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LEGAL BACKGROUND AND AUTHORITY

42 CFR 431, State Organization and General Administration, Subpart P -Quality Control

CITATION OF REGULATION

Subpart P - Quality Control

Section 131.800 Medicaid quality control (MQC) system.

(a) Basis and purpose. This section establishes State plan requirements for a medicaid quality control system designed to reduce erroneous expenditures by monitoring eligibility determinations, third-party liability activities, and claims processing.

(Sec. 1902(a)(4) of the Act)

(b) Definitions. For purposes of this section -
"Active case" means an individual or family determined to be currently eligible for medicaid.
"Claims processing error" means FFP has been claimed for a medicaid payment that was made -
(1) For a service not authorized under the State plan;
(2) To a provider not certified for participation in the medicaid program;
(3) For a service already paid for by medicaid; or
(4) In an amount above the allowable reimbursement level for that service.
"Eligibility error" means that medicaid coverage has been certified or payment has been made for a recipient under review who -
(1) Was ineligible when certified or when he received services under the State's plan; or
(2) Had not met recipient liability requirements when certified eligible for medicaid; that is, he had not incurred medical expenses equal to the amount of this excess income over the State's financial eligibility level.
"Negative case action" means a medicaid application that was denied or otherwise disposed of without a determination of eligibility (for instance, because the application was withdrawn or abandoned) or an individual or family for whom medicaid eligibility was terminated.
"State agency" means either the State medicaid agency, or a State agency that is responsible for determining eligibility for medicaid.

"Third-party liability error" means FFP has been claimed for a medicaid payment when -

(1) All or part of the medical services should have been paid for by a third party; and

(2) The State failed to meet the requirements of Section 433.135 of this subchapter for considering third party liability.

(c) State plan requirements. A State plan must provide for operating a medicaid quality control (MQC) system that meets the requirements of paragraphs (d) through (h) of this section.

(d) Basic elements of MQC system.

The agency -

(1) Must operate the MQC system in accordance with the policies, sampling methodology, review procedures, and reporting forms and requirements specified in medicaid quality control manuals issued by HCFA;

(2) Must select statistical samples of both active and negative case actions;

(3) Must review each case in the sample to identify eligibility errors; and

(4) Must review any claims pertaining to each active case to identify erroneous payments resulting from -

(i) Ineligibility

(ii) Recipient understated or overstated liability;

(iii) Third-party liability; and

(iv) Claims processing errors;

(5) In order to verify eligibility information, must conduct field investigations, including -

(i) Personal interviews for each case in the active case sample; and

(ii) Personal interviews for cases in the negative case action sample, to the extent necessary to verify erroneous eligibility determinations; and

(6) Must use 6-month sampling periods, from April through September and from October through March.

(e) Reporting requirements. The agency must submit reports to the Administrator, in the form and at the time specified by him, including -

(1) A description of the State's sampling plan for active cases and negative cases;

(2) A monthly report on eligibility case reviews completed during the month for all cases in the active case sample for that month and selected cases from the negative case sample for that month;

(3) A monthly report on payment reviews completed during the month for cases in the active case sample. (States must wait 5 months after each sample month before accumulating claims paid for each case - through the fourth month following the sample month);

(4) A summary report on eligibility findings and payment error findings for all cases in the 6-month sample, to be submitted by May

31 of each year for the previous April-September sampling period, and by November 30 for the October-March sampling period; and

(5) Other data and reports that the Administrator requests.

(f) Access to records. The agency, upon request, must provide HEW staff with access to all records pertaining to its MQC reviews to which the State has access.

(g) Corrective action. The agency must-

(1) Take action to correct any eligibility, third-party liability, claims processing or negative case action errors found in the sample cases;

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

(3) By July 31 each year, submit to the Administrator a report on its error analysis and a corrective action plan.

(h) Protection of recipient rights. Any individual performing activities under the Medicaid quality control program must do so in a manner consistent with Sections 435.902 and 436.901 of this subchapter concerning the rights of the recipient

(43 FR 45188, Sept. 29, 1978, as amended at 44 FR 17935, Mar. 23, 1979)

Section 431.801 Disallowance of Federal financial participation for erroneous State payments.

(a) Purpose. This section establishes rules and procedures for disallowancing Federal financial participation (FFP) in erroneous Medicaid payments due to eligibility errors, as detected through the Medicaid Quality Control (MQC) system required under Section 431.800 of this subpart.

(b) Definitions. For purposes of this section - "Base period" means a six month MQC sampling period used to calculate each State's error rate and the national standard. The initial base period is July through December 1978. For subsequent years, the base period is April through September.

"Eligibility errors" has the same meaning as specified in Section 431.800(b).

"National standard" means the weighted mean of all State error rates for a base period.

"State error rate" means the rate of eligibility payment errors detected under the MQC system for each review period.

"State target error rate" means the error rate that a State must achieve in order to avoid a disallowance of FFP under this section. A State's target error rate is equal to the high of the national standard or percent of that State's error rate during the base period.

(c) Setting the State's error rate. An error rate for each State will be determined for each MQC review period, in accordance with

instructions issued by HCFA. Erroneous eligibility determinations by the Social Security Administration (SSA) of Supplemental Security Income (SSI) eligibility will not be included in determining the State's error rate. If a State fails to complete a valid MQC review as required for any sampling period, HCFA will assign the State an error rate based on the best information available to HCFA.

(d) Establishing the target error rate. Each year, after the end of the base period, HCFA will calculate a national standard and will notify each State agency what that State's target error rate is for the following April through September and October through March MQC review periods.

Example. The State's payment error rate in the base period is 20 percent. The national standard is 8 percent. To find the target error rate, we start with 20 percent and multiply by 84.3 percent which gives a target error rate of 16.9 percent. If this State reduces its error rate only to 18.2 percent during one of the subsequent disallowance periods, its FFP for that period may be reduced by 1.3 percent, the short fall from the 16.9 percent target.

(e) Period for disallowance of FFP. The State target error rate established for each base period will be used to determine whether the State is subject to a disallowance during the following April through September and October through March MQC review periods. During each of these two periods, a State will be subject to a reduction in FFP for program services (see Section 433.10 of this subchapter) equal to the percentage points by which it exceeded its target error rate. The first disallowance period will be April through September, 1979.

(f) Procedures for disallowance of FFP. (1) HCFA will notify each State that is subject to a disallowance under paragraph (e) of this section. A State will have 65 days from the date on this notification in which to show that this disallowance should not be made because the State's failure to meet its target error rate was due to factors beyond its control.

(2) Events that will be considered by the Secretary in determining whether a State's failure to meet its target error rate was due to factors beyond its control include-

(i) Disasters such as fire, flood or civil disorders, that -

(A) require the diversion of significant personnel normally assigned to Medicaid eligibility administration, or

(B) destroyed or delayed access to significant records needed to make or maintain accurate eligibility determination;

(ii) Strikes of State staff or other government or private personnel necessary to the determination of eligibility or processing of case changes;

(iii) Sudden and unanticipated workload changes which result from changes in Federal law and regulation, or rapid, unpredictable caseload growth in excess of, for example, 15 percent for a 6 month period; and

(iv) State actions resulting from incorrect written policy interpretation to the State by a Federal official reasonably assumed to be in a position to provide such interpretation.

(3) The failure of a State to act upon necessary legislative changes or to obtain budget authorization for needed resources does not constitute a factor beyond the State's control.

(4) The Secretary may disallow the full amount calculated under paragraph (e) of this section or reduce the disallowance in whole or in part, to the extent he determines that the State's failure to meet its target error rate was due to factors beyond its control.

(5) A State may request reconsideration in accordance with the procedures specified in 45 CFR 201.14 and 45 CFR Part 16.

Section FR 12591, Mar.7, 1979

ADMINISTRATION AND OBJECTIVES

CHAPTER I

CHAPTER 2

SAMPLING METHODS

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7000. INTRODUCTION

Congress appropriates funds each year from tax revenues to share with States in the cost of Medicaid. The law also specifies uses for these funds and the categories of beneficiaries who are entitled to receive services.

In addition to the benefits of the program there have also been problems. Most prominent is that management controls have not kept pace with the growth of the program. For example, Medicaid funds have been lost through payments for medical services for ineligible recipients.

Large losses resulted from faulty quality controls. Medicaid managers did not have sufficient information to monitor their programs properly. In short, all programs need strong management controls.

To fill this need, the Medicaid Eligibility Quality Control (MEQC) System collects data on eligibility, beneficiary liability, and claims payments. The primary objective of the system is to measure, identify, and eliminate or reduce dollar losses as a result of erroneous eligibility determinations.

The diagram in §7099, Exhibit 1, graphically depicts the overall MEQC system.

7005. ADMINISTRATION OF MEQC

Sound State management is critical to achieving the objectives of the MEQC system, especially in positioning and staffing of the unit.

7005.1. Organization.--Assign the staff responsible for developing, directing, and evaluating MEQC so that it can report directly to top management. Separate the staff physically and functionally from operating units and policy units.

If you cannot establish an independent MEQC unit, clearly document the arrangements for maintaining objectivity and independence and forward them to the regional office (RO) for concurrence.

By maintaining objectivity, MEQC findings provide Medicaid management with accurate, reliable, and timely information to help determine whether policies are being carried out properly and if the program is operating at maximum efficiency. MEQC findings are supplemented by other administrative and management reviews.

It is essential that management demonstrate a commitment to error reduction through appropriate eligibility and personnel policies, availability of resources, and participation in corrective action planning.

7005.2 Staffing.--Staff MEQC units to keep the review process current within established reporting dates and at a quality level including adequate staff training to ensure valid MEQC findings. Recommended qualifications for staff are:

- For MEQC reviewers, experience equal to firstline supervisors of Medicaid eligibility or assistance payment workers, or as an AFDC-QC reviewer;

- For MEQC supervisors, prior supervisory experience in other quality control (QC) units, or prior experience as an AFDC-QC or MEQC reviewer.

The number of reviewers and supervisors required for effective MEQC reviews varies with the sample size, travel requirements, and complexity of State Medicaid requirements and operations.

Statistical staff must be qualified to select and manage case samples, process completed schedules, supervise tabulation, and prepare accurate and timely statistical summaries and analyses. Maintain close coordination between your research and statistical staff and the MEQC unit. Competent clerical support for MEQC is essential.

7015. FEDERAL MEQC STATE PLAN REQUIREMENTS

A State title XIX plan must meet the requirements set by the Health Care Financing Administration (HCFA) for operating a MEQC system. In addition, 42 CFR 431.800 specifies that each State agency submit copies of its State plan, the sampling plan, and periodic data reports within the format and timeframes described elsewhere.

7015.1 State Plan Requirements.--A State plan under title XIX of the Act must provide the basis, purpose and operational requirements for a MEQC system in accordance with 42 CFR 431.800. It must provide for the MEQC system to operate in accordance with the policies, sampling methodology, review procedures, and reporting forms and requirements issued by HCFA.

Document reports by conducting necessary field investigations, including in-person interviews in each active sample case. Use sampling periods of 6 months; October through March and April through September.

The reports include a:

- Description of the State's sampling plan,
- Flow transmission of completed review findings, and
- Summary of universe dollar and case counts (Table V) for the 6-month sample.

Other data and reports may be requested as needed by HCFA.

Provide authorized HCFA staff with all State records and MEQC reviews to which you have access. Take appropriate action to correct any eligibility errors found in the sample cases and to prevent or reduce the incidence of such errors. By September 15 of each year, submit to HCFA a report of your error analyses and a corrective action plan (CAP).

Federal requirements specify that all activities under the MEQC program must be performed in a manner consistent with 42 CFR 435.902 concerning the rights of the beneficiary.

7015.2 Contents of Required State Submissions.--Forward to the RO a copy of the sampling plan, periodic reports on MEQC findings, and an annual description of the State's comprehensive plan for analysis of, and corrective action on, the MEQC findings. (See Chapters 1, 2, and 4.)

A. Sampling Plan.--To achieve MEQC objectives, the planning, selection, and control of samples must provide a reliable basis for measuring the proportion of cases with errors due to beneficiary ineligibility or incorrect liability. (See Chapter 2.)

B. Periodic Data Reports.--Prepare and submit periodic data reports based on MEQC findings to HCFA. Table V is submitted to obtain universe data necessary for statistical calculations.

C. Description of Corrective Action Plan (CAP).--Submit a comprehensive plan to HCFA for analysis of and corrective action on the MEQC findings. Submit the CAP annually. (See §7055.)

The annual CAP includes the status of the corrective action process at the time the report is prepared and summarizes the results of actions taken since the last report.

The acceptance of the plan by the RO does not constitute meeting the requirements for a good faith waiver. The listed requirements for the plan are minimal requirements as opposed to those for good faith waivers, which require exceptional effort. Waiver reviews are far more encompassing in corrective action activities and go beyond SMM CAP requirements.

7015.3 Maintenance of Current State Plan.--When changes occur in any process or in the administrative arrangements described in the State plan, submit a revised plan to the RO.

7030. COMPONENTS OF THE MEQC SYSTEM

The MEQC system consists of a number of distinct, yet related components, which are further described in §§7031ff. (See §7099, Exhibit 2.). The tasks listed under each component need not be performed by the same unit of the State agency. The State administrator assigns responsibilities for the performance of specific tasks and arranges adequate staffing so all tasks are carried out effectively and promptly.

7031. SAMPLE SELECTION

Select MEQC sample cases each month according to the specifications listed in Chapter 2. The minimum required number of completed reviews is specified for a 6-month period. The size of the sample selected is approximately equal in each month. The recommended selection method is either a simple random or the systematic random method. Transmit case identifiers for cases to the MEQC unit for review.

7032. REVIEW PROCESS

The MEQC review documents the eligibility of sample case beneficiaries through case record reviews and field investigations. States that have opted to do an independent sample of Supplemental Security Income (SSI) recipients must conduct full MEQC investigations on every SSI case in the sample. States with more restrictive Medicaid eligibility requirements for the aged, blind and disabled must verify that beneficiaries meet the more stringent requirements.

During case record reviews, specific facts are collected about the circumstances of case members. Field investigations are required to verify the information, and include a personal interview with the beneficiaries, or someone acting on their behalf, and contacts with other sources. The information gathered is used to make an MEQC determination concerning the eligibility status of each case as of the review month.

Information is collected on paid claim findings to determine the dollars spent in error.

Ensuring the quality, timeliness, and independence of MEQC reviews is a major responsibility of top management. This requires the assignment of the MEQC function to an appropriate level of management with the capability to institute and accomplish the necessary activities which assure quality and timeliness. You may determine the quality of your MEQC reviews by examining:

- The timely reporting of completed case reviews,
- Personal client interviews,
- Number of difference cases,
- Number of inappropriately dropped cases,
- Adherence to verification standards, and
- Analysis of Federal re-review findings.

7033. INDIVIDUAL CORRECTIVE ACTION

Correction of case status is an established and integral part of your ongoing supervision of your operating units.

MEQC is responsible for referring individual sample cases found to be in error to the appropriate unit for action and follow-up after the review has been completed. The MEQC unit provides the local agency with information that identifies beneficiaries unwilling to cooperate or who could not be located. Appropriate agency units are notified of questionable beneficiary and/or provider actions that could indicate fraud or abuse.

7034. DATA MANAGEMENT

Data management consists of ordering, handling, and processing data collected in the review process. This involves keeping track of reviews that have and have not been completed, ensuring accurate and consistent data and preparing monthly status reports, statistical tables for Federal reports and additional tabulations, as needed, to facilitate data analysis.

7035. ERROR ANALYSIS

The MEQC error analysis provides clear and concise presentations of findings for planning and evaluating corrective actions. This involves analysis of MEQC data and other special studies along with review of programmatic circumstances in order to ascertain specific error causes. The essential components of this process are data and program analysis.

7036. DISSEMINATION OF FINDINGS

MEQC findings are disseminated after the data have been analyzed to ensure that appropriate staff receive the information timely. It involves determining specific information requirements and supplying it to administrative and program staff, as well as local agencies and other interested parties, such as State legislatures, other State agencies, or the general public.

7050. MEQC AND CORRECTIVE ACTION

The MEQC system provides State title XIX agency administrators with meaningful information on the nature of case and payment errors in Medicaid eligibility determinations so that State agencies can assess problem areas and develop corrective actions (CA) suited to their needs and available resources.

The CA process is the means by which States take administrative actions to reduce errors which cause misspent Medicaid dollars. An effective CA process will have a great impact on the reduction and elimination of errors. It involves five phases: data analysis, program analysis, and the planning, implementation, and evaluation of CAs. Each phase is a continuous decision-making process with the completion of each annual MEQC reporting period. The recognition and application of good management principles are the basis for establishing an effective CA process. The CA process outlined serves as a model for developing and implementing appropriate CAs. Tailor the process to your individual needs.

A. Organization.--The key ingredient to an effective CA process is the active participation and commitment of top management. This is particularly important because of the multi-departmental responsibilities within the program. Problems and their solutions are seldom limited to a single area of the Medicaid agency's operations. They are derived from a variety of responsibilities and activities at both the State and local level. Additional complications exist in States where an agency other than that administering the program has responsibility for the eligibility determinations. Accordingly, in addition to the Director or Deputy Director of the Medicaid agency, management involvement should entail the participation of the major department heads of the State agency(s). This typically includes management from:

- o Medicaid Eligibility Policy and Program Development
- o Eligibility Field Operations
- o Medicaid Eligibility Quality Control
- o Research and Statistics
- o Systems and Procedures/Management Analysis
- o Financial Division
- o Public Information
- o Data Processing
- o Staff Development
- o Legal Department

This top management group known as the CA panel makes all major decisions, including planning, implementation, and evaluation. On a regular basis conduct CA panel meetings. Given the multi-departmental or joint agency nature of the panel composition, leadership of the panel should rest with the State Medicaid agency Director, or Deputy Director rather than any single section or division head. This provides realistic panel direction for it to function as a decision-making body in support and commitment to CA.

B. Communication.--Communication plays a major part in the CA process. Convey your error reduction goals via agency policy and actions. Make your State and local staff aware of, and update them on the agency's error reduction goals through directives, memoranda, meetings, etc. In addition, the top management panel and/or its members should be accessible to your staff responsible for error reduction. This access is essential for the implementation and monitoring of CA tasks, feedback, and revisions when appropriate.

C. Resources.--The allocation of major resources to CAs is essential in management's commitment to error reduction. In many instances error reduction efforts include hiring additional staff or the temporary reassignment of staff when workloads become overburdening or a staff shortage occurs. Another resource allocation for error reduction may include the purchase/rental of hardware for automated processes. Often heads of divisions in need of additional resources are not authorized to hire or transfer staff, or acquire computer terminals. The commitment for the necessary resources to reduce errors must come from top management.

7052. MEQC CAP REQUIREMENTS

State title XIX agencies are directed in 42 CFR 431.800(i)(3) to report annually to the Administrator on error analyses and CAs developed from MEQC findings. The plan must include analyses and planned CAs based upon the 2 most recently completed 6-month sampling periods for which MEQC review data are available.

Submit State CAPs, in duplicate, to the Regional Administrator (RA) by August 31 of each year, with revisions to the plan submitted within 60 days after identifying additional error prone areas or when there are other significant changes in the error rate or changes in planned corrective action. The RA will review the plans, updates, and may request additional information. Submit supporting documentation on all completed corrective action initiatives upon request.

7055. MEQC CAP FORMAT

The CAPs submitted describe prospective actions planned for the upcoming year and provide status reports on corrective actions being implemented. Include these five sections:

A. Data Analysis.--Screen MEQC data to identify clusters of errors and their causes. Provide a statistical description of all payment and case errors and associated causes. (See § 7055.1.)

B. Program Analysis.--Review quality control findings (including Federal differences) and any other studies and analyses. Provide a narrative description of all payment errors (and case errors if appropriate), and the specific programmatic causes to which they are attributed. (See §7055.2.)

