percentum specified in subsection (a)(3)(B) to a percentum of not less than 50 percentum and not more than 70 percentum as the Secretary determines to be appropriate and commensurate with the nature of noncompliance by such State; except that such percentum may not be reduced by more than 10 percentage points in any four quarter period by reason of this subparagraph. No State shall be subject to a percentum reduction under this paragraph (i) before the fifth quarter beginning after such State's systems were initially approved, or (ii) on the basis of a review conducted before October 1, 1981.

(C) The Secretary may retroactively waive a percentum reduction imposed under subparagraph (B), if the Secretary determines that the State's systems meet all current performance standards and other requirements for reapproval and that such action would improve the administration of the State's plan under this title, except that no such waiver may extend beyond the four quarters immediately prior to the quarter in which the State's systems are reapproved.

(5)

(A) In order to be initially approved by the Secretary, mechanized claims processing and information retrieval systems must be of type described in subsection (a)(3)(B) and must meet the following requirements:

(i) The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

(ii) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's Medicaid fraud control unit (if any) certified under subsection (q) of this section.

(iii) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary under paragraph (6).

(B) In order to be reapproved by the Secretary, mechanized claims processing and information retrieval systems must meet the requirements of subparagraphs (A)(i) and (A)(ii) and performance standards and other requirements for reapproval developed by the Secretary under paragraph (6).

(6) The Secretary, with respect to State systems, shall --

(A) develop performance standards, system requirements, and other conditions for approval for use in initially approving such State systems, and shall further develop written approval procedures for conducting reviews for initial approval, including specific criteria for assessing systems in operation to insure that all such performance standards and other requirements are met;

(B) by not later than October 1, 1980, develop an initial set of performance standards, system requirements, and other conditions for reapproval for use in reapproving or disapproving State systems, and shall further develop written reapproval procedures for conducting reviews for reapproval, including specific criteria for reassessing systems operations over a period of at least six months during each fiscal year to insure that all such performance standards and other requirements are met on a continuous basis;

(C) provide that reviews for reapproval, conducted before October 1, 1981, shall be for the purpose of developing a systems performance data base and assisting States to improve their systems, and that no percentum reduction shall be made under paragraph (4) on the basis of such a review;

(D) insure that review procedures, performance standards, and other requirements developed under subparagraph (B) are sufficiently flexible to allow for differing administrative needs among the States, and that such procedures, standards, and requirements are of a nature which will permit their use by the States for self-evaluation;

(E) notify all States of proposed procedures, standards, and other requirements at least one quarter prior to the fiscal year in which such procedures, standards, and other requirements will be used for conducting reviews for reapproval;

(F) periodically update the systems performance standards, system requirements, review criteria, objectives, regulations, and guides as the Secretary shall from time-to-time deem appropriate;

(G) provide technical assistance to States in the development and improvement of the systems so as to continually improve the capacity of such systems to effectively detect cases of fraud or abuse;

(H) for the purpose of insuring compatibility between the State systems and the systems utilized in the administration of title XVIII --

(i) develop a uniform identification coding system (to the extent feasible) for providers, other persons receiving payments under the State plans (approved under this title) or under title XVIII, and beneficiaries of medical services under such plans or title;

(ii) provide liaison between States and carriers and intermediaries having agreements under title XVIII to facilitate timely exchange of appropriate data; and

(iii) improve the exchange of data between the States and the Secretary with respect to providers and other persons who have been terminated, suspended, or otherwise sanctioned under a State plan (approved under this title) or under title XVIII.

(I) develop and disseminate clear definitions of those types of reasonable costs relating to State systems which are reimbursable under the provisions of subsection (a)(3) of this section; and

(J) develop and disseminate performance standards for assessing the State's third party collection efforts in accoradance with section 1902(a)(25)(A)(ii).

(7)

(A) The Secretary shall waive the provisions of this subsection with respect to initial operation and approval of mechanized claims processing and information retrieval systems with respect to any State which --

(i) had a 1976 population (as reported by the Bureau of the Census) of less than 1,000,000 and which made total expenditures (including Federal reimbursement) for which Federal financial participation is authorized under this title of less than $100,000,000 in fiscal year 1976 (as reported by such State for such year), or

(ii) is a Commonwealth, or territory or possession, of the United States, if such State reasonably demonstrates, and the Secretary does not formally disagree, that the application of such provisions would not significantly improve the efficiency of the administration of such State's plan under this title.

(B) If the Secretary determines that the application of the provisions described in subparagraph (A) to a State would significantly improve the efficiency of the administration of the State's plan under this title, the Secretary may withdraw the State's waiver under subparagraph (A) and, in such case, the Secretary shall impose a timetable for such State with respect to compliance with the provisions of this subsection and the imposition of percentum reductions. Such timetable shall be comparable to the timetable established under this subsection as to the amount of time allowed such State to comply and the timing of percentum reductions.

(8)

(A) The percentum reductions provided for under this subsection shall not apply to a State for any quarter with respect to which the Secretary determines that such State is unable to comply with the relevant requirements of this subsection --

(i) for good cause (but such a waiver may not be for a period in excess of two quarters), or

(ii) due to circumstances beyond the control of such State

(B) If the Secretary determines under subparagraph (A) that such a reduction will not apply to a State, the Secretary shall report to the Congress on the basis for each such determination and on the modification of all time limitations and deadlines as described in subparagraph (C).

(C) For purposes of determining all time limitations and deadlines imposed under this subsection, any time period during which a State was found under subparagraph (A)(ii) to be unable to comply with requirements of this subsection due to circumstances beyond its control shall not be taken into account, and the Secretary shall modify all such time limitations and deadlines with respect to such State accordingly."

CITATION OF REGULATION

Subpart C - Mechanized Claims Processing and Information Retrieval Systems

Section 433.110 Basis and Purpose.

(a) This subpart implements the following sections of the Act:

(1) Section 1903(a)(3) of the Act, which provides for FFP in State expenditures for the design, development, or installation of mechanized claims processing and information retrieval systems and for the operation of certain systems. Additional HHS regulations and HCFA procedures for implementing these regulations are in 45 CFR Part 74, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

(2) Section 1903(r) of the Act, which--

(i) Requires reductions in FFP otherwise due a State under section 1903(a) if a State fails to meet certain deadlines for operating a mechanized claims processing and information retrieval system or if the system fails to meet certain conditions of approval or conditions of reapproval;

(ii) Requires at least an annual Federal performance review of the mechanized claims processing and information retrieval systems; and

(iii) Allows waivers of conditions of approval, conditions of reapproval, and FFP reductions under certain circumstances.

(b) The requirements under section 1903(r) of the Act do not apply to Puerto Rico, Guam, the Virgin Islands, American Samoa and the Northern Mariana Islands.

Section 433.111 Definitions.

For purposes of this section:

"Advance Planning Document (APD)" means a written plan of action to acquire the proposed system. Content requirements for the APD are in 45 CFR Part 95, Subpart F, and in Part 11 of the State Medicaid Manual (SMM).

"Design" or "system design" means the putting together of new or more efficient automatic data processing system. This includes the use of hardware to the extent necessary for the design phase.

"Development" means the definition of system requirements, detailing of system and program specifications, programming, and testing. This includes the use of hardware to the extent necessary for the development phase.

"Hardware" means automatic equipment used for a mechanized claims processing and information retrieval system. This equipment accepts and stores data, performs calculations and other processing steps, and produces information. Hardware includes:

(1) Electronic digital computers;
(2) Peripheral or auxilary equipment used in support of electronic computers;
(3) Data transmission or communications equipment; and
(4) Data input equipment.

"Improvement" means modification of or addition to an existing operational mechanized claims processing and information retrieval system, which benefits the efficient, economical or effective administration of the State plan.

"Installation" means the integrated testing of programs and subsystems, system conversion, and turnover to operational status. This includes the use of hardware to the extent necessary for the installation phase.

"Mechanized claims processing and information retrieval system" means a system of software and hardware used to process Medicaid claims, and to retrieve and produce utilization and management information about services that is required by the Medicaid agency or Federal Government for administrative and audit purposes.

"Operation" means the automated processing of claims, payments, and reports. "Operation" includes the use of supplies, software, hardware, and personnel directly associated with the functioning of the mechanized system.

"Software" means computer programs, procedures, and associated documentation used to operate the hardware.

Section 433.112 FFP for design, development, installation or improvement of mechanized claims processing and information retrieval systems.