C. Corrective Action Planning.--Provide a description of the CA initiatives to be implemented. Include the error concentration targeted, the major activities necessary for implementation, the evaluation procedures, the expected results, and the estimated associated potential cost and/or savings. (See §7055.3.)

D. Corrective Action (CA) Implementation.--Develop an overall implementation schedule for each CA initiative showing major tasks to be performed. Include a reasonable time schedule for each action. Schedule most actions for full implementation within 6 months, except for certain long range projects. Specify start, interim, and scheduled implementation dates. Identify the person and/or component responsible for overall implementation and monitoring of whether activities are on schedule. (See §7055.4.)

E. Corrective Action Evaluation.--Determine the effectiveness of the CA. Document the outcome of all planned CAs reported in the prior year CAP that have been fully implemented. Address actions continuing from prior years. If the CA was successful, indicate the concrete measures of its effectiveness and how it has impacted upon the error rate. (See §7055.5.)

You may include an optional section, Suggested Federal Initiatives, that addresses actions required of HCFA ROs or CO to assist States in CA efforts or to implement changes to improve the administration of the program.

7055.1 Data Analysis Content.--Provide clear and concise presentations of MEQC findings for planning and evaluating CAs. This initial phase of CA planning involves the collection and sorting of data using basic and sophisicated statistical techniques. The basic requirement for data analysis is the sorting of errors by:

- o Type--general classification, e.g., resources;
- o Element--specific kind of classification, e.g., bank accounts;
- o Source--agency or client; and
- o Nature--cause of error as coded on MEQC tables, e.g., failure of beneficiary to report a change.

This activity identifies clusters of errors, their causes, characteristics and frequency that can be corrected by specific action, and enables you to focus actions on the error concentration(s) that have the most significant impact on the payment error rate. Your analysis must account for all error cases (including those in the AFDC stratum). Avoid duplicative planning by utilizing AFDC CAPS when appropriate. (See Chapter 5.)

o Outline the major types of errors and the percentage of the payment error rate associated with the element within the type, e.g., "Excess Resources - Bank Accounts" (30 percent), "Unearned income - Retirement Survivors Disability Insurance (RSDI)" (17 percent).

o Identify the frequency and characteristics of each error concentration by error element, e.g., bank accounts, RSDI income.

- Is the specific source of error primarily agency or client caused?

- Has the occurrence of the error element remained constant over several review periods?

- Is the error primarily found in a certain geographic location?

o Identify the general nature (cause) of the error, e.g., information not verified, policy incorrectly applied.

o Identify the group or factor(s) which are more error prone than the rest of the Medicaid population, e.g., nursing home population, recipients of RSDI.

Base the analysis, at a minimum, upon the two most recent review periods for which case and payment data are available. Supplement the minimum requirements with more recent partial review data. The CAP should contain the tables used in the analysis. Present the statistical data analysis to program managers in a narrative form that will help them decide among alternative approaches to CA.

Error prone profiles, trend analyses, and geographical breakdowns are at the State's discretion. However, States with consistently high error rates or CAs which have proved ineffective in reducing the error rate should strongly consider additional data analysis or special studies.

Data analysis is not limited to MEQC findings. Utilize other data sources to supplement MEQC findings.

7055.2 Program Analysis.--This phase of the CA planning process is the most critical, as the proper identification of error causes is essential for the development of effective CAs. This phase requires familiarity with the agency's operational policies and procedures and an ability to analyze and identify the policies and/or procedures that cause errors.

The data analysis phase identifies the types of errors, error elements, their source and their nature. For CA planning, relate the errors to their actual cause in the program operation process.

Explain the program/operational cause in sufficient detail so that it identifies why a particular element is in error.

EXAMPLE: The data analysis indicates resources; i.e., joint bank accounts are 80 percent of the State's payment error rate and the majority of these errors are agency caused. Program analysis could entail an evaluation of the resource policy and procedures on application of policy in joint bank accounts to be sure staff understand the policy or whether it needs revision. Other evaluations could include kinds and locations of staff making the errors to determine if the problem involves new or overburdened staff.

To determine the specific causes of the error concentration(s) or extent of a problem, it may be necessary to utilize additional State studies or other reports such as State assessment reports, internal audits, and special studies.

Special studies may be done if additional data analyses are required to fully understand the nature and cause of the error situation. Special studies may be beneficial to:

- Pinpoint error causes when you have a small MEQC sample which does not provide sufficient data;
- Do effective CA planning when data are needed more frequently than every 6 months;
- Pilot test a particular CA initiative to assess its cost-effectiveness prior to implementation; and
- Evaluate local office adherence to revised policy instructions.

Identify and discuss any special studies or reports that were used to obtain additional information to identify errors and related causes.

The CA panel's primary activity in this phase is to determine what the data analysis indicates, what additional information is necessary to identify root error causes, and to identify the major error causes. Each member should review the QC data analysis prior to the panel's open discussion of error concentrations and their causes. The panel should decide on probable cause(s) for each error concentration and determine the extent and method of obtaining additional information necessary to determine the programmatic cause. Program analysis activity often includes, but is not limited to, conducting staff interviews or disseminating questionnaires, policy reviews, conferences with local managers, special studies, and error prone profiles. The analysis should show a relationship between the error concentrations and the agency's program operations and management practices and policies. This relationship permits the determination of each error cause. A good, extensive program analysis tells the State what to do in the most cost effective manner possible.

The end product of the program analysis phase of CA should be a narrative description of the specific programmatic error cause(s) for all payment errors and, at your option, case errors.

7055.3 Corrective Action Planning.--Focus CA planning on the error concentration(s) that has the most significant impact on the payment error rate or case error rate if appropriate. Identify errors that are not included in the planning and give the reason(s); e.g., isolated incident. The first step is the preliminary selection of alternative methods of CA which will reduce or eliminate the error causes identified in the program analysis phase. Prepare a descriptive summary of each alternative estimating the various staff resources, time, activities, eventual implementation problems, etc. necessary to conduct full planning of the CA. From this summary, study each alternative for potential cost benefits/feasibility, necessary resources for implementation, etc. The CA panel should review and discuss the positive and negative aspects of each alternative and select those which it considers the most appropriate solutions for the error causes. To increase the success of error reduction, the panel should clearly establish a connection between the CAs it chooses and the error cause(s) they will address, as indicated by the program analysis.

For each initiative selected for implementation include:

- o A summary description of the scope of the initiative in terms of processes, policies, costs, benefits, constraints, and anticipated implementation problems;

- o A detailed specification of necessary activities (preparing training plans, writing policy changes, writing computer programs, etc.);

- o Estimated cost/resources required for implementation;

- o Potential cost savings associated with effective implementation of the corrective action;

- o A concise description of planned evaluation methodology expressed in measurable quantitative/qualitative terms whenever possible. For example, if the selected action is a rewrite of the policy manual section on treatment of resources designated for burial, a proper evaluation technique may be a case review in a given local office(s) 3 months after the effective date of the revised policy to ascertain if the revised policy is being correctly applied; and

- o A statement as to why this particular action will resolve the problem. If training is used as a CA, it must be related to the error situations. Include subject(s) of training, dates, and audience.

7055.4 Corrective Action Implementation.--This phase of the plan includes the overall implementation schedule for each CA initiative. Include a reasonable time schedule (actual implementation within 6 months of the start date except for certain long-range projects) for each initiative. If the initiative is a long-range activity that requires more than 6 months for final implementation, include interim target dates along with an explanation of why the activity requires extended time; i.e., total manual revision needed, legislative change required, computerization of system needed.

Briefly describe the methodology you plan to use to accomplish each initiative. Include:

- o A description of pertinent tasks required to implement each action, e.g., corrective action meetings with appropriate staff;

- o Milestones and established interim target dates (include start dates and final implementation dates);

- o Individuals/components responsible for overall implementation and monitoring of each activity, e.g., CA panel, Medicaid Director, Director of Income Maintenance, Quality Control Director, etc.;

- o Identification of critical areas and any special assistance required; and
- o A monitoring plan to assure awareness by the CA panel of the progress in achieving goals.

If any significant changes or deviations from the implementation schedule occur, submit an updated report to the RO indicating the revisions and/or modifications. If an action is off schedule, include a revised implementation schedule with an explanation for the delay or change in target date.

The staff member responsible for the CA should ensure the operational activities are assigned and fully carried out. During the execution of CAs, the panel should monitor these activities, both administratively and technically.

7055.5 Corrective Action Evaluation.--This section documents the outcome of previously implemented actions reported in the prior year's CAP and any updates to it. In addition, an update on actions continuing from prior years should be presented much in the same manner as the recent CA evaluation. Include a description of the actions taken and when they were finally implemented compared to the planned implementation schedule. The purpose of the evaluation is to determine the effectiveness of the implemented actions. Focus on the reduction of the specified error(s), i.e., has the action achieved the desired result? If not, why not? What will you do instead to alleviate the error situation? This phase determines how the actual results compare with the anticipated results. For example:

- o Were target dates met?
- o Have expected results been realized? (Are errors in the pinpointed area decreasing?)
- o Are modification or termination of CAs warranted?
- o Were cost/resource estimates realistic?
- o Were additional problem areas encountered? If so, what were they?
- o What, if any, unanticipated effects occurred, i.e., increased errors in other program areas?

Define the methods and procedures used for evaluation purposes. Prepare an evaluation summary which includes the sources and methods of obtaining information. If the expected results are not being realized decide whether to continue or modify the action. If the CA is to be modified include the modification or revision in the CAP update. The update can also be utilized to report the results of special studies and to modify actions based upon the results of new data.

After implementation of CA initiatives, it is important to monitor local office application of the actions and the effect on overall program improvement and specific error reduction.

If you require any assistance in preparing your annual CAP contact the RO.

7099. ROLE OF A STATE MODEL SYSTEM IN THE EVALUATION PROCESS

Based on information provided in the initial stage of implementation, the CA panel determines the data necessary for evaluation purposes, (e.g., routine reports from QC data, supplemental reports such as geographical breakdowns, special reports if QC data is not sufficient or as frequently available as needed. The staff/component responsible for the activity prepares the necessary evaluation reports and submits them to the panel periodically to provide continuous feedback on each CA activity. From these reports the panel evaluates the effectiveness of the actions in meeting its objective. The panel's determination of effectiveness focuses on the reduction of errors occurring within the respective error element rather than reduction of the overall error rate, cost effectiveness, and any beneficial and detrimental side effects. The evaluation is the basis for determining which types of actions accomplish error reduction, the necessity of modifying/discontinuing CAs, and development of future CA activities. Once the panel is satisfied that the CA objectives have been achieved, or decide to modify/discontinue a CA, a final evaluation report is prepared documenting the results.

Exhibit 1 - Medicaid Quality Control Process

*SSI Cases in 1634 States not subject to review.

Exhibit 2 - Model State Quality Control System

Exhibit 3 - The Five Phases of Corrective Action

7100. QUALITY CONTROL SAMPLING

Sampling is the selection and study of a part of a whole, the universe, for the purpose of drawing conclusions about the universe. Sampling permits administrators to cut costs, reduce manpower requirements, gather vital information more quickly, obtain data not available otherwise, obtain more comprehensive data, and, in some instances, actually increase statistical accuracy.

In the Medicaid Eligibility Quality Control (MEQC) system, sampling is the only practical method of validating eligibility of the total caseload and determining the dollar value of errors. Any attempt to make such validations and determinations by reviewing every case would be an enormous and unwieldy undertaking. In addition to the considerable costs involved, the problems in administering such an operation would greatly increase the chance of obtaining poor quality data that could invalidate the findings.

The review of a sample is only incidentally concerned with identified errors. The prime concern is with the identification of types and amounts of errors for:

- Drawing inferences about the total caseload, and
- Utilizing the findings to develop cost-effective methods of eliminating errors that lead to erroneous Medicaid expenditures for the total caseload.

7102. OVERVIEW OF THE MEQC SYSTEM

A. Basis for MEQC System.--The MEQC system is based upon the following concepts:

- The sample unit is the Medicaid case as identified on the State eligibility file.
- The universe is the entire Medicaid caseload under consideration. This requires sample selection and data estimates for all appropriate categories of Medicaid cases.
- The review process uncovers misspent funds that result from eligibility errors.
- The sample includes:
  - The AFDC-QC sample for that month, and
  - A random sample of non-AFDC cases.

B. Steps in MEQC Process.--The essential steps in the MEQC process are:

- Selecting a monthly sample of Medicaid cases.

- Determining the eligibility status of sampled cases for the review month.

- Collecting claims for services received during the review month which are paid during and for 4 months after the review month, and assembling them at the beginning of the sixth month following the review month.

- Calculating payment error rates using correct and incorrect payment amounts based on claims paid for services received during the review month.

7104. MEQC SAMPLING REQUIREMENTS

Though the basic MEQC sample requirements are the same for all States, there are variations in how the lists are established and how the selection proceeds.

The different categories of States are:

A. 1634 Contract States.--States in which Medicaid eligibility determinations for SSI recipients are made by the Federal Government under a contract with the State using primarily the same criteria as in SSI eligibility determination. In these States SSI cases are not sampled or reviewed.

B. 209(b)/1902(f) States.--States which make Medicaid eligibility determinations for SSI recipients and in which Medicaid benefits may not be afforded to all SSI recipients because Medicaid eligibility requirements are more stringent than SSI eligibility requirements. In these States SSI cases are sampled and reviewed.

C. State Determination/SSI Criteria States.--States which make Medicaid eligibility determinations for SSI recipients using primarily the same criteria the Federal Government uses in determining SSI eligibility. In these States SSI cases are also sampled and reviewed.

7109. TYPES OF ERRORS

In determining estimates of population characteristics two types of errors may occur:

A. Sampling Errors.--When a sample is selected through a random procedure the estimates of a universe characteristic from that sample generally will be different from the true value of the universe characteristic because the estimates are based upon a sample.

A sampling error may be defined as the difference between the value of the characteristic as estimated from the sample and the true universe value of the characteristic. Although such errors cannot be avoided, they can be controlled and measured (in probability samples).

B. Nonsampling Errors.--Nonsampling errors generally are not measurable (except by the use of sample checks). They are usually of two types, both of which may result in biased data:

1. Errors Caused by People or Machines.--Mistakes in the collection of data, and in processing the data; e.g., errors in coding and errors in tabulating the results and making calculations; and

2. Errors Inherent in the Measurement Process.--Errors which result from many sources; e.g., dropped cases, "convenient" rather than scientific sampling, and use of improper methods of estimating from the sample.

7110. VALIDITY AND RELIABILITY OF STATISTICAL DATA

Sampling and statistical procedures by themselves cannot assure validity (or freedom from bias); i.e., that the errors found are "true" errors and that their correction is important to effective operation of the program. The validity of the data depends upon adequacy of the Review Schedule in relation to the scope, detail, and significance of the data collected and the degree to which reviews are carried out effectively.

Sound sampling procedures can assure a known degree of reliability (also referred to as precision) of statistical data. If sampling procedures are soundly based, the results obtained from one sample taken from the total caseload will be the approximate results obtained if the whole were reviewed. The MEQC sample is designed so that the reliability of the sample results is measurable and can be shown to be relatively high. These results can be made more reliable through proper application of statistical methods as well as through an increase in sample size.

Because of their importance, examples of sources of bias (which affect validity) and explanations of the formulas involved in measuring precision (reliability) are detailed.

7110.1 Bias.--A biased sample does not represent the population or universe from which it was selected. For example, suppose that an opinion survey was conducted in the middle of the day by interviewing everyone on a busy street willing to stop for 10 minutes for the interview. If 90 percent of those interviewed had a favorable opinion on the issue involved it would not necessarily follow that about 90 percent of the city residents have a favorable opinion. People on a particular street at a particular time of day would more than likely be unrepresentative of the total city population. Also, the fact that the sample consisted only of individuals who could spare 10 minutes in the middle of the day may make the sample even more unrepresentative. Such a sample could contain bias.

One source of bias in QC deals with cases which cannot be reviewed. "Nonreviewed" cases fall into several categories. Such cases should have been included in the sample but could not be reviewed by the QC unit for certain reasons; e.g., beneficiaries who could not be located or were unwilling to give information.

If the number of "nonreviewed" cases is small the bias resulting from their noncompletion also will be small. If the number of such cases is large a considerable bias may be introduced. In effect, a segment of the total caseload is unrepresented if the sample cases for that segment are not reviewed. If a substantial number of sample cases are not reviewed there is no assurance that conclusions drawn from the sample apply to the total caseload. The number of such cases can be anticipated and should be compensated for by oversampling. However, nonresponse bias may still be present.

Another source of bias is prior knowledge by the local agency as to which cases will be reviewed. This bias could result if the agency, intentionally or unintentionally, treats these cases in a special manner, thus making the QC results unrepresentative. Therefore, take special precautions to ensure that the cases selected are not known to the local agency earlier than required.

7110.2 Precision.--Findings computed from a sample are "point estimates." To predict the actual caseload error rate with any degree of certainty, a range of possible values (confidence interval) is computed. The first step is to compute the "variance" of the point estimate. For systematic random samples, when simulating random selection, the estimated variance of a rate of error (proportion) with a fixed sample size is computed approximately by the following equation:

$$VAR\ (\hat{p}) = \hat{p}_x \quad \frac{(1-\hat{p})}{n}$$

where $_p$ is the estimated case rate of error (proportion) in the sample, and n is the sample size.

The precision of a sample estimate is measured by the standard error of the estimate, SE ($\hat{p}$), which is the square root of the estimated variance.

$$SE(\hat{p}) = \sqrt{VAR(\hat{p})} \quad or \quad \sqrt{\frac{\hat{p}\,(1-\hat{p})}{n}}$$

The precision specification consists of two elements. The administrative decision on the desired degree of reliability determines the sample size necessary to meet the specified probability level and precision range. For example, the administrator might specify that he would like his estimate of the ineligibility case rate in the caseload to be within one percentage point of the figure that would be obtained by a complete review of the entire caseload. This is the tolerance specification or limit.

Since the administrator is dealing with a sample he also assumes a certain degree of risk. Thus, in the example given above, if the sampling error had been computed so that the estimate plus or minus one percent includes the value estimated in 95 of 100 repeated samples of the same universe, the estimate plus or minus one percent is the 95-percent confidence interval. The 95-percent confidence interval is approximately equal to plus or minus two standard errors of the normal distribution and is expressed:

$$95\%\ CI = \hat{p} \pm 2\ SE\ (\hat{p})$$

This confidence interval covers the true value of "p" about 95 percent of the time when sampling repetitively. Expressed in another way, we can be reasonably confident that about 95 percent of the sample proportions will be within two standard errors of their corresponding population proportion.

By algebraic rearrangement it is possible to compute the sample size needed to obtain the minimum sample size required for 95- percent confidence that a sample proportion p will be within $\pm$ 1 percent of the true proportion p when p is assumed to be 4 percent; the computation follows:

$$n = \frac{4p\,(1-p)}{e^2}$$

where e is the acceptable error in estimating p.
Substituting 4 percent for p

$$n = \frac{(4)\,(.04)\,(1-.04)}{(.01)^2}$$

$$n = 1536$$

In MEQC the sample design is stratified. (See § 7113.) Precision for stratified samples is computed differently from the example shown.

In a stratified sample any estimate for the entire population is computed from information in each stratum or group. Likewise the variance of the estimate must take into account variance information from each stratum, appropriately weighted and combined.

If, in each stratum, a systematic sample (approximating a simple random sample) is chosen the formula for estimating the overall error rate ($\hat{p}$) and its variance is:

$$\hat{p} = \sum_{h=1}^{K} \frac{Nh}{} \bullet \hat{p}h \qquad \text{and}$$

$$\text{VAR}(\hat{p}) = \sum_{h=1}^{k} \frac{(Nn)^2}{N} \bullet \frac{\hat{p}h\ (1-\hat{p}h)}{nh}$$

where:

K is the number of strata,

N_h is the population size in stratum h,

N is the total population size,

$\hat{p}_h$ is the estimated case error rate in stratum h, and

n_h is the sample size in stratum h.