(a) FFP is available at the 90 percent rate in State expenditures for design, development, installation or improvement of a mechanized claims processing and information retrieval system only if the APD is approved by HCFA prior to the State's expenditure of funds for these purposes.

(b) HCFA will approve the system described in the APD if the following conditions are met:

(1) HCFA determines the system is likely to provide more efficient, economical, and effective administration of the State plan.

(2) The system meets the system requirements and performance standards in Part 11 of the State Medicaid Manual, as periodically amended.

(3) The system is compatible with the claims processing and information retrieval systems used in the administration of Medicare for prompt eligibility verification and for processing claims for persons eligible for both programs.

(4) The system supports the data requirements of peer review organizations established under part B of Title XI of the Act.

(5) The State owns any software that is designed, developed, installed or improved with 90 percent FFP.

(6) The Department has a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, or otherwise use and authorize others to use for Federal Government purposes, software, modifications to software, and documentation that is designed, developed, installed or improved with 90 percent FFP.

(7) The costs of the system are determined in accordance with 45 CFR 74.171.

(8) The Medicaid agency agrees in writing to use the system for the period of time specified in the advance planning document approved by the Administrator or for any shorter period of time that the Administrator determines justifies the Federal funds invested.

(9) Medicaid Agency agrees in writing that the information in the system will be safeguarded in accordance with 45 CFR Part 205.50.

Section 433.113 Reduction of FFP for failure to operate a system and obtain initial approval.

(a) Except as waived under section 433.130 or 433.131, FFP will be reduced as specified in paragraph (b) of this section unless the Medicaid agency has in continuous operation a mechanized claims processing and information retrieval system that meets the following conditions:

(1) The APD for the system was approved by HCFA;

(2) The system is operational by the earlier of--

(i) September 30, 1982; or
(ii) The last day of the sixth month following the date specified for operation in the State's most recently approved APD that was submitted before October 7, 1980; and

(3) The system is initially approved by the last day of the fourth quarter that begins after the date the system became operational as determined by HCFA.

(b) HCFA will reduce FFP in expenditures for compensation and training of skilled professional medical personnel and support staff under section 1903(a)(2) of the Act, and for general administration under section 1903(a)(7) of the Act, by the following increments applied separately to those two categories of expenditures:

(1) Five percentage points for the first two quarters beginning after a deadline in paragraph (a) of this section;

(2) An additional five percentage points during each additional two-quarter period, through the quarter in which the the State achieves compliance with the conditions for initial operation or initial approval of an operating system. FFP reductions will not exceed 25 percentage points for each type of reduction.

(c) The amount of FFP (determined under section 1903(a)(3)(B)) that would be available retroactively for operating a system that later receives initial approval will be reduced by HCFA by the same percentage points for the identical periods of time described in subparagraph (b) of this section, until the system is initially approved. No reduction will be made after the first quarter during which the system is initially approved.

Section 433.114 Procedures for obtaining initial approval; notice of decision.

(a) To obtain initial approval, the Medicaid agency must inform HCFA in writing that the system meets the conditions specified in §433.116(c) through (h).

(b) If HCFA disapproves the system or determines that the system met requirements for initial approval on a date later than the date required under §433.113(a)(3), the notice will include--

(1) The findings of fact upon which the determination was made; and

(2) The procedures for appeal of the determination in the context of a reconsideration of the resulting disallowance, to the Departmental Grant Appeals Board.

Section 433.116 FFP for operation of mechanized claims processing and information retrieval systems.

(a) Subject to §433.113(c), FFP is available at 75 percent of expenditures for operation of a mechanized claims processing and information retrieval system approved by HCFA, from the first day of the calendar quarter after the date the system met the conditions of initial approval, as established by HCFA (including a retroactive adjustment of FFP if necessary to provide the 75 percent rate beginning on the first day of that calendar quarter).

(b) HCFA will approve the system operation if the conditions specified in paragraphs (c) through (h) of this section are met.

(c) The conditions of §433.112(b) through (4) and (7) through (9), as periodically modified under section 433.112(b)(2) must be met.

(d) The system must have been operating continuously during the period for which FFP is claimed.

(e) The system must provide individual notices, within 45 days of the payment of claims, to all or a sample group of the persons who received services under the plan.