The standard error of $\hat{p}_h$ is the square root of the estimated variance and is used in the calculation of confidence intervals which are calculated in the same manner as for the nostratified sample.

For example, a sample is drawn from two strata. The population sizes in the strata are 1,000 and 4,000, the sample sizes are 50 and 200, and the case error rate estimates are .05 and .2, respectively. The overall error rate estimate is:

$$\hat{p} = (.05 \times \frac{1000}{5000}) + (.2 \times \frac{4000}{5000}) = .17$$

and

$$\text{Var}(\hat{p}) = \frac{(1000)2}{5000} \times (\frac{(.05)(.95)}{50}) + \frac{(4000)2}{5000} \times \frac{(.2)(.8)}{200}$$

$$= .00055$$

and SE $(\hat{p}) = \sqrt{\text{var}(\hat{p})} = \sqrt{.00055} = .023$.

The resulting 95-percent confidence interval is $.17 \pm 2\ (.023)$ or from .124 to .216.

7112. TYPES OF ESTIMATORS

Among the measures computed from sample results are:

A. Totals.--Total dollars paid or total dollars paid in error.

B. Averages.--Average dollars in error per case.

C. Proportions.--The proportion of cases in error.

D. Ratios.--The proportion of dollars in error to total dollars.

E. Regression estimates.--Projections of values based on linear relationships.

Note that all of these estimates have different implicit formulas for the computation of the respective point estimates and confidence intervals. The examples in §7110.2 are based on estimates of proportions, which are simple estimates from a computational standpoint. Ratio estimates of dollar values are more complex and require more sophisticated computations, and thus are not shown here.

7113. STRATIFICATION

In many populations, the elements may differ markedly, and the measure of variability may be relatively high. Consequently, when a sample is selected, it may be necessary to use a relatively large sample size to achieve a given level of precision. To reduce the sample size for a given level of precision, the universe may be divided into several homogeneous groups so that the elements in each group are more alike than the elements in the total universe. Each group is called a stratum, and the process of dividing the population into groups is called stratification. In general, this allows greater precision for a given sample size or allows a smaller total sample for a given level of precision.

Stratification may be used for other reasons. These include obtaining estimates for particular portions of the population and administrative convenience. (The population may be stratified by geographic locations or some other organization of the population when the population is "naturally stratified.")

The sample selection is performed independently in each stratum, and results are combined based on universe weights. (See §7110.2.)

7120. GENERAL SAMPLING REQUIREMENTS OF MEQC

The MEQC system operates on a 6-month sampling cycle. There are two cycles in each Federal fiscal year. The first is October 1 through March 31, and the second is April 1 through September 30. Each cycle is divided into six monthly periods. Approximately one-sixth of the 6-month sample is selected for each of the 6 review months. (See §§7133 and 7134.) Conduct the reviews according to the MEQC review process. (See Chapter 3.)

To minimize the effort required to select the sample and conduct the required reviews, the AFDC-QC sample is integrated into the MEQC sample to represent that portion of the Medicaid population who are also AFDC recipients.

7121. SAMPLE UNIT

The sample MEQC unit is the Medicaid case. A Medicaid case is:

- For the AFDC population, the case which receives a payment for the month; and

- For noncash payment cases, a group of Medicaid beneficiaries which are subject to Federal matching of State funds for the cost of medical services and are identified on the State eligibility file as a case. Cases are typically identified by a case number which includes a suffix used to identify individual members within the case. In this situation, the sample unit is the higher level case number, ignoring the case member suffix. If you identify cases by multiple level identifiers, e.g., by coverage codes within household groups, then either grouping is acceptable, provided the grouping is defined in the sampling plan. The cases on the file must be mutually exclusive, i.e., Medicaid eligible beneficiaries must not have multiple chances of being selected in the sample. All individuals must be subject to sampling.

7122. SAMPLE SIZES

Minimum numbers of case reviews to be completed have been established for the medical assistance only (MAO) stratum. (See §7123.) The minimum case reviews to be completed for the AFDC stratum are determined by AFDC-QC. If AFDC-QC sample sizes or requirements change, then MEQC requirements reflect these changes.

Exhibit 1 shows the minimum numbers of case reviews that you are required to complete. Base the number of cases to be selected on these minimum numbers of required case reviews. Select a larger sample than the prescribed minimum sample in consideration of a number of variables, e.g., dropped cases. Federal matching is available for all costs associated with the selection and review (if necessary) of samples larger than the minimum.

You have the option of targeting 25 percent of your MAO sample on focused reviews. You may choose the type of targeted sample selected. The review activity associated with this targeted sample can also be restricted to specific problem areas. The sample selection can be done on a nonrandom basis since the targeted case findings are excluded from the error rate calculation. Your error rate calculation is, therefore, based upon 75 percent of your MAO minimum required sample size.

This 25 percent targeted sample is not intended to reduce your workload. You must maintain equal workload requirements with that currently being done. For example, if you find that you are doing limited reviews requiring half the work with the 25 percent sample, then you must review twice as many targeted cases. The addition of more focused review cases in no way diminishes your responsibility to review 75 percent of the original MAO sample to determine your error rate. The main objective of these targeted reviews is to collect as much information as possible for corrective action purposes. Therefore, target these reviews on problem areas to determine causes and solutions of misspent dollars.

7123. POPULATIONS TO BE SAMPLED

The Medicaid case population in each sample month includes all cases which were listed as eligible for Medicaid during any part of the month (excluding retroactive cases except when using retrospective sampling). The definitions of inclusions and exclusions in the AFDC population are determined by AFDC-QC.

When primary samples are selected prior to the end of the sample month, select a supplemental sample from cases determined eligible between the primary selection and the end of the sample month. Although cases making application in the sample month may not be determined eligible for months subsequent to the sample month, you are not responsible for sampling cases added to the eligibility file after the last day of the sample month. If you select primary samples before the end of the sample month, select a supplemental sample covering cases added up to the end of the month, as identified up to the first file update including the last day of the month.

The eligibility of every Medicaid beneficiary is subject to a review except for:

- Those cases for which Medicaid eligibility was determined by SSA in 1634 contract States;

- o Cases eligible for Medicaid based on title IV-E adoption or foster care;
- o Cases funded 100 percent by the Federal Government (e.g., Indo-Chinese, Cuban refugees); and
- o Retroactively eligible cases (except in States using retrospective sampling).

Other cases may not be reviewed for other reasons. (See §7230.) However, these cases are not generally identifiable as drops during the sampling process. Any beneficiary not shown as an exception above whose eligibility is not subject to review as part of the AFDC-QC system is included in the MAO populations and thus subject to MEQC eligibility review. Therefore, even if Medicaid beneficiaries' financial circumstances are used in determining the amount of the grant for AFDC, but eligibility for these beneficiaries would not be established in an AFDC-QC review, group them as a case in the medical assistance only population, e.g., an AFDC group with a dependent child not eligible for AFDC because of school attendance or enumeration requirements. Include the following in populations to be sampled:

A. AFDC.--Members of AFDC families who receive cash payments, excluding:

- o Presumptive eligibility;
- o Death of a payee or applicant;
- o Cases in which a check was not received for the review month even though the name appeared on the payroll from which the sample was drawn (e.g., canceled checks, withheld checks, returned checks);
- o AFDC foster care; and
- o Emergency assistance.

B. Medical Assistance Only (Non-AFDC Cases).--See §7272 for individual category listings of these cases.

7124. SAMPLING FRAMES

Sampling frames for each population must contain all cases in the population. However, additional items (i.e., listed-in-error (LIE) cases) may be on the list if it is difficult to remove them before sampling. Discard such LIE cases if they were drawn in the sample.

To minimize the risk of bias due to excessive numbers of LIE cases, demonstrate that your sampling frames are at least 98 percent accurate. Perform this demonstration the first time a new sampling frame or program identifier coding scheme is used. This is necessary to ensure that significant numbers of cases are not improperly excluded from sampling due to their being sampled in the wrong stratum. States which do not successfully document 98 percent accuracy must sample from the entire eligibility file or equivalent and determine program participation or LIE status through a field investigation as part of the MEQC review.

To demonstrate sample frame accuracy, select a sample of 400 cases from the entire active Medicaid eligibility list and determine the actual program status of each. Verify program status for AFDC and SSI cash assistance cases (where applicable) by checking AFDC payroll and SDX tape records to verify cash payment. Verify program status for any noncash-based case types against the local case record. If at least 392 of the 400 cases selected are included in the appropriate stratum, the sample frame is considered acceptable. Consider cases which have minor coding errors which do not cause improper omission of a case from a sampling frame as correct for purposes of this test.

7125. SAMPLE SELECTION

Systematic sampling or simple random sampling procedures are recommended for selecting the MEQC sample. (See §7132.) Sample selection may be done at any time after the beginning of the review month. Insure that all cases with eligibility during the month, which are either added to or deleted from the eligibility list, are subject to sampling. Include all cases for which a Medicaid card is issued for any part of the review month. Do not include cases made eligible in a later month retroactive to the review month (except when retrospective sampling is used). If you sample after the first eligibility file update following the sample month, do not supplement your sample with cases for which eligibility was established after that date.

For the Federal MEQC unit to more effectively track cases through the system, submit to the RO a sample selection list which identifies all cases selected in your MEQC sample (MAO stratum). Submit these lists each month immediately subsequent to your sample selection and prior to the assignment of these cases to review staff. Assure that the number of cases contained on the lists conform to those required as stipulated in your individual sampling plans.

The sample of cases for the 25 percent targeted review (see §7122) may be selected at any time during the review period; i.e., the focused sample can come from one month's sample universe or selected evenly throughout the entire 6-month period. You can adjust your normal sampling interval to yield 75 percent of the usual sample. You, however, must maintain that chosen interval for the entire period for the 75 percent portion of the sample.

7126. CLAIMS COLLECTION

For each sampled case in the population, collect claims for both completed review cases and dropped cases if Federal rereview subsequently completes the case. Collect paid claims for the services received during the review month and prior to the review month, where necessary, as dictated by your spenddown period. For claims where the service dates overlap months, either (1) divide claim amounts by associated month of service, or (2) determine the review month by the date the service was terminated and assign the total amount of the paid claims to the month in which the service was terminated, i.e., the month the beneficiary was discharged from the hospital or long term care facility as specified in your State's sampling plan.

HMO premiums and Medicare buy-ins <u>are</u> considered claims for the month of medical care which they cover.

Collect claims which are paid before, during, and for 4 months following the review month. However, <u>do</u> <u>not</u> start the claims collection procedure until the beginning of the sixth month following the review month. The reason for this requirement is that sampled cases if identified to a payment unit prior to the expiration of this time period could be treated differently from nonsampled cases, either intentionally or unintentionally. This generates results unrepresentative of the universe from which the sample is selected, producing distorted estimates of payment error rates.

Because this procedure may be too expensive for some States, you may collect claims for sampled cases on a monthly basis. However, comply with the following rules if this alternate methodology is used.

- The administrative unit which collects the claims must be a separate governmental unit from the unit charged with administration of the Medicaid program;

- The official in charge of this administrative unit must not report to and must be at least equivalent in rank to the official charged with administration of the Medicaid program;

- The unit responsible for collecting the claims must not identify or release paid claim information on sampled cases to any personnel responsible for eligibility determination before the sixth month following each service month; and

- The official in charge of the unit collecting the claims must certify in writing to the requirements in the above item to both the head of the unit charged with administering the Medicaid program and the HCFA Regional Administrator.

7130. REQUIREMENTS FOR SAMPLING PLAN DOCUMENTATION

Each State operates its MEQC system under a sampling plan approved by the RO. Before implementation, submit documentation of the proposed plan which describes:

- The population to be sampled;

- The list(s) from which the sample is selected;

- The sample size;

- The sample selection procedure;

- The claims collection procedure;

- The option to drop/not drop cases selected more than once in the sample period;

- The option to use paid claims, billed amounts, and denied claims to offset beneficiary liability in the eligibility review. (No indication in the plan is interpreted to mean the contrary);

- The option to divide multiple service-month claim amounts by associated months of service, or use the date the service was terminated to determine the service month for the entire claim amount; and

- The option to use 25 percent targeting as described in §7122. Specify exact number and types of cases to be selected for this targeted area and the expected results you hope to obtain. If you perform a limited review of the targeted sample cases, the sampling plan must demonstrate a workload equivalent to the full review of the random sample.

In the sampling plan, document the definition of the case sample unit used on the eligibility file.

Before making revisions in the sample design, document them in a revised sampling plan, and submit them to the RO for review and approval. Submit basic sampling plans to the RO 60 days prior to the corresponding review period. Submit detailed universe estimates and sampling intervals at least 2 weeks prior to the first sample selection of the period. Submit a basic sampling plan only when a revision to the most recent approved plan is proposed. Resubmit detailed universe estimates and interval calculations for each sample period if the estimates differ from the previous period.

The same sampling plan must be in effect during each 6-month period.

7130.1 Population To Be Sampled.--Describe in the sampling plan the specific classifications of Medicaid cases included in each Medicaid category for which minimum numbers of reviews are established. These classifications must conform to the guidelines in §7272.

If for any reason deviations from these guidelines are made, explain them in detail in the sampling plan submitted to the RO. Identify groups of cases by their numbers in §7272, e.g., " §7272 - 4, 5, 7, 8, 10."

7130.2 Sample Selection Lists.--Describe in detail in the sampling plan the lists from which the sample of Medicaid cases is selected. It is expected that these lists are the actual eligibility files. In any case, the sampling plan must explicitly describe the following characteristics of the sample selection lists for each population:

- Source(s);
- All types of cases included in the selection list;
- Accuracy and completeness of sample lists in reference to the population(s) of interest;
- Whether the selection list was constructed by combining more than one list;
- The form of the selection list (e.g., computer file, microfilm, hard copy). If different parts of the selection list are in different forms, specify the form of each part;
- Frequency of and length of delays in updating the selection lists or their sources;
- Number of items on the lists and proportion of LIE items;
- Methods of deleting unwanted items from the selection lists, including the findings and date of the most recent 400 sample test of eligibility codes; and

- Structure of the selection lists (e.g., the MEQC sample unit or beneficiary). If the selection list is not organized according to case, specify the method employed in identifying a case so an unbiased random selection of cases can be made.

Specify these characteristics for each category of a Medicaid case for which a minimum number of reviews has been established (excluding AFDC).

7130.3 Sample Size.--The basic sample sizes (i.e., the minimum number of reviews that must be completed) for the 6-month review period are in Exhibit 1. (Note that any changes in sample sizes by AFDC-QC change the requirement for MEQC.) You may increase sample sizes and receive Federal matching funds for increased administrative costs. If deviations from the sample sizes in Exhibit 1 are proposed, document the reasons for making such deviations and the effects of doing so in the sampling plan submitted to HCFA. Specify in the plan the expected number of cases to be selected, dropped LIE cases, cases dropped for other reasons, and cases completed, by stratum, as well as the minimum number of completed reviews.

7130.4 Sample Selection Procedures.--Describe in detail the procedures used in selecting the sample review cases in the sampling plan. The general procedures must be in compliance with the guidelines provided. (See also §7132.) If more than one selection list is used, describe the method of selection from each. Also include any stratified sampling techniques proposed. See §7154 for guidelines on stratification.) Include a time schedule for each step in the sampling procedure (by stratum, if it differs by stratum).

Retrospective sampling procedures are outlined in Appendix C. This optional methodology may be mandated in the future. HCFA also considers alternative State sampling plans which provide a valid statistical sample. Plans using methods other than systematic or simple random sampling as outlined in §7132 require approval of the general methodology by HCFA central office (CO). The HCFA RO statistician retains responsibility for the final approval recommendation of the detailed plan. The main criteria a plan must meet are those stratification rules in §7154 (if applicable) and the alternative sampling methodology must provide an ineligible plus liability understated payment error rate estimate. The variance formula for the estimate must be included in the sampling plan submittal.

Note that for the AFDC-QC integration, the only statement needed to describe the sample selection procedure is "The AFDC-QC sample will be used."

7130.5 Claims Collection Procedures.--Document in the sampling plan the procedures used to collect paid claims for services incurred for a review month sampled case. The documentation must include the identifier (name, number, etc.) used for matching all claims to the case, the timing of this procedure, the method used (computer or manual), and tracking procedures. For identifying claims prior to the sixth month following the review month, include in the sampling plan the required certification. (See §7126.) Note that the procedures used must properly identify services for each individual in the case unit subject to sampling.

7132. RANDOM SAMPLE SELECTION PROCEDURES

Use either systematic random or simple random sampling procedures for selecting cases to be reviewed except for the 25 percent targeted review. (See §7122.) Systematic sampling is preferred. It provides a system or pattern of selection of individual cases from the sample selection list, e.g., a file, computer tape, or listing, at equally spaced intervals, with the starting point determined by random selection. It is important that cases with a similar probability of error are not also placed on equally spaced intervals. Otherwise, a systematic sample does not yield a truly random sample. The pattern of the sample frame must be such that the probability of case errors is unrelated to the sample selection list structure.

Simple random sampling or other more complex sampling methodologies are, in most cases, more difficult to administer. In simple random sampling, assign each case a unique identifying number. Select numbers at random (usually from a table of random numbers or computerized random number generator), and include cases having the identifying numbers corresponding to the random numbers.

Below are the steps necessary in selecting a sample from an established sample selection list. You may divide these steps into two parts. The first (see §7133) presents the steps that must be taken in calculating the sampling interval used in the selection of cases from the sample selection list (generally calculated once every reporting period).

The second (see §7134) outlines the procedures used in the actual selection of cases from the list (performed monthly).

7133. CALCULATION OF SAMPLING INTERVAL

Undertake these six steps only at the beginning of each 6-month review period.

Step 1: Estimate the Average Monthly Sample Frame Size.--The average monthly sample frame size is an estimate of the average number of cases contained on the list subject to sampling during each month of the 6-month review period. The monthly sample frame size may vary. In estimating the average monthly sample frame size consider any known circumstances, such as policy changes, that would appreciably affect the size.

Step 2: Determine the Number of Required Completed Case Reviews.--Exhibit 1 contains a list of the minimum number of completed reviews required for each 6-month review period. You may increase the number of complete reviews.

Step 3: 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 case reviews to be completed for the 6-month review period (Step 2) by six.

Step 4: Estimate the Proportion of Cases Listed in Error.--Listed-in-error cases are those cases included in the sample selection list which are not in the population of interest, e.g., AFDC cases included on a list from which medical assistance only cases are to be selected. The estimate should reflect the true proportion for the entire 6-month period.

Step 5: Estimate the Proportion of Cases Dropped for Other Reasons.--Some case reviews may not be completed for the following reasons:

- Moved out of State,
- Unwilling to give information,
- Unable to locate, and/or
- Other.

Step 6: Calculate the Sampling Interval.--Calculate the sampling interval using the following formula:

W - Average monthly sample frame size (Step 1)
X - Average number of reviews to be completed monthly (Step 3)
Y - Proportion of cases dropped for reasons other than listed in error (Step 5)
Z - Proportion of cases listed in error (Step 4)

Sampling Interval (I) = W x (1-Y) x (1-Z)/X

Unless a correction for undersampling or excessive oversampling is necessary (see §7150), apply the same sampling interval in each month of the 6-month review period. Always round down this sampling interval to the next lowest integer; i.e., 25.67 becomes 25.

As an example assume that:

- The average monthly sample frame size (W) is 10,000,
- The average number of reviews to be completed monthly (X) is 100,
- The proportion of cases dropped for reasons other than listed in error (Y) is 1/100 or (.01), and
- The proportion of cases dropped because they are listed in error is 5/100 or (.05).

Then the sampling interval (I) is:

I = 10,000 x .99 x .95 / 100
I = 94.05

Round this down to 94.