(f) The notice required by paragraph (e) of this section --

(1) Must specify --

(i) The service furnished;
(ii) The name of the provider furnishing the service;
(iii) The date on which the service was furnished; and
(iv) The amount of the payment made under the plan for the service; and

(2) Must not specify confidential services (as defined by the State) and must not be sent if the only service furnished was confidential.

(g) The system must provide both patient and provider profiles for program management and utilization review purposes.

(h) If a State has a Medicaid fraud control unit certified under section 1903(q) of the Act and §455.300 of this chapter, the Medicaid agency must have procedures to assure that information on probable fraud or abuse that is obtained from, or developed by, the system is made available to that unit. (See §455.21 of this chapter for State plan requirements.)

Section 433.117 Initial approval of replacement systems.

(a) A replacement system must meet all conditions of initial approval of a mechanized claims processing and information retrieval system.

(b) The agency must submit an APD that includes--

(1) The date the replacement system will be in operation; and

(2) A plan for orderly transition from the system being replaced to the replacement system.

(c) FFP is available at--

(1) 90 percent in expenditures for design, development, and installation in accordance with the provisions of §433.112; and

(2) 75 percent in expenditures for operation of an approved replacement system in accordance with the provisions of §433.116(b) through (h), from the date that the system met the conditions of initial approval, as established by HCFA.

(d) FFP is available at 75 percent in expenditures for the operation of an approved system that is being replaced (or at a reduced rate determined under §433.120 of this subpart for a system that has been disapproved) until the replacement system is in operation and approved.

Section 433.119 Conditions for yearly reapproval; notice of decision.

(a) HCFA will review yearly each system operation initially approved under §433.114 and reapprove it for FFP at 75 percent of expenditures if the following conditions are met:

(1) The system meets the conditions of §433.112(b) , (3), (4), and (7) through (9).

(2) The system meets the conditions of §433.116(d) through (h).

(3) The system meets the performance standards for reapproval and the system requirements in Part 11 of the State Medicaid Manual as periodically amended.

(b) HCFA will issue to each Medicaid agency by the end of the first quarter after the fiscal year of the review, a written notice informing the agency whether its system is reapproved or disapproved. If the system is disapproved, the notice will also include--

(1) HCFA's decision to reduce FFP for system operations, and the percentage to which it is reduced, beginning with the next calendar quarter.

(2) The findings of fact upon which the determination was made; and

(3) A statement that State claims in excess of the reduced FFP rate will be disallowed and that any such disallowance will be appealable to the Grant Appeals Board

Section 433.120 Procedures for reduction of FFP after yearly reapproval review.

(a) If HCFA determines after the yearly review that the system no longer meets the conditions of reapproval in §433.119, HCFA will reduce FFP for systems operations for at least four quarters. However, no system will be subject to reduction of FFP for at least the first four quarters after the quarter in which the system is initially approved as eligible for 75 percent FFP.

(b) HCFA will reduce FFP in expenditures for system operation from 75 percent to no more than 70 percent and no less than 50 percent; however, HCFA will not reduce FFP by more than 10 percentage points in any four-quarter period. The percentage to which the FFP is reduced will depend primarily on the following criteria:

(1) The number of conditions judged unsatisfactory;

(2) The extent to which conditions were not met;

(3) The significance of the unsatisfactory conditions in overall mechanized claims processing and information retrieval system operations; and
(4) The actual and potential program impact attributable to the unsatisfactory conditions.

Section 433.121 Reconsideration of the decision to reduce FFP after the yearly review.

(a) The agency may appeal to the Departmental Grant Appeals Board, under 45 CFR part 16, a disallowance concerning a reduction in FFP claimed for system operation caused by a disapproval of the State's MMIS. If the Board finds such a disallowance to be appropriate, the discretionary determination to reduce FFP by a particular percentage amount (instead of by a lesser percentage) is not subject to review by the Board unless the percentage reduction exceeds the range authorized by section 1903(r)(4)(B) of the Act.

(b) The decisions concerning whether to restore any FFP retroactively and the actual number of quarters for which FFP will be restored under section 433.122 of this subpart are not subject to administrative appeal to the Grant Appeals Board under 45 CFR part 16.

(c) An agency's request for a reconsideration before the Board under paragraph (a) of this section does not delay implementation of the reduction in FFP. However, any reduction is subject to retroactive adjustment if required by the Board's determination on reconsideration.

Section 433.122 Reapproval of a disapproved system.