The number of cases selected for a review period must exceed the number of sample cases required for two reasons:

- o Cases selected not in the population of interest (listed in error), and
- o Dropped reviews for reasons other than listed in error.

The actual cases to be reviewed include only those selected from the population of interest.

7134. SELECTION OF CASES FOR THE REVIEW MONTH

The procedures for selection of cases for the review month consist of three steps. Repeat them for each month of the review period using the same sampling interval. (See §7133.)

Step 1: Make Any Necessary Adjustments in the Sampling Interval for Undersampling or Excessive Oversampling.--Undersampling or excessive oversampling exists when the actual number of completed case reviews is below (or significantly above) the required number. Correct undersampling to achieve minimum sample size. Excessive oversampling may be reduced at your option so that actual sample sizes will be closer to the minimum planned sample sizes. See §7140 for detailed procedures for correction. The new sampling interval calculated as part of these procedures is used in selecting sample cases for the review month.

Step 2: Select a Random Start.--The random start, j, is an integer between one and the sampling interval, I, inclusive. The starting point for any list other than the first list sampled for the 6-month period may be positionally generated by using the remainder from the previous list sample. The corresponding start number is the interval size minus the previous remainder.

Step 3: Select Sample Cases.--The first case selected is the j'th case (random start number) on the sample selection list. Every I'th (sampling interval) entry following the j'th case on the sample selection list is also chosen as part of the monthly sample. Thus, if the random start is 28 and the sampling interval is 94 select the 28'th, 122'd, 216'th, 310'th, etc., entries on the sample selection list for the sample. (Only the cases selected are to be reviewed in the sample. If case 122 is selected, reviewing case 121 or 123 is not acceptable.) Continue the process of selection until the end of the list is reached.

7140. PROCEDURES FOR CORRECTING THE MONTHLY SAMPLE FOR EXCESSIVE OVERSAMPLING AND UNDERSAMPLING

Sections 7140-7146 deal with correction of the sample for either undersampling or excessive oversampling. Correct undersampling (completion of fewer cases than required) using the procedures outlined here. However, correcting for oversampling is a State option; the preferred method for such correction, outlined in §7142, does not bias the sample results. An alternate method presented in §7146, while acceptable, is not generally recommended because it requires complex weighting procedures to analyze and report the data.

7142. CORRECTING FOR EXCESSIVE OVERSAMPLING

Oversampling is a normal part of the sampling operation which compensates for anticipated "not reviewed" cases. Under certain circumstances, however, you may find that you have oversampled more than necessary. This oversampling could be due to such factors as a larger allowance made for anticipated "not reviewed" cases than actually found, or to an underestimated caseload size for the reporting period resulting in the use of a smaller sampling interval than necessary.

If you wish to reduce this sample, follow the recommended method:

A. Using the methods described in §7133, recompute the correct sampling interval for the reporting period using revised estimates of the sample frame size and/or the fraction of reviews to be dropped for all reasons.

For each month in which sample cases have already been selected:

B. Compute a revised estimate of the number of sample cases which should have been selected in the month, as follows:

$$\text{Revised estimate of the number of sample cases for the month} = \frac{\text{Monthly Sample Selection List}}{\text{Revised Sampling Interval}}$$

C. Subtract the number of cases obtained in Step B from the number already selected. This is the number of cases to be eliminated.

D. Divide the number of sample cases that have been selected to be eliminated by the number obtained in Step C to obtain the secondary sampling interval to be used in identifying the cases to be eliminated.

E. Use a random start, and apply the secondary sampling interval obtained in Step D to select cases from the list of sample cases already selected. Eliminate the cases identified regardless of whether or not reviews had already been conducted.

For months for which sample cases have not yet been selected:

F. Use the corrected sampling interval for the reporting period obtained in Step A to select sample cases from the monthly frames.

7144. CORRECTING FOR UNDERSAMPLING

Undersampling generally occurs if the number of dropped cases is greater than expected or the estimate of the caseload 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 is:

A. Using the methods in § 7133, 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 all reasons.

For each month in which sample cases have already been selected:

B. Compute a revised estimate of the number of sample cases which should have been selected in the month, as follows:

$$\text{Revised estimate of the number of sample cases for the month} = \frac{\text{Monthly Sample Selection List}}{\text{Revised Sampling Interval}}$$

C. Subtract the number of cases already selected from the number obtained in Step B. This is the number of additional cases to be selected from the monthly frame.

D. Divide the total monthly sample frame size by the number identified in Step C to obtain the secondary sampling interval to be used in identifying the additional cases to be selected from the monthly sample frame.

E. Use a random start, and apply the secondary sampling interval calculated in Step D to the monthly sample frame from which cases have been selected. Add the specific cases identified to the cases already selected and reviewed for the same month as the month of the sample frame from which they were selected. (If a case previously selected in the sample is identified select an alternate case by use of a table of random numbers.) This procedure oversamples for cases selected which are listed in error.

For months for which sample cases have not yet been selected:

F. Use the corrected sampling interval for the reporting period obtained in Step A to select sample cases from the monthly frames.

7146. ALTERNATE METHOD OF CORRECTING FOR UNDERSAMPLING OR OVERSAMPLING

This procedure involves no adjustment of the months for which cases were already selected. It involves, however, the computation of a new sampling interval which either:

- Undersamples the remaining months of the reporting period to meet minimum sample size requirements if the earlier months had been oversampled, or

- Oversamples the remaining months of the reporting period to meet minimum sample size requirements if the earlier months had been undersampled.

Compute the new sampling interval using revised assumptions according to §7133 applied to the remaining months of the review period with the objective of completing the minimum required sample size. However, since different sampling intervals are used, a substratified sample is created (since the MEQC sample is already stratified, e.g., AFDC and MAO) with cases selected using each sampling interval forming the substrata. Procedures for reporting data are different since the results from each stratum cannot be added directly to obtain statewide counts, but must be weighted according to directions in §7520.

7150. GUIDELINES FOR EXPANDED AND SUBSTRATIFIED SAMPLES

You may choose to modify the basic sample requirements by expanding the size of the sample, i.e., increasing the number of cases to be reviewed or dividing the sample into strata representing homogeneous subgroups of the population of interest. (See §7113.)

Sections 7152 and 7154 provide additional guidelines.

7152. GUIDELINES FOR EXPANDING SAMPLE SIZE

You may choose to increase the number of completed reviews beyond the minimum numbers specified in Exhibit 1. However, adhere to the following:

- If additional cases are selected across the entire spectrum of one of your MEQC populations (AFDC and MAO) in accordance with your sampling plan, consider the additional cases as part of the MEQC sample. Include these cases and associated review information in all reports submitted.

- If, however, the additional cases are to come only from a particular segment of one of the populations, e.g., a geographic area or a particular case type, you may exclude them from the MEQC sample and from reports to HCFA. However, the sampling plan submitted to the RO must identify this segment, and, when the sample from the segment is selected, apply appropriate controls to separate them from the rest of the cases included in the MEQC process. If these cases are included in reports to HCFA, they must be weighted in accordance with the requirements of Chapter 4. If these additional cases are selected with a different sampling methodology, they are excluded from reports to HCFA.

Explain in detail any planned expansions in sample size in the sampling plan documentation submitted to HCFA for approval.

7154. GUIDELINES FOR FURTHER STRATIFICATION

The basic MEQC sample design requires that the Medicaid population in a State be stratified by AFDC cash and MAO cases.

You may choose to further stratify into substrata any MEQC sample stratum which you independently select and review (other than the AFDC sample). For example, a 209(b) State may divide its MAO caseload into three substrata, each of which represents a different region of the State, and select sample cases independently from regional sample selection lists.

In substratifying, the sample must comply with the following guidelines:

- There can be no more than three substrata in each stratum, and
- There can be no fewer than 75 completed case reviews per substratum.

If you substratify the sample, specify how you will substratify in the sampling plan documentation. If you substratify your sample, designate one character of your review number as a predefined substratum indicator and provide the RO with this designation.

Substratification plans which do not adhere to the above may be submitted to the RO for consideration if a compelling case can be made for the proposal.

GLOSSARY OF TERMS

The following terms include statistical terms that are encountered in sampling as well as specific terms included in this chapter.

1. Absolute Value - disregards all negative values of numbers; considers all numbers positive.

2. Adequate Sample - pertains most commonly to the size of a sample. A sample is adequate if its size is large enough to give the degree of precision or reliability required in a given sample estimate.

3. Alpha - the allowable probability associated with observed differences attributed to chance. If the probability associated with sample differences is less than alpha, we can reasonably conclude that a real difference between samples exists.

4. Bias - systematic error, leading to distortion in one direction of a statistical result; distinct from random error, where distortion in both directions may be largely self-canceling.

5. Caseload - the "target" population, comprised of only those cases included in the QC system for Medicaid.

6. Confidence Interval - the interval between two sample values, known as confidence limits, within which it may be asserted with a specified degree of confidence that the true population value lies.

7. Confidence Limits - the values which form the upper and lower limits of the confidence interval.

8. Equal Probability of Selection - selection of a sample where every case has an independent and equal chance of inclusion in the sample (also called self-weighted sample).

9. Frame - the list of cases from which the sample is actually selected; also known as the sample selection list.

10. Listed in Error - cases included in the sample selection list that are not included in the population of interest.

11. Mean - a measure of the central tendency of data; the sum of the values divided by the number of values.

12. Nonsampling Error - the error or deviation from the true population value in sample estimates which cannot be attributed to chance sampling variations. Examples are errors resulting from imperfections in the selection of sample units, bias in the estimating procedures used, mistakes in arithmetical calculations, inconsistent review procedures, etc.

13. Normal Distribution - a symmetrical, bell-shaped curve which describes the sampling distribution of many common sample statistics. While the sampling distributions of proportions and "percents in error" as used in QC are more correctly described by the binomial distribution, they are often closely approximated by the normal distribution, and it is common practice to use the normal distribution for this purpose. The normal distribution provides the theoretical basis for the determination of confidence limits and QC limits for the specification of particular levels or degrees of confidence involved in making sample estimates and in evaluating sampling error.

14. Oversampling - selecting more sample cases than required to compensate for cases that will have to be dropped.

15. Parameter - a value, property, or characteristic of a population which is estimated from a sample. Examples are a mean, proportion or percentage, total, range, or standard deviation.

16. Population of Interest - those units about which we wish to form conclusions from which a sample is selected and estimates made.

17. Precision - (See definition for reliability.) The degree to which a sample estimate approximates the true values; the sampling error of a sample estimate.

18. Probability - relative frequency of occurrence; the probability of an event is the relative frequency of occurrence of the event in an indefinitely large number of series of observations.

19. Probability Sampling - any method of sample selection which is based on the theory of probability. Probability sampling, which requires that at any stage of selection the probability of any unit or set of units being selected must be known, is the only general method of sampling which makes it possible to obtain a mathematical measure of the precision of the sample estimate.

20. Random Numbers - series of digits, each occurring independently of each other. Each digit tends to appear as many times as any other, in any progression, if the series selected is large.

21. Random Sampling - the process of selecting a sample from a population so that every unit in the population has a known chance of being included in the sample.

22. Random Start - In selecting a systematic random sample at intervals of some specified number of items in an ordered frame, it is mandatory to select the first item completely without bias. Such selection is then said to have given the sample "a random start."

23. Range - the largest minus the smallest of a group of values.

24. Reliability - (synonymous with precision) - the uniformity of sample results when obtained from repeated samples of the same size and type from the same population; the degree to which a sample estimate approximates the true value.

25. Risk - as used here, refers to the degree of risk associated with given degrees of confidence. For example, if a statement is made "with 95-percent confidence" that the true population parameter lies within a specified interval, there is a "5-percent risk" that the parameter actually lies outside that interval (also called alpha).

26. Sample - part of a universe; a limited or finite number of items selected from a universe, by a prescribed procedure, with the objective of estimating certain values (mean, total proportion, etc.) of the parent universe or of testing in respect to particular properties of the universe.

27. Sample Selection List - the list of cases from which the sample is actually selected; also known as the sample frame.

28. Sample Size - the number of items in the sample.

29. Sampling Distribution - the distribution of a (sample) statistic, such as a sample mean or a sample proportion or percentage, that would be formed by obtaining such statistics from all possible samples of a given fixed size selected by some specified sampling procedures; a population of all possible sample values of the statistic under consideration.

30. Sampling Error - that part of the difference between a universe value and an estimate of that value obtained from a random sample which is due solely to the fact that only a sample of values is observed; to be distinguished from non-sampling error which is due to biased or imperfect sample selection or real difference due to changes over time, error of observation, recording calculation, etc.

31. Sample Interval - in systematic sampling the number of cases between selections on the sampling frame.

32. Significant Difference - A difference is statistically significant if it can be concluded from a sample, with a given degree of risk, that the difference actually exists in the universe. A difference observed in a sample is judged not statistically significant if it could easily have occurred purely as a result of random sampling variations.

33. Simple Random Sample - a probability sample selected in such a way that each unit of the frame has an equal and independent chance of being included in the sample; for samples of any given size all possible combinations of units that could form samples of that size must have the same probability of selection (usually uses random digits for item selection).

34. Standard Deviation - the most widely used measure of the dispersion (scatter or variability) of frequency distributions from their arithmetic means. The standard deviation of the sampling distribution of any given statistic is also known as the "standard error" of that statistic.

35. Standard Error - the standard deviation of the sampling distribution of a given statistic; used in measuring precision of an estimate.

36. Stratified Random Sampling - random sampling of a universe which has been divided into a number of subuniverses according to some predetermined criterion (geographic location, characteristic, etc.). The percentage size of each sample must be equal or have individual weighing factors taken into account before the subuniverse sample results can be combined.

37. Stratum - a segment of the universe for which separate estimates are computed for some special reason. All strata must be combined if an estimate of the total universe is to be made.

38. Systematic Random Sample - a sample attained by selecting from a file, list, or computer tape individual items at equally spaced intervals (as every 10th, 140th, 850th, etc., item, as required to obtain a total sample of a given size), with the starting point within the first such interval being determined by random selection.

39. Tolerance - the proportion of sampling error which has been determined to be acceptable.

40. Universe (also called a population) - all units about which information is desired; a probability sample of these units yields an estimate of universe values within certain limits of reliability.

41. Weighted Sample - a sample in which the probability of selection is not equal, thereby requiring weighing by various factors so that no segment of the caseload is overrepresented.

MEQC ERROR RATE CALCULATION

The MEQC fiscal year error rate and lower limit are based on the following:

$$R_{FYLL} = R_{FY} - 1.96 \sqrt{VAR(R_{FY})}$$

$$R_{FY} = \frac{D_1 R_1 + D_2 R_2}{D_1 + D_2}$$

$$VAR(R_{FY}) = \frac{D_1^2 VAR(R_1) + D_2^2 VAR(R_2)}{(D_1 + D_2)^2}$$

Where D_p is the AFDC + MAO universe dollars for review period, P and R_p is the error rate for review period P. For each review period, the error rates and variances are computed as follows:

$$R_P = \left(\sum^{L} \bar{w}_h \bar{x}_h\right) / \left(\sum^{L} \bar{w}_h \bar{u}_h\right)$$

$$VAR(R_P) = \sum^{L} w_h^2 VAR(R_h)$$

$$VAR(R_h) \frac{\sum^{n_h} (x_{hi}^2) - 2 R_P \sum^{n_h} (x_{hi} u_{hi}) + R_P^2 \sum^{n_h} (u_{hi}^2)}{\bar{u}_h^2 \cdot n_h (n_h - 1)}$$

Where (For strata from h=1 to L, and assuming all sustained Federal findings have been substituted for State findings) :

x_{hi} = The error amount for the i^{th} case in the h^{th} stratum

$\bar{x}_h$ = The full sample average error dollars per case in stratum h

u_{hi} = The payment amount for the i^{th} case in the h^{th} stratum

$\bar{u}_h$ = The full sample average State dollars paid per case in stratum h

n_h = The number of completed sample reviews in stratum h

w_h = N_h / N_p = The universe case weight for stratum h

CRITERIA FOR ADJUSTING ANTICIPATED ERROR RATES

PURSUANT TO 42 CFR 431.865(d)

Initial Calculation of Anticipated Error Rate

Unless you submit rebuttal evidence as described below, your anticipated error rate is the lower of (1) the Medicaid eligibility quality control (MEQC) payment error rate for the latest 6-month period, or (2) the weighted average of the error rates for the latest two 6-month periods completed by you and the Health Care Financing Administration (HCFA).

Basis for Rebuttal

Effective May 31, 1990, program changes published in the Federal Register (see 42 CFR 431.865) state that any State may rebut its anticipated error rate only if its anticipated error rate is based on erroneous data. This applies to subsample findings or Federal data entry errors only. Data errors do not include State-transmitted original State review findings, except for the situations outlined in §7500.

Timeframes

Inform HCFA at least 70 days prior to the beginning of a quarter that you intend to submit valid evidence to rebut the anticipated error rate. Submit the evidence to HCFA at least 40 days prior to the beginning of the quarter. You may request copies of data used to compute your error rate within 7 days of receiving notification of your projected error rate.

Criteria for Acceptance of State Evidence

Acceptable examples of erroneous data regarding Federal data errors include keypunching of universe or monitor data or regional office changes to State data. State challenges of the methodology used to compute the error rates are unacceptable, as specified in 42 CFR 431.865(d)(2)(vi). Also, citing incorrect HCFA instructions in the State Medicaid Manual is not accepted.

Documentation Requirements

Your submittal must include all documentation necessary for HCFA to verify that the evidence requirements are met (i.e., the list of erroneous subsample cases, the error rate computation, and your projected error rate).

Time Validity of State Evidence

You may submit the above-specified evidence and request that it be considered to rebut the error rates for both the quarter in question and the following quarter preceding the availability of another review period's data.

The next page is 7-2-47.

RETROSPECTIVE SAMPLING

The purpose of retrospective sampling is to improve precision by stratifying cases by dollar value of claims.

Sample Selection

Draw an initial oversized sample each month. Select each sample from the universe of cases which were eligible in the fourth month prior to the sample month; (e.g., samples selected in October will be for cases reviewed for eligibility in June; thus, June is the "service" (or eligibility review) month, and October is the "sample" month). Determine paid claims for each case in the oversized sample and include all payments for services rendered in the "service" month and paid anytime during that month up to and including the "sample" month. Assign each case to one of the three strata. These cases then constitute the sample frames for selecting three samples within three dollar based strata. Insure that the initial monthly oversized sample is large enough to provide an adequate sampling frame so that the prescribed number of cases within each stratum is provided. Review retroactive eligibles but exclude them from the error rate computations. Do not count retroactive eligibles toward satisfying the minimum sample completion requirement.

Stratum Boundaries

Recommended Approach for Determining Strata and Sample Sizes

Accumulate MAO stratum sample cases for the last three 6-month reporting periods for which data are available. Partition these cases by paid claim dollar values into incremental categories of $100. Count the number of cases in each category and establish strata boundaries.

Let the jth $100 category = C_j=1,...K, and the number of cases in the jth $100 category = n_j j=1,...,K.

Also, let $z_k=\Sigma\sqrt{n_j}$ j=1,..,K be the total sum of the square roots of the number of cases in the K $100 dollar categories.