When FFP has been reduced under section 433.120(a), and HCFA determines upon subsequent yearly review that the system meets all current performance standards, system requirements and other conditions of reapproval, the following provisions apply:

(a) HCFA will resume FFP in expenditures for system operations at the 75 percent level beginning with the quarter following the yearly review determination that the system again meets the conditions of reapproval.

(b) HCFA may retroactively waive a reduction in FFP in expenditures for systems operations if HCFA determines that the waiver could improve the administration of the State Medicaid plan. However, HCFA cannot waive this reduction for any quarter before the fourth quarter immediately preceding the quarter in which HCFA issues the determination (as part of the yearly review process) stating that the system is reapproved.

Section 433.123 Notification of changes in system requirements, performance standards or other conditions for approval or reapproval.

(a) Whenever HCFA modifies system requirements or other conditions for approval under sections 433.112 or 433.116, or performance standards or other conditions of reapproval under section 433.119, HCFA will --

(1) Publish a notice in the Federal Register making available the proposed changes for public comment;

(2) Respond in a subsequent Federal Register notice to comments received; and

(3) Issue the new or modified standards or conditions in the State Medicaid Manual.

(b) For changes in system requirements or other conditions for approval, HCFA will allow an appropriate period for Medicaid agencies to meet the requirement determining this period on the basis of the requirement's complexity and other relevant factors.

(c) For performance standards and other conditions for reapproval, HCFA will notify Medicaid agencies at least one calendar quarter before the review period to which the new or modified standards or conditions apply.

Section 433.127 Termination of FFP for failure to provide access to claims processing and information retrieval systems.

HCFA will terminate FFP at any time if the Medicaid agency fails to provide State and Federal representatives with full access to the system, including onsite inspection. HCFA may request such access at any time to determine whether the conditions in this subpart are being met.

Section 433.130 Waiver of conditions of initial operation and approval.

(a) HCFA will waive requirements for initial operation and approval of systems under section 433.113 for a State meeting the requirements of paragraph (b) of this section and that had a 1976 population of less than one million and made total Federal and State Medicaid expenditures of less than $100 million in fiscal year 1976. Population figures are those reported by the Bureau of the Census. Expenditures for fiscal year 1976 are those reported by the State for that year.

(b) To be eligible for this waiver, the agency must submit its reasons to HCFA in writing and demonstrate to HCFA's satisfaction that an MMIS will not significantly improve the efficiency of the administration of the State plan.

(c) If HCFA denies the waiver request, the notice of denial will include-

(1) The findings of the fact upon which the denial was made; and

(2) The procedures for appeal of the denial.

(d) If HCFA determines, after granting a waiver, that an MMIS would significantly improve the administration of the State Medicaid program, HCFA may withdraw the waiver and require that a State obtain initial approval of an MMIS within two years after the date of waiver withdrawal.

Section 433.131 Waiver for noncompliance with the conditions of approval and reapproval.

If a State is unable to comply with the conditions of approval or of reapproval and the noncompliance will cause a percentum reduction in FFP, HCFA will waive the FFP reduction in the following circumstances:

(a) Good Cause. If HCFA determines that good cause existed, HCFA will waive the FFP reduction attributable to those items for which the good cause existed. A waiver of FFP consequences of the failure to meet the conditions of approval or reapproval based upon good cause will not extend beyond two consecutive quarters.

(b) Circumstances beyond the control of a State. The State must satisfactorily explain the circumstances that are beyond its control. When HCFA grants the waiver, HCFA will also defer all other MMIS deadlines for the same length of time that the waiver applies.

Related Regulations

Other regulations which authorize requirements contained in this guide for all levels of FFP are:

45 CFR Part 74 - Administration of Grants
42 CFR 431.15 - Methods of Administration
42 CFR 431, Subpart F - Safeguarding Information on Applicants and Recipients
42 CFR 431.16-17 - Reports and Maintenance of Records
42 CFR 432 - State Personnel Administration
42 CFR 433.34 - Cost Allocation
42 CFR 433, Subpart A - Federal Matching Provisions
42 CFR 433, Subpart D - Third Party Liability
42 CFR 447 - Payments for Services
42 CFR 455 - Program Integrity
42 CFR 456 - Utilization Control
45 CFR 95, Subpart F - Automatic Data Processing Equipment and Services -Conditions for Federal Financial Participation