Then the optimal $100 dollar value boundaries (upper values) for the first two strata are:

1st stratum-the C_j which corresponds to the first $Z_j > Z_{k/3}$

2nd stratum-the C_j which corresponds to the first $Z_j > 2/3\ Z_k$

Example

State X will test retrospective sampling in the October 1995-March 1996 review period. MEQC data for the October 1993-March 1994, April 1994-September 1994, and October 1994-March 1995 review periods are available, and the number of cases by $100 category are as follows:

Number of Cases

j	Paid Claim $Category	10/93-3/94	4/94-9/94	10/94-3/95	Total (n_j)
1	0-100	571	568	555	1,694
2	101-200	64	62	69	195
3	201-300	21	28	30	79
4	301-400	10	12	15	37
5	401-500	8	8	13	29
6	501-600	14	13	17	44
7	601-700	15	17	26	58
8	701-800	43	38	30	111
9	801-900	41	43	31	115
10	901-1000	40	40	37	117
11	1001-up	48	53	54	155
		875	882	877	2,634

j	$z_j = \Sigma\sqrt{n_j}$	C_j
1	41	0-100
2	55	101-200
3	64	201-300
4	70	301-400
5	75	401-501
6	82	501-600
7	90	601-700
8	100	701-800
9	111	801-900
10	122	901-1000
11	134	1001 up

and, $Z_k = 134.25$ $Z_{k/3} = 44.752$ $2Z_{k/3} = 89.50$

and the 1st stratum upper boundary is j=2 since

Z_2=55 is the first $Z_j > Z_{k/3}$

and the 2nd stratum upper boundary is j=7, since

Z_7=90 is the first $Z_j > 2/3\ Z_k$.

Thus, for State X, dollar value boundaries for the three strata are:

	Cases With Claims Between
Stratum 1	$0-$200
Stratum 2	$201-$700
Stratum 3	$701 up

Strata Sample Sizes

Determine stratum sample sizes by the following formula utilizing the same data:

$$n_h = n \frac{N_h S_h}{\Sigma N_h S_h}$$

Where n = required 6-month MAO sample size
n_h = strata sample sizes
N_h = number of cases in stratum h for the three periods
S_h = standard deviation of stratum h eligibility and liability error dollars

Example

For State X:

$N_1 = 1{,}889 \quad N_2 = 247 \quad N_3 = 498$

$S_1 = 16.6 \quad S_2 = 48.3 \quad S_3 = 300.1$

Where $S_h = \sqrt{\frac{\Sigma(X_{jh} - X_h)^2}{N_h - 1}}$

Thus:

$\Sigma N_h S_h = (1{,}889)(16.6) - (247(48.3) - (498)(300.1)$
$= 192{,}737.3$

and the required sample sizes for the strata for the 6-month period are:

$$\text{Stratum 1} = \frac{(875)N_1S_1}{192{,}737.3} = \frac{(875)(1{,}889)(16.6)}{192{,}737.3}$$

$= 142$

Stratum 2 = $\frac{(875)(247)(48.3)}{192,737.3}$

= 54

Stratum 3 = $\frac{(875)(498)(300.1)}{192,737.3}$

= 678

Initial Oversized Sample

Draw the initial oversized sample large enough to insure that it represents an adequate sampling frame for the final strata samples.

Example

For State X, the strata for paid claim dollar values larger than $701 must be at least 678 cases. However, only 18.9 percent of all cases, (111 + 115 + 117 + 155)/2,634 on average, have at least $701.

Therefore, the initial oversized sample must be at least:

$\frac{678}{.189}$ = 3,588 cases not accounting for drops, etc.

Use of Standard Sampling Methodology

Once the initial oversized sample and the strata sample sizes are established, use standard sampling procedures for each stratum.

7199. EXHIBITS

Exhibit 1 - Sample Sizes
Exhibit 2 - Table of Random Sampling Numbers

EXHIBIT 1

SAMPLE SIZES

Minimum Required Number of Completed Reviews for MAO Stratum in 6-Month Period*

Region I	SSI Relationship	MAO
Connecticut	. 209b	375
Maine	. 1634 Contract	225
Massachusetts	. 1634 Contract	875
New Hampshire	. 209b	175
Rhode Island	. 1634 Contract	175
Vermont	. 1634 Contract	175
Region II		
New Jersey	. 1634 Contract	375
New York	. 1634 Contract	875
Region III		
Delaware	. 1634 Contract	175
D.C.	. 1634 Contract	275
Maryland	. 1634 Contract	275
Pennsylvania	. 1634 Contract	875
Virginia	. 209b	550
West Virginia	. 1634 Contract	175
Region IV		
Alabama	. 1634 Contract	225
Florida	. 1634 Contract	275
Georgia	. 1634 Contract	275
Kentucky	. 1634 Contract	375
Mississippi	. 1634 Contract	175
North Carolina	. 209b	375
South Carolina	. 1634 Contract	175
Tennessee	. 1634 Contract	175
Region V		
Illinois	. 209b	875
Indiana	. 209b	275
Michigan	. 1634 Contract	550
Minnesota	. 209b	550
Ohio	. 209b	875
Wisconsin	. 1634 Contract	550
Region VI		
Arkansas	. 1634 Contract	225
Louisiana	. 1634 Contract	175
New Mexico	. 1634 Contract	175
Oklahoma	. 209b	375
Texas	. 1634 Contract	550

*AFDC stratum sample sizes based on AFDC_QC sample requirements.

Region VII	SSI Relationship	MAO
Iowa	. 1634 Contract	175
Kansas	. State Determination/SSI Criteria	275
Missouri	. 209b	275
Nebraska	. 209b	275
Region VIII		
Colorado	. 1634 Contract	275
Montana	. 1634 Contract	175
North Dakota	. 209b	175
South Dakota	. 1634 Contract	175
Utah	. State Determination/SSI Criteria	225
Wyoming	. 1634 Contract	175
Region IX		
Arizona	. 1634 Contract	175
California	. 1634 Contract	875
Hawaii	. 209b	175
Nevada	. State Determination/SSI Criteria	175
Region X		
Alaska	. State Determination/SSI Criteria	175
Idaho	. State Determination/SSI Criteria	175
Oregon	. State Determination/SSI Criteria	225
Washington	. 1634 Contract	275

TABLE OF RANDOM SAMPLING NUMBERS

A table of random numbers is a compilation of numbers whose frequency and sequence of occurrence have been determined by chance. Since the position that any digit occupies is a result of chance, any number formed by a combination of these digits, in any sequence, by any progression, systematic or random, in any direction from any starting point, may be regarded as a random grouping or selection.

The only requirement is that all items from which a random selection is to be made have, or were assigned, individual identifying numbers. The entire group of numbered items may be regarded, for certain purposes, as a statistical population. A selection of any part of that statistical population by means of a table of random numbers may be regarded as a random sample of the population.

The number of digits required for the numbers to be used in any given application of the table depends in general upon the size of the population from which the selection is to be made. More specifically it depends upon the number of digits in the highest number assigned to units of the population to be sampled.

For example, if the population to be sampled consists of 84 cases, numbered from 1 through 84, random numbers of 2 digits are required. If the highest number assigned in a group is 796, random numbers of 3 digits are required. To obtain a two-digit, three-digit, seven-digit, or other size number from the table, combine adjacent digits as needed. It makes no difference where in the table one begins or in which direction one moves in selecting random numbers. However, each time the table is used, select a different starting point.

EXAMPLE: Let us assume that the highest consecutively numbered case in the population is 5743, and that the analyst has randomly selected the location horizontal row 20, vertical columns 05-09. This assumes that a decision is made to use the left four-digits of each five-digit number for sample selection. Reading down the table from this starting point, the sample would be selected as follows: 1295, 3711, 4387, 0033, 0112, 1316, 4286, and so on until the desired sample size is obtained. The numbers 6689, 6708, as well as any other numbers larger than 5743, or the same as a number previously encountered during sample selection, should be rejected.

THIS RESERVED FOR TEN THOUSAND
RANDOMLY ASSORTED DIGITS

RESERVE SPACE FOR CHART

RESERVE SPACE FOR CHART

THIS SPACE RESERVED FOR
EXHIBIT 2 (CONT.)

7200. MEDICAID ELIGIBILITY OVERVIEW

The Medicaid program was established by the Congress to help maintain the health care of needy Americans. Aged, blind, and disabled individuals, families with dependent children, and pregnant women who cannot afford necessary medical treatment are primarily the ones for whom the program was designed.

The program is jointly funded by the Federal Government and the participating States or United States jurisdictions.

To participate in the Medicaid program, you must cover certain groups of individuals. In addition, you have the option of extending Medicaid eligibility to a variety of other groups. (See §7272.)

These groups fall into three classifications:

- Mandatory categorically needy,
- Optional categorically needy, and
- Medically needy.

Mandatory categorically needy coverage groups are often recipients of cash assistance under any plan approved under titles I, X, XIV, or XVI or part A or part E of title IV of the Act. There are, however, groups of categorically needy individuals who do not receive cash assistance payments. For example:

- Individuals who are deemed to be recipients of title IV-A benefits (Aid to Families with Dependent Children (AFDC)).
- Qualified pregnant women and children.
- Those whose eligibility was protected under policies in effect in a State for aged, blind, and disabled individuals on December 1, 1973, prior to implementation of the supplemental security income (SSI) program under title XVI. These groups are usually referred to as grandfathered groups.
- Individuals whose eligibility was protected due to cost of living increases in Social Security benefits in 1972 and since 1977. These coverage groups are referred to as pass-along groups.
- Individuals who are aged, blind, or disabled in a State which has elected not to provide Medicaid to all SSI recipients, but has elected to use more restrictive criteria for determining eligibility than those used in the SSI program but no more restrictive than those contained in the State's January 1, 1972, Medicaid State plan. Section 1902(f) of the Act creates this option and exempts these States from the general requirement of providing Medicaid to all SSI recipients. Such States are referred to as 209(b) States, the section in Public Law 92-603 which established this option.
- Qualified Medicare beneficiaries (QMBs) for Medicaid payment of Medicare cost sharing and premiums.

You may also elect in your State plan to cover certain additional categorically needy groups. These groups are called the optional categorically needy. A more detailed description of these groups is located in 42 CFR 435.200-232.

You may further expand your Medicaid program to cover individuals and families who have enough income and/or resources to provide for normal living expenses, but do not have income sufficient to cover unusually high medical expenses. This group is known as the medically needy.

In addition to the option to elect the more restrictive 209(b) criteria for determining the eligibility of the aged, blind, and disabled, you have two options as to the determination of eligibility if you elect to cover all SSI beneficiaries. You may choose to contract with the Social Security Administration (SSA) to determine eligibility for SSI beneficiaries, or you may make that determination by requiring a separate application for Medicaid. States which elect to contract with SSA are referred to as §1634 States. This is a reference to §1634 of the Act under which these contracts are allowed. States which require a separate application for SSI beneficiaries for Medicaid are referred to as SSI-criteria States. The phrase "SSI-related" is used throughout this manual. In jurisdictions not having an SSI program, substitute the terms "aged," "blind," or "disabled" as appropriate.

7203. DEFINITIONS OF KEY TERMS

Active Case--An assistance unit which is authorized as eligible and is on the State eligibility listing for the review month.

Administrative Period--A period of time recognized by the MEQC program for the State agency to reflect changes in the status or circumstances of the assistance group, i.e., a change in a common program area during which no case error based on the circumstance is cited. The common program area is defined as a common program element of eligibility. This period consists of the review month and the month prior to the review month. (See §7278.)

AFDC (Aid to Families with Dependent Children)--A needs-based program funded by the State and Federal governments and administered by each State. Beneficiaries must meet income and resource limits, as well as prove deprivation of parental support or care by death, continued absence, physical or mental incapacity, or unemployment of one or both parents.

Beneficiary Liability--Either the amount of excess income that must be offset with incurred medical expenses to gain eligibility (spenddown) or the amount of payment a beneficiary must make toward the cost of long term care, or, in some instances, for home and community-based services.

BENDEX (Beneficiary Data Exchange System)--An automated communication system between State assistance agencies and SSA which provides a record of Retirement, Survivors, and Disability Insurance (RSDI) benefits.

Case Record--A file retained by the State agency (including electronic storage data) which contains all pertinent information of a beneficiary's basis for Medicaid eligibility.

Case (Sample Unit)--The family/child(ren)/pregnant women in the AFDC cash assistance population and the Medicaid assistance group in the remaining portion of the Medicaid population. A Medicaid assistance group is any number of Medicaid beneficiaries who are identified on the State eligibility file as a Medicaid case(s).

Cash Surrender Value--The monetary amount which an insurer pays upon cancellation of a life insurance policy prior to the death of the insured.

Categorically Needy--Aged, blind, or disabled individuals or families and children who (1) meet financial eligibility requirements of AFDC, SSI, or

receive optional State supplemental payments and are otherwise eligible for Medicaid, (2) meet coverage requirements for QMB, or (3) have their Medicaid eligibility protected by statute.

Change in Circumstance--A change in a beneficiary's living situation, income, or resources which affects eligibility or liability.

Collateral Contact--Any contacts made by the reviewer, other than the beneficiary, to determine eligibility of any case member, e.g., banks, landlord, neighbors.

Countable Income--The amount of money remaining after all allowable deductions and exemptions have reduced a beneficiary's/applicant's gross income.

Countable Resources--Liquid and/or nonliquid resources which are used in determining whether an individual meets the limitation on resources.

Date of Action--The date on which the State agency responds to a beneficiary's change in circumstances by revising the eligibility/liability status of the beneficiary. In applications and redeterminations, the date the Agency inputs the change into the eligibility system is considered the date of action.

Deemed Income--Income attributed from one person to another whether the income is actually available to the second person.

Documentation--Copies of official evidence that support the beneficiary's eligibility determination, e.g., birth certificate, death certificate, court order, insurance policies, pay stubs, award letters, medical bills and expenses, letters and responses from collateral sources.

Dually Eligible Individual--Beneficiary who is certified as eligible for both QMB coverage and another regular Medicaid coverage category.

Elements of Eligibility--The factors systematically listed on the Form HCFA 316 worksheets which the reviewer analyzes and documents completely for each review.

Eligibility Error--Errors that occur when a beneficiary under review authorized as eligible (1) was ineligible when he/she received services under the State plan, or (2) had not met his/her liability when certified eligible, or (3) was ineligible for certain services received.

Eligibility Review--A review completed by MEQC to determine if and to what extent a case member(s) is entitled to Medicaid benefits for the review month.

Erroneous Payment--The Medicaid payment that was made for an individual or family under review who:

- Was ineligible for the review month or, if full month coverage is not provided, was ineligible at the time services were received;
- Had not properly met beneficiary liability prior to receiving Medicaid services; or
- Was ineligible for certain services received.

Face Value--The amount of a life insurance policy which is to be paid in case of death of the insured or upon maturity of the policy. It is usually stated on the first page of an insurance policy.

Home or Community-Based Services--Services not otherwise furnished under the State's Medicaid plan that are furnished under a waiver granted under the provisions of 42 CFR 441, Subpart G. A list of these services may be found in 42 CFR 440.180.

Income and Eligibility Verification System (IEVS)--A computer match system that requires State agencies to exchange income and resource information and to obtain data from the Internal Revenue Service, SSA, and unemployment insurance benefit files to make accurate eligibility determinations and benefit payments.

In-kind Income--A service or benefit provided to a Medicaid beneficiary to which a monetary value may be assigned, e.g., rent, food, clothing.

Integrated Review Schedule (IRS)-(Form HCFA 301)--A comprehensive data entry form for all QC reviews in the AFDC, Adult, Food Stamp, and Medicaid programs.

Liability Error--An error which occurs when an individual's income and/or medical expenses were incorrectly counted by the agency.

Liability Overstated--An error which occurs when a case certified eligible for Medicaid had more than the proper amount of excess income applied to incurred medical expenses. Overstated liability also exists when an eligible institutionalized individual or certain individuals receiving home and community-based services under a waiver granted under 42 CFR 441, Subpart G were made liable for more than the correct amount to be applied to the cost of institutional care or the cost of home and community-based services.

Liability Understated--An error which occurs when an individual has not incurred medical expenses at least equal to excess income prior to being certified eligible for Medicaid. Understated liability also exists when an individual was made liable for less than the correct amount to be applied to the cost of institutional care or for home and community-based services.

Liquid Resource--A resource which is negotiable. Normally this consists of cash on hand or checking accounts, saving accounts, bonds, stocks, etc. which are readily converted to cash.

Mandatory State Supplement--A cash payment a State is required to make under 42 CFR 435.230 to an aged, blind, or disabled individual. The purpose is to provide an individual with the difference in the amount of cash assistance he/she was receiving in 1973 under certain other federally funded assistance programs if his/her SSI payment was less than that amount.

Medicaid Beneficiary--An individual who is certified eligible to have payments made from title XIX funds for specified medical services received during the month(s) or portion(s) covered by the certification.

Medically Needy Income Level--A monetary standard of income used by States having a medically needy program. This standard is applied to beneficiaries whose income exceeds the categorically needy level.

Nonliquid Resources--Resources consisting of assets such as real property or personal or business assets that are not readily convertible to cash.

Optional State Supplement--A cash payment made by a State to an aged, blind, or disabled individual in addition to any SSI or mandatory State Supplement.

Payment Review--A review completed by MEQC after the eligibility review in which the Medicaid claims payments for a Medicaid beneficiary are collected and a determination made as to the correctness of these payments based on the eligibility review.

Personal Needs Account--An account similar to a savings account used by institutionalized persons. This account is intended for material goods such as reading matter, small gifts, and toiletries. The accounts are often kept at the institution.

Qualified Medicare Beneficiary (QMB)--Medicare beneficiaries who are eligible for Medicaid payment of Medicare cost sharing expenses and Medicare Part A and Part B premiums.

QMB Determination Decision--The earliest documentation in the case file or automated system that the State has established the beneficiary's eligibility for QMB coverage.

Recoupment--A recovery process by which a designated office or department of the State seeks to retrieve misspent cash assistance and/or Medicaid funds from beneficiaries, third party sources, or service providers whom Medicaid has erroneously reimbursed.

Review Month--The calendar or fiscal month or portion for which the sampled case, which has been certified eligible for medical assistance, is reviewed.

Review Period--The 6-month period (April-September or October-March) for which States must select and complete a review of a sample of cases.

Sampling Plan--Written documentation provided by the State specifying in detail which strata are to be sampled for a given review period and how the sample is to be selected. See §7130 for more specific information on sampling plans.

Spenddown--This applies to individuals in medically needy and 209(b) States. It allows individuals with income above the established level and who meet all other eligibility criteria to incur medical expenses or remedial care expenses that equal or exceed the amount of income the individual has over the State's income level to become eligible for Medicaid. The amount of incurred medical or remedial care expenses necessary to become eligible is referred to as the spenddown amount.

State Agency--Either the State Medicaid agency or State organization responsible for determining eligibility for Medicaid.

State Data Exchange (SDX)--An information system providing data regarding recipients of SSI provided to States by SSA.

Stratum--For sampling purposes, the entire Medicaid population as a whole is referred to as the universe. Isolated segments of this universe with similar characteristics are each referred to as a stratum, e.g., AFDC stratum, Medical Assistance Only (MAO) stratum.

Three Hundred Percent Cap--Maximum income level used for purposes of determining eligibility for recipients of optional State supplements, for certain institutionalized individuals, and for certain individuals receiving home and community-based services.

7206. MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC) REVIEW

The MEQC review is directed at improving the quality of eligibility determinations under the various coverage groups. The design of the process and the methods for proper MEQC verification are detailed in the following sections.

The MEQC system is operated by a Medicaid agency to monitor the administration of its Medicaid program. The system is based on a monthly review of Medicaid beneficiaries identified through statistically reliable statewide samples of cases selected from eligibility files. Reviews are then conducted to determine whether the sampled cases meet applicable State and Federal requirements. States must adhere to MEQC program requirements unless HCFA has approved an alternative method of administering all or part of the program, e.g., pilot projects.

Conduct the MEQC review in accordance with your Medicaid eligibility policies in effect as of the review month and the procedures in this chapter. For the purposes of MEQC, State Medicaid eligibility policy is defined as all written policy instructions issued by the State for administering the Medicaid program so long as those instructions are clearly consistent with either the State plan or proposed amendments which have been submitted to, but have not been acted upon, by HCFA. Effective October 1, 1992, conduct MEQC reviews in accordance with written operations policy until notified by HCFA in writing that the policy is not in accordance with Federal policies.

MEQC will not cite errors based on inappropriate policy until 3 months after HCFA has notified a State of the inappropriate policy. This provision applies only when legislation or regulations are not clear or if HCFA has not issued written clarification (i.e., manual provisions, memorandums).

The State plan is the formal document which represents the contract between the State and HCFA for providing Medicaid services. It is a preprinted document which contains the commitments by the State to administer the Medicaid program within the CFR. It is the responsibility of the State agency to maintain the State plan and to assure that it is current.

Have available for reference a current copy of the State plan. Be familiar with its contents and be able to identify any State policy or procedure that appears to be in conflict with the plan. If policy is discovered that appears in conflict with the plan, bring it to the attention of the MEQC supervisor for verification. If verified, MEQC reviews against the plan and not the State policy.

For MEQC purposes, if the State plan directly addresses an issue, the State plan prevails, even if the plan has been cited by the HCFA regional office (RO) to be out of compliance with Federal regulations, so long as a final decision to disapprove the plan has not been made by HCFA. If, however, the State plan does not address an issue, Federal regulations prevail and the MEQC review is conducted against the CFR. Medicaid eligibility regulations are found in 42 CFR, Parts 435 and 436.

The following are guides for determining the criteria for the MEQC review:

- Against written State policies and procedures when they are clearly in accordance with the approved State plan (the approved State plan includes approvable plan amendments submitted to HCFA);

- Against the approved State plan if written State policy is in conflict with the plan;

- o Against Federal regulations if the State plan is silent on the issue and written State policy conflicts with Federal regulations; and

- o Against Federal statutes if regulations do not exist.

7209. SCOPE OF MEQC SYSTEM

The Medicaid sample includes persons and families whose eligibility is determined by an agency of the State. This includes recipients of AFDC in all States, recipients of SSI in SSI-criteria States, and those who are eligible as MAO cases, i.e., those whose eligibility is based on criteria other than receipt of AFDC or SSI. In 209(b) States, eligibility for aged, blind, or disabled individuals is not based on receipt of cash assistance because these States employ more restrictive requirements than SSI.

Therefore, an individual may be receiving SSI but may not be eligible for Medicaid. Some individuals are eligible for SSI or AFDC but for certain reasons do not receive cash assistance. All of these groups are subject to sampling.

Since eligibility is determined by SSA in §1634 States for SSI beneficiaries, these cases are not included in the MEQC population.

7212. MEQC OPERATION

The steps in the MEQC operation follow.

1. Each month draw a representative sample of cases from the eligibility file;

2. Review their eligibility for the review month;

3. Identify the paid claims of the sampled cases for services received during or applied to the review month; and

4. Assign dollars to eligibility errors.

The MEQC system operates in the following manner for the AFDC population. Your State MEQC staff collects claims for all State selected AFDC-QC sample cases. Those cases found to be ineligible by AFDC-QC are reviewed by your State MEQC staff to determine Medicaid eligibility under another coverage code. AFDC ineligible cases with overpayments or with ineligible members resulting in an overpayment are to be reviewed by MEQC for potential Medicaid coverage in another coverage group.

7212.1 MEQC State and Regional Cycles.--The sampling period for MEQC reviews is 6 months: October through March and April through September. Samples are drawn monthly, case reviews are completed, and findings reported. Complete the eligibility portion of reviews for all cases in the MAO sample and all ineligible cases and cases with ineligible members in the AFDC sample. Submit these cases to the RO according to the following time frames: 90 percent within 105 days of the end of the review month, 95 percent within 125 days of the end of the review month, and 100 percent within 150 days of the end of the review month. All AFDC eligible case review findings are due within 150 days of the end of the review month. The agency must not combine or otherwise integrate case findings from the MAO and AFDC strata to meet these case percentages.

The State must complete and report claims collection reviews for 100 percent of the active case reviews in its sample. The State must wait 5 months after the end of each review month before associating said claims for services furnished during the review month unless retrospective sampling is elected. Report the findings within 60 days after the first day of the month in which the claims collection process begins.

7215. ROLE OF REVIEWER

A. Reviewer Responsibilities.--The QC reviewer is responsible for collecting and verifying all information necessary to determine the eligibility status of the case as of the review month.

The reviewer must have a thorough knowledge of State Medicaid plan eligibility requirements and AFDC State plan policies and procedures.

B. Reviewer Activities.--The MEQC reviewer activities include:

- Analyzing the case record and recording the analysis on the worksheets;
- Conducting field investigations, including an in-person interview with the beneficiary or the beneficiary's representative to determine eligibility for all MAO stratum cases;
- Verifying the elements of eligibility through collateral contacts as required, and recording the information on worksheets;
- Determining the eligibility status of each case member;
- Collecting copies of all State paid claims or beneficiary profiles for services delivered during or applied to the review month for the case under review;
- Associating dollar values with eligibility errors; and
- Completing the IRS.

The reviewer's role does not encompass provision of service. When individuals bring their service needs to the reviewer's attention, identify the proper unit in the agency to be contacted. At the same time, notify the local agency of the request through proper channels.

Perform the above activities in a manner consistent with 42 CFR 435.902 and 436.901 concerning the rights of the beneficiary.

7218. INDEPENDENCE OF MEQC REVIEW

Obtain eligibility information from State AFDC-QC and local agency case records and obtain claims for services from State files. Other local agency resources may be used. For example, it is proper to use official processes and program units of the local agency for determining facts and obtaining documentary evidence, e.g., birth certification and property verifications. When additional medical information about a beneficiary's disabilities or incapacity is required, request a local agency to refer the beneficiary for a medical examination and supply the results to the reviewer.

The review and the reviewer's decision must be completely independent of the agency that originally determined eligibility. It is improper for a reviewer to question an eligibility worker about a case. The responsibility for

evaluating the information obtained and making a decision is solely the reviewer's.

State agency MEQC policies specify the extent and procedures by which methods, such as those cited above, are employed. State MEQC policies must conform to requirements outlined in §§7269 and 7269.1 and in 42 CFR 431.812.

7221. DOCUMENTATION OF REVIEWS

The primary tools used by the reviewer are the Integrated QC Worksheets, the Information and Verification Requirements by Element (see §§7260-7269), the Verification Guide for Medicaid Eligibility Review (see §7272), and the IRS. These provide a systematic means for the reviewer to analyze the case record, plan and carry out the field investigation, and review and record findings. The MEQC review files must contain full documentation for the review month for the elements on each of the worksheets and for other information in such detail that the criteria upon which the review decision was based are evident. (See §7248.)

7224. APPROACH TO MEQC

The major steps in the MEQC review process, when the individual is AFDC-related or SSI-related, follow.

Determine if the beneficiary is eligible under all elements required for the indicated coverage group as of the review month and, if not, determine if the beneficiary is eligible under all elements required for any other coverage group included in the State plan as of the review month. Then, when applicable, determine:

- Whether there is beneficiary liability that must be met;
- If beneficiary liability was met prior to being certified eligible for Medicaid;
- If the monthly amount of the beneficiary's liability was computed correctly;
- If the monthly amount of nursing home or home and community-based services liability was computed correctly;
- Type of eligibility error(s);
- Total amount by which resources exceed the State allowable limit; and
- If the beneficiary received services for which he/she was erroneously certified as eligible.

To determine whether a beneficiary is eligible under any of the State's prescribed coverage groups, conduct an investigation of the beneficiary's circumstances which affect eligibility in the review month. If the review indicates that all members are ineligible due to applying common financial eligibility factors, the individual members may still be eligible in their own right. Consult your State plan and procedures manuals to determine the appropriate policy.

Include a review of QMB criteria when you determine whether a beneficiary may be eligible under any of the State's prescribed coverage groups. Determine whether the beneficiary met the criteria for QMB coverage (except the requirement that the State has made a determination that the beneficiary is

eligible for QMB) in the review month and the month prior to the review month. If the beneficiary did meet the criteria for QMB coverage, count as correct any claims which could have been paid under QMB coverage.

7227. CASES TO BE REVIEWED

Make every effort to complete the review of each sampled beneficiary. In all cases, attempt to contact the beneficiary. The inability to contact the beneficiary does not necessarily preclude completion of the review if all elements of eligibility can be verified. If repeated efforts by the reviewer to obtain cooperation fail, another reviewer may visit the beneficiary or you may request assistance from the certifying agency. Continue the investigation to the extent possible. When the beneficiary does not cooperate and verifications can be obtained without assistance from the beneficiary, complete the review. If a dollar error is found, cite it even though other elements may remain unverified.

Several specific situations occur frequently that reviewers should question if a review is necessary. These specific situations follow.

A. Action to Terminate Occurred Prior to Review Month.--If a local agency action to terminate a beneficiary's eligibility has commenced, but has not been completed prior to the review month, complete the review. This includes cases which were ostensibly closed prior to the review month but still appear on the eligibility file.

B. Cases in Which Eligibility Terminated Since Review Month.--The fact that eligibility had terminated after the review month but prior to the reviewer's interview does not obviate the need for the review. Make every effort to enlist the beneficiary's cooperation in completing the review.

C. Cases of Suspected Beneficiary Fraud.--When there appears to have been willful misrepresentation of facts in the application for Medicaid (e.g., the failure to report a change in circumstances, the use of an invalid Medicaid card, or the use of a valid Medicaid card by an unauthorized beneficiary), complete the review. Notify the appropriate investigatory agency.

D. Death Prior to, in, or Subsequent to Review Month.--Death of the beneficiary during the administrative period including the review month is an unacceptable reason to drop an MEQC review. This also applies to cases in which the beneficiary dies after the review month. If the beneficiary dies prior to the administrative period, code the case ineligible. In the case of death prior to, during, or subsequent to the review month, drop the case only if no information can be gathered from other sources and only with concurrence from the RO.

7230. CASES WHICH ARE NOT REVIEWED

A. Cases Not To Be Reviewed.--Do not review cases listed in error, i.e., cases which have been determined to be sampled in error. Examples of cases listed in error are:

- A case selected in the MAO stratum subject to AFDC-QC review or SSI-quality assurance (QA) review in a §1634 State;

- All case members of a case selected in the MAO stratum are receiving cash assistance from AFDC or SSI (in a §1634 State) under another case number. In these cases, notify the agency in order that one of the cases may be closed;

- o A case from the AFDC stratum not on the Medicaid eligibility file; and
- o All refugee cases which are 100 percent federally funded.

Other listed in error situations could arise. Consult with the RO.

B. Acceptable Reasons for Not Completing Reviews.--Incomplete reviews, unless kept to a minimum, may raise questions about the validity of MEQC findings. Make every attempt to review cases that are properly selected in the sample. However, there are acceptable reasons for not completing a case review. Fully record on the worksheets the reason(s) for not completing an investigation.

Acceptable reasons for not completing MEQC reviews are:

1. Beneficiary Does Not Cooperate.--Drop the review due to lack of cooperation by the beneficiary only after all efforts have failed and you have notified the local agency that the beneficiary did not assist in substantiating his/her eligibility status. Also, if a beneficiary is uncooperative when approached by the reviewer, obtain assistance from the local agency and/or send a second reviewer to attempt to complete the review.

2. Beneficiary Cannot be Located.--Make all reasonable efforts to locate a beneficiary who is assigned for review. Make more than a single visit to an address unless the initial visit positively establishes that the client no longer resides there. The aid of the agency, relatives, businesses, postal authorities, employers, and other sources may be necessary to locate the beneficiary. Drop the review only when all reasonable attempts to locate the beneficiary have failed and a definitive conclusion on eligibility cannot be made. Notify the local agency of such beneficiaries so that proper action may be taken. Show all steps taken to locate the beneficiary on the worksheets.

3. Beneficiary Moved Out of State.--If the beneficiary has moved out of State since the review month, and the review could not be completed without an in-person interview, drop the case. However, if the beneficiary moved out of State before or during the review month, make all efforts to complete the review since the case may be ineligible due to lack of State residency. This does not refer to temporary absences from the State.

4. Appeals.--If the beneficiary's Medicaid eligibility is being properly continued based upon an appeal from a proposed termination, and as of the review month the appeal decision has not been rendered, drop the case and code the reason as "Other". This does not apply to cases involving only appeals of denied services.

You may revise your findings due to a fair hearings officer's decision. Also, if Federal AFDC-QC changes its findings for cases based on its fair hearings policy, reflect this change. Thus, if the AFDC-QC regional office changes its finding from ineligible to eligible, that also becomes MEQC's finding.

5. Other.--Before dropping a review for any reason other than those already discussed, consult with the RO. Do not drop reviews in which errors can be substantiated, even if they meet the above criteria. Instead, cite these errors. Do not drop cases until all possible attempts to complete the review have been made.

7233. CASH ASSISTANCE ELIGIBILITY DETERMINATIONS

If a case is selected in the MAO stratum, do not use cash assistance coverage codes if possible. In some cases, such as AFDC under $10 cases not sampled by AFDC, AFDC supplemental payments, or SSI cases in SSI-criteria States, it may be necessary to use cash assistance codes. If the case is not eligible under any other MAO coverage code and you believe it is eligible for cash assistance, you may include the apparent cash assistance eligibility information in the notification of Medicaid ineligibility to the State agency.

7236. REVIEW OF AFDC CASH CASES/INDIVIDUALS

All cases with an AFDC-QC finding of no payment error/amount correct, code 1 in element 7 on the IRS, are also automatically found eligible for Medicaid. No further eligibility review is required.

For cases found ineligible by AFDC-QC and for overpaid error cases caused by ineligible individuals, perform a complete review to determine Medicaid eligibility. This includes an AFDC case file review, telephone contacts, and a field investigation, if necessary, to verify elements of eligibility.

If a Medicaid eligibility decision on an ineligible AFDC-QC case cannot be reached, concur with the AFDC finding of ineligible unless the sole cause of AFDC ineligibility is a technical error for MEQC. (See §7309.) In those instances, code the case eligible as an AFDC cash case or individual.

Effective with the October 1990 review month, conduct reviews of any ineligible individual(s) in AFDC overpayment cases to determine if Medicaid eligibility exists under another coverage code. Code the amount of claims paid for any/all individuals not found Medicaid eligible under any other coverage code as claims paid in error.

Other AFDC cash cases/individuals which AFDC-QC finds ineligible but which MEQC finds eligible for AFDC cash require AFDC-QC concurrence prior to MEQC's recording of such findings. However, if MEQC can substantiate eligibility under another coverage, no such concurrence from AFDC-QC is necessary.

Medicaid beneficiaries made eligible for AFDC in the review month, but not subject to AFDC-QC sampling, must be included in the MEQC sample. Review these cases for Medicaid eligibility using any appropriate coverage code requirements.

7237. REVIEW OF AFDC-RELATED AND SSI-RELATED CASES

As indicated in §7209, MEQC reviews MAO cases in which Medicaid eligibility is based on criteria other than receipt of AFDC or SSI cash assistance. These cases are related either to the AFDC or SSI program and, as such, MEQC must review these cases against appropriate AFDC or SSI policies. The SSA Program Operations Manual System (POMS) contains detailed SSI policy. All MEQC reviewers have access to the POMS chapters dealing with financial aspects of eligibility. MEQC reviewers also may find it necessary to consult AFDC references to answer questions that arise on AFDC-related reviews. Necessary references in AFDC are generally the State's AFDC plan and implementing policy manuals. Consult with your Medicaid eligibility policy expert for technical assistance.

7239. REVIEW OF SSI CASH CASES UNDER §1903(u) OF THE ACT ENACTED BY TEFRA 1982

42 CFR 431.814, which implements the MEQC provisions of §1903(u) of the Act, states that in §1634 States the SSI stratum is not to be included in the calculation of the payment error rate. Therefore, do not review or sample the SSI stratum in §1634 States.

In §1634 States, since QMB eligibility is determined based on information provided only by SSA, do not sample or review SSI/QMB cases.

7242. REVIEW OF SSI CASH CASES IN SSI-CRITERIA AND 209(b) STATES

SSI-criteria States base Medicaid eligibility on receipt of SSI cash assistance payments, but the beneficiary must make a separate application for Medicaid. Title XIX of the Act provides that all individuals to whom SSI benefits are being paid and who meet State residency, assignment/cooperation for third party liability (TPL) benefits, and transfer of resource (TOR) requirements are eligible for Medicaid in SSI criteria States. The MEQC administrative period (see §7278) applies to the termination of receipt of SSI benefits and to State residency and is, therefore, applicable to these cases. The only exception to these review procedures involves the death of the beneficiary. If the State learns that the beneficiary died prior to the administrative period, the case is ineligible for Medicaid even if an SSI check was sent to the deceased beneficiary in the review month.

Determine Medicaid eligibility by verifying receipt of an SSI check for the review month, State residency, TPL and TOR requirements. However, if an SSI check was not issued for the review month or the check was withheld not solely due to SSI recoupment procedures and the administrative period does not apply, review all elements of eligibility to determine if the beneficiary meets the eligibility conditions of any other coverage code. If the beneficiary is not eligible under any other coverage code, the case is ineligible. If the beneficiary meets all conditions of eligibility for any other coverage group except for excess income in States which cover the medically needy, code a liability understated error in the appropriate dollar amount. If the beneficary meets all conditions of eligibility for any other coverage group, the case is eligible.

For SSI/QMB beneficiaries in SSI-criteria States, the MEQC review encompasses the review of eligibility for Medicaid as described above for the SSI recipient and also encompasses a full determination of categorical and financial eligibility for QMB coverage.

In 209(b) States, the SSI cash assistance recipient is not automatically eligible for Medicaid because some eligibility criteria are more restrictive than SSI. Review 209(b) cases according to the State plan for the aged, blind, and disabled, completing all elements of eligibility. In 209(b) States, conduct a full determination of categorical and financial eligibility for QMB coverage for SSI/QMB beneficiaries. Not all 209(b) States may use their more restrictive eligibility criteria in determining QMB eligibility. If not, the reviewer must use SSI income and resource methodologies and the income and resource standards specified in the statute. Refer to your State plan for more specific information on QMB review methodology.

7245. REVIEW OF AGED, BLIND AND DISABLED CASES IN 209(b) STATES AND UNITED STATES TERRITORIES

The jurisdictions of Guam, Puerto Rico, Virgin Islands, and American Samoa do not have an SSI program. They may offer financial aid under titles I, X, XIV, or XVI (Aged, Blind and Disabled) of the Act. Eligibility for Medicaid for the adult categories is based on categorical relationship to these titles of the Act rather than on SSI. Similarly, States which have elected the option under §209(b) may not utilize all SSI eligibility criteria.

These U.S. territories and 209(b) States must, therefore, pull a sample from all cases that are aged, blind, or disabled. Review these cases based upon the State plan for eligibility of the aged, blind, and disabled.

7248. CASE RECORD REVIEW

The definition of case record is located in §7203. The case record contains the eligibility certification and information for the beneficiary(ies) and all related documentation. It also assists the reviewer in planning and focusing the field investigation by providing some recorded information which does not need reverification during the field investigation. The case record review includes analyzing the case record of the eligibility unit and completing the case record section of the worksheets.

Analyze the case record to become familiar with the case circumstances, to identify the information related to the Medicaid eligibility coverage classification under which the beneficiary may qualify, and to note gaps or deficiencies in information. Identify all information required to be requested under the IEVS. (See §7264.) Where documents or statements are contained in the record, identify those which may be used as verification. Examples of such documents or statements are official documents or reports, certified or reproduced copies of official documents or reports, and full recording by a person who has obtained information directly from public or other records. For recorded material to be accepted as verification, it must contain specific information such as volume and page references to public records. Record this information on the worksheet.

Make every effort to locate and analyze the beneficiary's case record. However, if the case record cannot be located or does not contain copies of supporting documentation, complete the review through the beneficiary interview and collateral contacts. Obtain all the necessary information and analyze these documents and verifications (see §7269) in terms of the case situation as of the review month. If the agency can demonstrate that an application for Medicaid was made and the elements of eligibility can be verified to be correct, the case may be coded as eligible. For example, if a beneficiary's name appears on the eligibility file as of the review month, it is evidence of application.

A separate application is not required for QMB coverage.

For eligible cases in the AFDC-QC stratum for which the MEQC reviewer does not review the case record, include Form HCFA 301 (IRS) in the State MEQC file. For ineligible cases, include the above material plus MEQC worksheets.

7251. FIELD INVESTIGATION

Once the case record review is completed, conduct a field investigation to document and verify all elements affecting eligibility and payment status during the review month. Pursue the field investigation to the point where

conclusive findings on eligibility and beneficiary liability can be made according to appropriate Medicaid eligibility requirements. The full field investigation includes an in-person interview with the beneficiary or someone acting on his/her behalf, obtaining and using all IEVS data, contact with collateral sources of information, correspondence, review of documents, telephone conversations, and accurate recording of all activities pertinent to the review. Attempt to complete the full field review on all MAO sample cases. Some may be dropped due to circumstances explained in §7230. Report relevant information in column 3 of the MEQC worksheets (Form HCFA 316). Attach copies of verifications, e.g., bank and Department of Motor Vehicle (DMV) statements, to the review package, where possible.

7254. IN-PERSON INTERVIEW

Make an in-person contact for all reviews, except in circumstances specified in subsection D.

A. Location of Interview.--Generally, hold the interview in the home or institution. Personal interviews may be held elsewhere in cases involving life threatening or dangerous situations or at a beneficiary's request. Provide beneficiaries with advance notice on what is needed to establish eligibility, especially when the interview is not held in the home.

Do not structure or direct the interview in such a manner as to preclude a beneficiary's active participation. Make clear to beneficiaries the purpose of the interview and cover relevant topics in a manner which permits the beneficiary to discuss each topic fully.

B. Structure of Interview.--Focus the interview on:

o Establishing identity and categorical relationship of all members of the medical assistance group as required; and

o Discussion of each relevant element of eligibility to:

- Obtain statements, review whatever documentary evidence is available from the beneficiaries, and/or secure leads to appropriate evidence; and

- Ensure that all significant aspects of eligibility have been thoroughly explored and ascertain whether there have been changes in the situation in relation to elements of eligibility which are relevant to the review month.

C. Procedures for Interview.--Conduct in-person interviews as follows:

1. Review unverified elements and information gaps as identified through comparison of case record findings with the information required by the Verification Guide and Verification Requirements by Element. Record notes for the interview on the Integrated QC Worksheets.

2. Schedule an interview with the beneficiary or individual acting on his/her behalf. Explain the purpose of the interview and information requirements.

3. Conduct an interview according to information needs defined. Obtain consent for collateral contacts and authorization for release of medical or financial information.

4. Complete column 3 of the worksheets to document any verification of elements occurring during the personal interview.

5. Note elements which require further investigation through collateral contacts.

D. Other Elements of Interview.--There are instances when it may not be appropriate or possible to personally interview a beneficiary. When the only beneficiary is a child, conduct the personal interview with the parent or caretaker of the child. If the beneficiary is physically unable to participate in an interview, conduct the interview with a relative or representative. If there are two parents of an AFDC categorically related beneficiary, it may not be necessary to interview both if one parent can provide necessary information about the Medicaid assistance group. It may not be necessary to interview both members of an SSI categorically related couple. When a beneficiary has moved or otherwise can not be located, make every effort to complete the review using collateral contacts. If the appropriate elements of eligibility cannot be verified, drop the case.

In-person home visits are not required for cases involving transitional medical assistance WHEN the required information/documentation can be obtained from the local agency case record and by collateral contacts. If the required documentation is not available, conduct a home visit as appropriate. Similarly, home visits are not required to verify the eligibility of all groups of pregnant women or infants under age 1 who are deemed eligible for 1 year from birth (coverage code 35), unless the necessary verifications are not available from the case record or collateral contacts.

In addition, an in-person interview is not required for certain beneficiaries in nursing homes or other medical facilities. Modify or eliminate the interview when the beneficiary's health or recovery will be negatively affected or the beneficiary is not able to provide accurate or useful information. In these cases, rely on collateral sources of information such as relatives and representatives of the institution.

Further, when a beneficiary dies in or after the review month, an in-person interview is not required with the family. You may contact the relatives by telephone and/or mail to secure the appropriate eligibility information.

Before eliminating an in-person home visit for any reason other than those discussed, consult with your supervisor.

7257. COLLATERAL CONTACTS

Discuss the need for additional information and make every effort to enlist the beneficiary's cooperation and participation in the identification and selection of the best sources of information. For institutionalized beneficiaries, contact with administrative personnel of the institution is desirable.

If possible, obtain the beneficiary's or his/her representative's consent for contacting collateral sources for information essential to determining eligibility. If the beneficiary or representative refuses to give consent for collateral contacts, contact collateral sources to the extent possible to arrive at an eligibility decision. Even if the beneficiary requests that his/her eligibility be terminated, continue the investigation to the fullest extent. In such instances, advise the beneficiary that you are pursuing the review and make all possible collateral contacts.

Although space on the worksheets is limited, record all important facts. If space on the form is insufficient for any item, continue the entry on the back or on a full size separate sheet of paper. The recording covers both the method used for verification and the information obtained. Also, complete the recording in a manner which is both legible and easily understood. When acronyms are used, spell out the words at least once in each review. Use cross references sparingly and only where appropriate.

7260. WORKSHEET FOR INTEGRATED AFDC, ADULT, FOOD STAMP, AND MEDICAID ELIGIBILITY QUALITY CONTROL REVIEWS (FACESHEET)

The documentation requirements for individual MEQC reviews include a facesheet for identification and control information.

Instructions for completing each section of the facesheet are referenced in the Integrated Manual for AFDC, Adult, Food Stamp, and Medicaid Eligibility Quality Control Reviews.

7263. ELEMENTS OF ELIGIBILITY AND PAYMENT DETERMINATION (INTEGRATED QC WORKSHEET)

Instructions for completion of the Integrated QC Worksheet for AFDC, Adult, Food Stamp, and Medicaid eligibility are located in the Integrated Manual for AFDC, Adult, Food Stamp, and Medicaid Eligibility Quality Control Reviews.

Record the specifics of the review on the worksheet. Information on the worksheets substantiates the eligibility review findings. Record concisely but sufficiently to establish the facts upon which each relevant decision was based.

7264. MANDATORY USE OF IEVS INFORMATION

The information required to be requested and verified under IEVS is valuable in establishing Medicaid eligibility and the correctness of liability determinations. Use of IEVS information is mandatory in fulfilling the primary documentation/verification requirements for §§7269.2 (Resources) and 7269.3 (Income).

For all Medicaid cases, identify all information which has been requested to verify income and eligibility, e.g., wage information maintained by the State Wage and Unemployment Insurance Benefit Files, unearned income information obtained from the Internal Revenue Service, and other income and wage data from the SSA. Verify that all required information requests were made and responses received. If verification of all requests has not been made or if all requests identified are no longer current, request the missing or outdated information from the appropriate agency.

7264.1 Computer Matching Errors.--Do not cite MEQC errors in cases in which the State eligibility worker made an incorrect eligibility determination based on current but inaccurate information received from any primary source Federal agency using automated computer matching. A primary source agency is one which is the originator of the information. For example, SSA is the primary source of information concerning SSI benefits and RSDI benefits.

Information received from the Internal Revenue Service is limited to unearned income (e.g., interest paid on savings). This information is only a lead to resources and is not considered a primary source of information. Therefore,

inaccurate data received from the Internal Revenue Service do not fall within the scope of erroneous eligibility determinations being considered. Similarly, information received from the BENDEX for which the SSA is not the primary source (i.e., wage data from the Beneficiary Earnings Exchange Record System) is not considered primary data.

If the primary source Federal agency provided erroneous information, HCFA excludes the error if the State agency documents that the data remain current as of the review month (e.g., there was no change in the amount of payment since the eligibility determination) and the information had been requested correctly (e.g., correct case information was input properly).

The documentation provided by States must indicate that the match was timely as of the review month. The State agency records must document the date the information was received (e.g., the run date), and that the correct case information was input properly. If the State agency does not have this information documented in the case record, HCFA does not exclude the error.

7265. HOLD HARMLESS PROVISION OF IMMIGRATION REFORM AND CONTROL ACT (IRCA)

Section 121(a)(1) of IRCA provides that a State be held harmless in certain circumstances for purposes of compliance, disallowance, or other regulatory penalty on eligibility errors based on citizenship or immigration status. To hold the State harmless for MEQC errors under this provision, code a technical error if an error in Citizenship and Alienage (element 130) is caused solely by:

- Certification of eligibility based on erroneous information provided by Immigration and Naturalization Service (INS) if the State provided accurate alien identification for verification;

- Continuation of eligibility provided for a reasonable period, as defined by the State, for a beneficiary to obtain documentation of immigration status; or

- Continued certification of eligibility pending verification of documentation from INS of immigration status submitted timely to INS by the agency.

Document that the case record contains a declaration signed by the beneficiary that (s)he is in legitimate immigration status and that the agency has met the appropriate criteria for certifying or continuing eligibility.

IRCA also provided that the State be held harmless when a case was under appeal due to citizenship/alienage requirements. See §7230 for MEQC instructions regarding cases under appeal.

7265.1 Systematic Alien Verification of Entitlement (SAVE) Documentation.--

A. INS Primary Verification.--For each direct inquiry to the INS-SAVE data base, the INS system assigns a unique inquiry number known as the Alien Status Verification Index (ASVI) query number as part of the system response. The State agency records must document the date of the State's transmission and the ASVI Query Verification Number when a SAVE response is received.

B. INS Secondary Verification.--This procedure requires the State agency to submit to INS a photocopy of the documentation presented by the alien for further review and verification. The secondary verification is accomplished through completion and transmissions of INS Form G-845 (Document Verification Request) with an attached copy of the alien's document. If the State agency is waiting for a response from INS, the agency records must contain a copy of the annotated INS Form G-845.

If the State agency does not have this information documented in the case record, do not exclude the error under the hold harmless provisions set forth above.

7266. DOCUMENTATION

Document each element of eligibility to the maximum extent possible. (See §7269.) Show on the worksheet the sources of information used, the information obtained, and the basis for the conclusion reached regardless of verification method used. Record the source, date, and relevant content when documentary evidence is cited. When a person is used as a collateral source of information, record the name, address, and telephone number along with the person's significance to the investigation, e.g., landlord, employer, married daughter living out of home. When a written document is used for verification, attach a copy or summarize the relevant content on the worksheet and the date of the document.

When evaluating a document, check all identifying information shown on the record, e.g., beneficiary's name, parents' names, place of birth, to make certain that it applies to the case under review. Resolve any discrepancies between the record and other identifying information in the file as well as conflicting information from collateral sources.

There may be instances in which you are unable to obtain hard copy verification. In such instances, be sure to record the basis for your conclusions.

Entries on the worksheet such as "none" do not reflect adequate recording. Record the basis for deciding that the beneficiary did not have income, resources, etc.

Safeguard information received under the IEVS in accordance with the requirements prescribed by the agency disclosing the data. For example, Internal Revenue Service information must be safeguarded in accordance with the requirements prescribed by its Commissioner. States must, at a minimum, meet the requirements described in 42 CFR 431.300ff.

7269. VERIFICATION STANDARDS

The purpose of the MEQC case review process is to develop correct and reliable case findings based upon the actual circumstances. The following standards determine the extent to which the review obtains evidence relevant to eligibility and payment status of the case member(s). These standards have

been established to provide a systematic and nationally uniform method of substantiating decisions regarding each eligibility and payment determination element. Minimum verification standards have been developed for each element. The verification standards establish the level of evidence on which to make decisions so that the number of dropped cases is kept to a minimum. However, these verification standards are not all-inclusive. If you are unable to obtain the documentation specified in the primary/secondary listing, you are free to use other reasonable evidence to substantiate decisions regarding eligibility.

A. Primary and Secondary Evidence.--By definition, primary evidence is of a higher probative value than secondary evidence. Consider evidence to be primary only if it is listed as primary in the standard for that element. If primary evidence is not obtainable, obtain secondary evidence if it correctly establishes the facts of the case. Acceptable evidence for each element is identified within the individual standards.

Evaluate evidence in terms of its probative value. Clearly document on the worksheet what steps you took to obtain the verification. Determining the probative value of any record is a matter of judgment made by examining all the facts surrounding the establishment of the record. The date the evidence was established is important. There may be instances in which you are unable to secure documentary evidence or to obtain complete verification. Based on observation and/or the information on hand, a decision can be made. Clearly reflect the basis for the conclusion on the worksheet. For elements of eligibility subject to change (such as income and resources), it is not acceptable to use verification from a previous review.

B. Positive and Negative Allegations.--Verification standards differ in some instances, depending on whether the beneficiary responds positively or negatively to a question. For example, if a beneficiary states that he/she has a bank account, contact that bank to verify the balance as of the review month.

Follow up on any evidence which conflicts with a beneficiary's negative allegation. For example, the reviewer might suspect that the beneficiary had a bank account in spite of his/her denial. In such cases, do not accept the beneficiary's negative allegation, but proceed to investigate the particular circumstances by further questions or by making collateral contacts, i.e., IEVS.

C. Evaluating Evidence.--Evaluate each piece of evidence in relation to the other evidence obtained from the case record, the case member(s), and collateral sources. The evidence must be sufficient to resolve factors subject to change and to resolve any question(s) about case members. In determining the value of evidence, apply the following criteria.

1. Age of Evidence or Date Evidence Was Established--Does the date the evidence was established lend credence to the factor being established or does it raise questions?

2. Purpose for Which Established--Why was the evidence prepared? Is there any reason for falsifying the evidence?

3. Basis for Record--What is the source? Is it reliable? For example, was proof of the person's age requested? If not, who provided the date of birth information on the evidence?

4. Formal or Official Nature of Evidence--Is the evidence official, such as a birth certificate, or is it prepared in a formal way, such as a deed, will, or other legal instrument?

5. Custody of Evidence and Its Availability--Is the evidence in the custody of a person who might have vested interest in changing or slanting the evidence?

6. Way in Which Specific Information is Recorded--Does written evidence clearly establish the facts of the issue being reviewed? (For example, is the specific date of birth shown or does it show only age, and if the latter, does it indicate last, next or nearest birthday?)

7269.1 Basic Program Requirements (100).--

110. Age

111. Student Status

Verify one or both of the above elements if age is a condition of eligibility or if enrollment in a school or vocational training program is a consideration in the eligibility determination.

Primary Sources

1. Birth certificate
2. Adoption papers or records
3. Hospital or clinic records
4. Immigration records/passport
5. Baptismal certificate
6. Bureau of Vital Statistics
7. Naturalization records
8. Family Bible records
9. Indian census records
10. Midwife's record of birth
11. School records
12. U.S. passport
13. Local government records
14. Military records
15. Statement of age from SSA

Secondary Sources

1. Census records
2. Court support order
3. Physician's statement
4. Juvenile court records
5. Driver's license
6. Insurance policy
7. Minister's signed statement
8. Affidavits
9. Church records

120. Relationship

If relationship to another individual(s) is pertinent to the eligibility determination, verify relationship by using the following sources of verification.

Primary Evidence

1. Birth certificates
2. Adoption papers or records
3. Marriage licenses

4. Divorce papers
5. Indian census records
6. Separation papers
7. Bureau of Vital Statistics (BVS) or local government records of birth and parentage
8. Hospital or clinic records of birth and parentage
9. Baptismal record of birth and parentage
10. Court records of parentage
11. Court child support records
12. Juvenile court records
13. INS records

Secondary Evidence

1. U.S. passport
2. Family Bible records
3. School records
4. Census records
5. Physician's records
6. Social service agency records
7. Insurance policy

130. Citizenship and Alienage

An individual must be a citizen, an alien lawfully admitted for permanent residence, or otherwise permanently residing in the U.S. under color of law to qualify for Medicaid coverage. Review the case record to establish whether the beneficiary has signed a declaration of citizenship/alienage. If no declaration is present in the record, cite a technical error and obtain a written declaration by the individual stating whether the individual is a citizen or national of the United States. Obtain and verify documentation supporting the content of the declaration.

Primary Sources

1. Birth certificate
2. Immigration and Naturalization Services (INS) Form I-94
3. U.S. passport
4. Certificate of naturalization
5. Birth records
6. Record of receipt of SSI
7. Evidence of continuous residence in the U.S. prior to June 30, 1948 (including school records, a marriage license, voter registration card, insurance policy, military service records, social security number issued prior to June 30, 1948, etc.). Effective January 1, 1987, IRCA of 1986 (P.L. 99-603) amended the date to January 1, 1972.
8. Computer printout, tape, or INS Form G-845 showing State/INS verification of alien status for individuals who are not citizens or nationals.
9. Form SSA 2853
10. BVS or local government records of birth and parentage
11. Hospital or clinic records of birth and parentage
12. Baptismal record of birth and parentage
13. Court records of parentage
14. Court child support records
15. Juvenile court records
16. Indian census records

Secondary Sources

1. Consular report of birth
2. Alien registration receipt
3. Property records

140. Residency

Verify this element for all beneficiaries reviewed. Beneficiaries must meet residency requirements in order to be eligible for Medicaid. Refer to your State plan for specific requirements for your State.

Primary Sources

1. Property ownership records
2. Rent or mortgage receipt
3. Statement from nonrelative landlord
4. Current driver's license
5. Employer affidavit
6. School records
7. Institutional records
8. Property tax receipts
9. Receipts for household expenses

Secondary Sources

1. Local telephone directory
2. Local post office records
3. Tax office records
4. Church records
5. Signed statement from nonrelative

150. Household Composition
151. Living Arrangement

Verify this element for beneficiaries when appropriate. Refer to your State plan and/or AFDC Quality Control manual for specific requirements.

Primary Source

1. School records
2. Institutional records
3. Statement from nonrelative
4. Statement from nonhousehold member

Secondary Sources

1. Hospital, clinic, health department, or private physician's records
2. Court support order
3. Juvenile court records
4. Nonrelative landlord statement
5. Child care provider
6. Minister's statement
7. Signed statement from nonrelative
8. Day care center records
9. Visual confirmation
10. Contributions to household budget
11. Property tax records
12. Sources of cost for payment of institutionalization

160. Employment and Training Programs

Complete this element if employment and training is a condition of eligibility. If the beneficiary refuses to register, it is treated as a MEQC payment error. However, if (s)he did not register due to an oversight by the agency, record a technical error. (See §7309.)

170. Social Security Number (Enumeration)

Complete this element for all cases. Section 2651 of the Deficit Reduction Act (DRA) added §1137 to the Act to require the application for or possession of a social security number (SSN) as a condition of Medicaid eligibility. Failure to meet enumeration requirements results in a technical error. A completed Form SSA 2853 is sufficient case file documentation that application has been made for an SSN.

180. Categorical Relatedness

Verify categorical relatedness for all beneficiaries when appropriate. This may apply to pregnant women as well as living children and unborn children. Categorical relationship for AFDC-related cases is established by the following elements:

- o Death of a parent,
- o Incapacity of a parent,
- o Continued absence of a parent,
- o Unemployment of a parent, or
- o Pregnancy.

181. Death

When eligibility is based upon deprivation due to death, verify and document (1) the death of the deceased individual(s) and (2) the relationship of the deceased to the child(ren) or unborn child(ren). When the beneficiary does not have a copy of the death certificate, use other sources of verification.

Primary Sources

1. Copy of the death certificate
2. Bureau of Vital Statistics
3. Widow's or survivor's benefits on the deceased parent's social security number
4. Veterans Administration or military service records
5. Hospital records
6. Signed funeral director's statement
7. Indian census records
8. Newspaper death notice
9. Insurance company records
10. Social Security records
11. Institutional records
12. Veterans Administration death payment correspondence
13. Insurance company death settlement correspondence
14. Minister or clergy statement

182. Incapacity

When the eligibility is based upon deprivation due to incapacity, verify the incapacity and relationship of the incapacitated person to the child(ren) or unborn child(ren). Follow State policy requirements for establishing and verifying incapacity.

Primary Sources

1. Disability certification by State medical review unit
2. Medical examination report
3. Receipt of RSDI (disability) benefits
4. Receipt of SSI benefits based on disability
5. Medical statement from doctor, hospital, or clinic (if accepted by State plan)
6. Visual observation of the disability when permitted by State plan
7. Medical records or disability examination report
8. Physician's records
9. Hospital records
10. Clinic records
11. Bureau of Vocational Rehabilitation
12. Veterans Administration
13. Rehabilitation center records
14. Office of the Blind or Visually Handicapped case records
15. Psychometric test
16. Psychological test records
17. Psychiatric records

183. Continued Absence

Verify continued absence and whether support payments were made. However, evaluate receipt and amount of support payments as directed in §7269.3 (Income). Refer to the State plan and State procedures manuals for necessary verification of this element.

Primary Sources

1. Divorce papers
2. Military papers or induction notice (when permitted by State plan)
3. Separation papers
4. Annulment papers
5. Correctional institution records
6. Probation office records
7. Rent receipts from absent parent's nonrelative landlord
8. Court records
9. Unemployment records of absent parent
10. DMV records showing the absent parent's address (includes driver's license, motor vehicle registration or identification card)
11. Employment records for absent parent
12. Telephone directory showing absent parent's address
13. Union records showing absent parent's address
14. Statement from absent parent's and/or recipient's landlord
15. Absent parent's child(ren)'s school records
16. Absent parent's health insurance card and/or insurance company's records
17. Statement from law enforcement officials

18. Post office address records of absent parent's address
19. City directory listing of absent parent's address
20. Signed statement from minister or other knowledgeable nonrelative
21. Tax records showing the absent parent lives and owns property elsewhere
22. Social Security Administration, Veterans Administration or other government agency records
23. Signed statement from the absent parent

Secondary Sources

1. Shelter record of absent parent, e.g., lease, rent receipts
2. Voter registration records
3. Statements from reputable sources in community

184. Unemployed Parent

Verify unemployment within the State's definition. Refer to Administration for Children and Families (ACF) regulations, the State plan, and State procedures manual for necessary verification of this element.

Primary Sources

1. Employer's records
2. State Employment Agency records
3. Bureau of Employment Security employment office
4. Unemployment compensation payment
5. Company layoff notice

Secondary Sources

1. SSA records
2. Current employment registration card
3. Training program records
4. Union records

185. Blindness/Disability Determination

Verify this element for all SSI-related blind and disabled beneficiaries.

Do not attempt to determine blindness or disability. If the period covered by the medical determination expired prior to the review month, refer the beneficiary to the appropriate State agency for a new medical determination. If the medical determination is not completed prior to the reporting deadline for case completions, report the individual ineligible (element 550, nature code 096).

Primary Sources

1. Disability certification by State medical review unit
2. Medical examination report
3. Receipt of RSDI (disability) benefits
4. Receipt of SSI benefits based on disability
5. Medical statement from doctor, hospital, or clinic (when permitted by State plan)
6. Visual observation of the disability when permitted by State plan
7. Medical records or disability examination report
8. Physician's records
9. Hospital records
10. Clinic records

11. Bureau of Vocational Rehabilitation
12. Veterans Administration
13. Rehabilitation center records
14. Office of the Blind or Visually Handicapped case records
15. Psychometric tests
16. Psychological test records
17. Psychiatric records

186. Other Categorical Relatedness

Verify this element for all beneficiaries in a State which applies additional basic program requirements as a basis for Medicaid eligibility. Use this element to denote pregnancy as the categorical relationship.

Define and verify the nature of the additional requirements on which the beneficiary's eligibility is based in accordance with the State plan. For example, if children in foster care are Medicaid eligible in the State, verify that the beneficiary is in fact approved for participation in the foster care program as of the review month.

Use this element for conditions of eligibility not described elsewhere on the worksheet.

EXAMPLES: Factors related to reasonable classifications of individuals, e.g., individuals under 18, 19, 20 or 21 and beneficiaries of optional State supplements.

Medicaid verification of pregnancy and conditions of eligibility specific to individuals receiving 6-12 months of continued eligibility under 42 CFR 435.115.

Entitlement to Medicare Part A for QMBs or evidence of pending State buy-in for Medicare Part A.

191. Assignment of Support

Do not complete this element for MEQC reviews.

192. Cooperation in Support Payments

Do not complete this element for MEQC reviews.

7269.2 Resources (200).--Review each element to document those resources declared by the beneficiary and fully evaluate the possibility of ownership of resources when they are not declared. Although the beneficiary may not have any of the resources identified, obtain evidence so that the absence of each resource can be conclusively supported.

Resources whose values are subject to change require particular consideration. Verify independently these resources, e.g., real property, bank deposits, stocks and bonds or personal needs accounts.

Review for transfers of resources as prescribed in the State plan. Document findings in the appropriate resource element. Use nature code 028 to document errors. For MEQC, do not code transfer of resource errors under element 225 (combined resources).

Determine the amount of countable resources, if any, for each resource element. If total resources exceed the allowed amount, record the difference as excess resources.

211. Bank Accounts or Cash on Hand

Verify this element for all beneficiaries. The primary source for this element is IEVS. Determine if the beneficiary owns or has legal access to any:

- Savings bonds,
- Promissory notes,
- Stocks and bonds,
- Certificates of deposit,
- Mutual funds,
- Bank accounts, or
- Cash on hand.

These resources may also be jointly owned or held by another individual for the beneficiary. When reviewing an SSI-related case involving a joint bank account that could adversely impact on the individual's eligibility, determine if the individual was offered an opportunity to submit evidence in rebuttal. If not, ask the individual if (s)he wishes to rebut full ownership. This rebuttal may be made retroactive to the review month. If the State offered this opportunity and the individual rebutted full ownership, determine if the rebuttal evidence was acceptable. When reviewing a case involving a joint bank account that does not impact on the individual's eligibility, if an opportunity to rebut ownership was not afforded, alert the appropriate staff so they may inform the local office. For cases involving power of attorney and representative payee, refer to SSI policies. Determine if the individual was offered the opportunity to set aside funds for burial. If not, ask the beneficiary if (s)he wishes to designate funds for burial. The beneficiary must provide a written declaration of intent to designate burial funds by the case review completion date. These funds must be separately identified and must not be commingled with other funds. Refer to the POMS at SI 01130.410 for application of burial funds exclusion to resource determinations.

Positive Allegation

If the beneficiary does have a bank account, document:

- The name of the financial institution(s),
- Address,
- Type of account,
- Type of ownership,
- Account number,
- Balance, and
- Any interest income from these accounts (document in element 346).

Negative Allegation

Inquire further as to where the beneficiary cashes his/her check, or what banks, institutions, or sources of financing were used for past transactions as a means to obtain leads to sources of bank deposits. In cases in which the case record or another source indicates past banking activity, contact that bank to determine whether the past bank account has been and remains closed.

212. Nonrecurring Lump Sum Payments

Verify this element when appropriate. Be aware that beneficiaries may receive lump sums from such sources as SSA, VA, other government programs, insurance companies, and utility companies. Be aware that application of administrative period provisions may reduce the number of citable errors in this element.

213. Other Liquid Assets and Personal Property

If the beneficiary owns any articles of value not exempted as essential to basic needs under the State plan, obtain an estimate of the value of the item(s). If the value placed on these articles by the beneficiary appears unrealistic, determine the value through any reliable and reasonable method (i.e., sales slips, catalogs, existing insurance appraisal, local merchants). Examples of such items are:

- Antiques,
- Art work,
- Heirlooms,
- Silver,
- Collections,
- Farm equipment (not used in farming), and
- Boats/campers.

221. Real Property

When it is known from the beneficiary's statement, local agency case record information, or other sources that the beneficiary owns real property, verify the property's availability to the beneficiary in accordance with the State plan. Record the following:

- Type of ownership (sole or shared),
- Right of disposition (full, limited, none),
- Description of property (size and construction),
- Existence of mortgage (amount of equity), and
- Current market value or assessed value.

The address of the beneficiary during the review month provides another lead to possible ownership of real property.

Primary Sources

1. Deed
2. Sales agreement
3. Mortgage
4. Courthouse records
5. Articles of agreement
6. Real estate tax receipts
7. Income tax return

Secondary Sources

1. Estate data
2. Tax records
3. Real Estate Tax Triangle
4. Title search

5. Utility company records
6. Charge account or charge account application records
7. Municipal building inspection compliance records
8. Municipal fire code records
9. School receipts

222. Vehicle

Verify ownership of a motor vehicle(s) as of the review month for all beneficiaries. The primary verification for ownership is clearance with the State agency responsible for the registration of motor vehicles. This agency can establish whether the beneficiary owned a vehicle. In some States, the agency can also furnish evaluative data on the vehicle. Information available usually includes the purchase price, encumbrances against the vehicle, and the name of the organization financing the purchase. This information aids the reviewer in evaluating the effect of car ownership on eligibility. The blue book and red book of car valuations are additional sources to establish the value of motor vehicles. Other sources include car dealers who can provide an approximate valuation based on make, year, and model of vehicle. Use the State motor vehicle registration agency to establish nonownership of a vehicle.

Primary Sources

1. State vehicle registration agency
2. County, city, or other local government agency
3. Car title and registration

Secondary Source

1. Auto financing data
2. Statement from auto insurance company

223. Life Insurance

When the case record shows ownership of life insurance, verify the pertinent information as of the review month through examination of the policy(s), records in the possession of the beneficiary, or other documentary sources such as a statement from the issuing company. Determine whether policy values conform to State and Federal requirements. For each insurance policy, record the:

- Name of the insurance company,
- Date of issue,
- Policy number,
- Ownership,
- Beneficiary,
- Face value, and
- Cash surrender value.

If the value of the insurance cannot be determined, contact the appropriate insurance company. Contact the insurance agent or other parties who may have knowledge of such policies. If the beneficiary denies having any life insurance, but individual case circumstances indicate otherwise, attempt to determine which insurance companies might be potential carriers for the beneficiary by checking sources of both existing and noncurrent policies for automobile, home, personal property, and policies held by other family members. These inquiries may furnish leads as to which brokers or companies to contact.

Primary Sources

1. Clearance with insurance company
2. Insurance policies
3. Clearance with local insurance agent
4. Employer's insurance records
5. Lodge, club, or fraternal organizational records
6. Relatives and friends holding policies for beneficiary
7. Union records
8. Veterans Administration records

224. Other Nonliquid Resources

Use this element to verify any other nonliquid resources. Treat such resources in accordance with the State plan requirement.

225. Combined Resources

Use this element to calculate the total value of all countable resources.

7269.3 Income (300).--Determine whether each beneficiary has income. Verify the accuracy of the income determination for the State's computation period including the review month. Verify all income declared, identify the possibility of additional income from any source, and verify information obtained under the IEVS. Sources of income include earned income, Social Security benefits, other government program benefits, pensions or other benefits, support payments, income in-kind or deemed, rental property, farm produce, roomers/boarders, and child care.

311. Wages and Salaries

Review this element for all beneficiaries. This element refers to income earned by a beneficiary through receipt of wages, salaries, tips, or commissions. Child care income is also considered under this element. Verify and document whether the beneficiary is employed and verify the amount and frequency of earnings. When the beneficiary acknowledges receipt of wages, collateral contact with the employer is usually required to verify the frequency and amount of wages earned. In lieu of contacting the employer, wage stubs may be used as primary evidence if they cover the period of employment under review and there is no indication of other employment.

Substantiate a beneficiary's statement that he/she had no earnings. Go beyond the beneficiary's statement to reach a decision. Document any past employment history, types of work, names and addresses of any former employers, current attempts to find work, and registration with the employment security office. Follow up on leads to possible employment as such information may be obtained from collateral contacts while verifying other elements of eligibility.

Routinely review the wage and income information maintained in the State Wage and Unemployment Insurance Benefit files, in the SSA files, and in the Internal Revenue Service unearned income files. Also, verify the SSN.

Primary Sources

1. Pay stubs
2. Employer's wage records
3. Pay envelope
4. Wage tax receipts
5. Income tax return - State and/or Federal
6. Employment Security Office

Secondary Sources

1. Employee's W-2 form
2. State form for clearance of earnings from employment
3. State Income Tax Bureau
4. State unemployment records

312. Self-Employment

Review this element for all self-employed beneficiaries. You must first determine gross receipts from the business and deduct allowable expenses to arrive at a net income. Then apply allowable deductions per the State plan. Refer to the State plan and policies for inclusions, exclusions, and deductions.

Primary Sources

1. Recent tax returns/business records
2. Receipts for goods and services

Secondary Sources

1. Beneficiary's statement when expenses cannot be verified
2. Signed statements from business associates

313. Earned Income Tax Credit

Review this element for all beneficiaries. The earned income credit is applied in accordance with the methodologies specified in the State plan.

Primary Sources

1. Employer's payroll records
2. Earned income tax credit table and pay stubs
3. Pay stubs
4. Earned income advance payment certificate (Form W-5)

Secondary Source

1. Statement from beneficiary's employer
2. Statement in State agency local record whether beneficiary was advanced credit
3. Past pay stubs

314. Other Earned Income

Review this element for all beneficiaries. Include any earned income not covered above here.

Earned Income Disregards

The items under these eligibility/payment determination elements relate to earned income disregards. The elements are applicable to all cases in which the beneficiary has earned income and as such appropriate provisions of the State plan related to each disregard have been properly applied and correctly computed.

321. Earned Income Deductions

Review and verify this element for all beneficiaries who have earned income.

Verify that the proper deductions were utilized and that the correct amount of deductions was computed. Apply $30 and 1/3 disregard or just $30 disregard, as appropriate.

Primary Sources

1. Case record
2. Assistance payment records
3. Monthly report forms
4. Evidence of employment history and earned income

322. Work Related Expenses

Each full time employee or individual self employed full time in an AFDC assistance unit is eligible to receive a disregard for his or her work expenses. Apply the disregards of the State's AFDC plan and implementing policies.

Primary Sources

For employees:

1. Wage stubs - covering entire review period and indicating number of hours worked
2. Information from employer
3. Employment and Training Program information

For self employed individuals:

1. Recent tax returns
2. Current business records

323. Child or Dependent Care

In AFDC-related cases, after the work expense disregard is applied to earned income, a State must disregard the actual cost of care for a child or

incapacitated adult up to the allowed amount if the individual is employed full time. For an individual not engaged in full time employment or not employed throughout the month, a State must have in place a procedure under which it determines and applies a disregard amount less than the allowed amount for cost of care for a child or incapacitated adult.

Contact the employer or use wage stubs that cover the period under review and show the hours worked to verify full time or part time employment for an employee. Check recent tax returns and current business records to determine if a self employed individual was working full time or part time. Based on employment records, determine the child care expenses allowable.

Primary Sources

For employment: verification of full or part time employment as determined by the AFDC program.

For dependent care expenses:

1. Receipts for child care expenses
2. Statement from child care provider
3. Income tax and social security payment records

Unearned Income--Determine if any case member is receiving any unearned income such as:

- o Federal or State Government benefits,
- o Rental income,
- o Interest income, dividends, or royalties,
- o Workers' or unemployment compensation
- o Deemed income or contributions in-kind
- o Grants, loans, or scholarships,
- o Support payments,
- o Income tax refund, or
- o Other (identify).

Indicate on the worksheet that all potential sources of unearned income were explored with the beneficiary, including negative and positive allegations.

When the beneficiary states that he or she does not receive a benefit, evaluate this statement in terms of the beneficiary's background, past work history, and present circumstances. For example, a review of the employment history may indicate possible eligibility for a company retirement pension. Past union membership could indicate possible benefits from that source, etc.

Establish a basis for a decision of nonreceipt of benefits more substantial than the beneficiary's denial of receipt of the income. Clearly reflect the basis for the decision in the worksheet recordings.

331. Retirement, Survivors, and Disability Insurance (RSDI) Benefits

Verify the amount of RSDI payment when the beneficiary alleges receiving RSDI benefits. Determine if the beneficiary is receiving RSDI benefits from SSA. Occasionally, payments are made to a representative payee. These payments are countable to the beneficiary.

Make a routine clearance for RSDI benefits in all instances when an AFDC-related child is deprived of parental support because of death or incapacity and for all SSI-related beneficiaries.

The primary verification for RSDI benefits is the BENDEX system, i.e., the automated communication system between State public assistance agencies and SSA in Baltimore regarding Social Security benefits. Use Form SSA-1610 (Request for Information by State Public Assistance Agency) when BENDEX information is not available or when it is known that BENDEX is not updated timely. When special circumstances warrant, check directly with the SSA district office to obtain RSDI benefit information.

Primary Sources

1. RSDI benefit payment check for review month
2. Recent RSDI award letter
3. BENDEX system
4. SSA (Form SSA-l6l0)
5. Other official correspondence from SSA

Secondary Sources

1. Statement from institution where check is cashed
2. Copies of past checks

The next page is 7-3-45.

332. Veterans Benefits

Verify whether or not the beneficiary received veterans benefits and the amount received during the review month. When the beneficiary states that he or she does not receive benefits evaluate this statement in terms of background, past military service, and present circumstances. Establish a basis for a decision of nonreceipt of benefits more substantial than the beneficiary's denial of receipt of the benefits.

A copy of the Veterans Administration (VA) award notice or VA check received as of the review date is primary verification of VA payments. When the VA award notice or VA check is unavailable the reviewer must contact the VA to verify the dollar amount of the VA payment as of the review date.

Primary Sources

1. VA check for review month
2. VA award letter applicable for review month
3. VA written correspondence

Secondary Sources

1. VA award letter from previous years
2. Copies of past checks
3. Statement from institution where check is cashed

333. SSI

Verify whether or not the beneficiary is receiving SSI benefits.

If an individual is determined to be receiving SSI benefits the reviewer will consider this income only for the individual's needs.

Primary Sources

1. Current award certificate
2. Most recent check
3. Official correspondence (1610)
4. SDX

Secondary Sources

1. Statement from institution that cashed the check

2. Prior worker's compensation (WC) award notice
3. Copies of past checks

334. Unemployment Compensation

Document that there was no evidence of receipt or indicate the steps taken to verify that benefits are not being paid. Obtain records from the State employment office to verify employment and to verify whether unemployment compensation is being received.

Primary Sources

1. Current award certificate
2. Most recent check
3. Official correspondence
4. Bureau of Employment Security - Unemployment Compensation Section

Secondary Sources

1. Statement from institution where check is cashed
2. Prior award notice
3. Copies of past checks

335. Worker's Compensation

Verify the amount of the WC benefit for all beneficiaries reviewed. The WC award notice or WC payment check which covers the review date is the primary source of evidence. When the award notice or payment check is unavailable, contact the WC office to verify the amount of the WC payment as of the review month. If there is no record or receipt of compensation or the beneficiary denies receipt examine beneficiary's past work history and present circumstances, especially if the beneficiary's present categorical relationship is because of disability.

Primary Sources

1. WC award notice
2. WC payment check
3. WC office correspondence

Secondary Sources

1. Prior award notice
2. Statement from institution where check is cashed
3. Copies of past checks

336. Other Government Benefits

Verify this element for all beneficiary's reviewed.

Verify whether or not the beneficiary received benefits from any other Government programs during the review month.

The beneficiary's circumstances may provide leads to certain Government program benefits. Verify receipt of pensions and/or benefits and determine the correct amount of income for inclusion in the budget.

When it is known from the beneficiary's statement, case record information, or other sources that the beneficiary receives pension or benefit income verify receipt of the income and establish the amount received.

When the beneficiary states that benefits were not received evaluate this statement in terms of the beneficiary's background, past work history, and present circumstances.

Primary Sources

1. Correspondence on benefits
2. Copy of government benefit check received

Secondary Sources

1. Past award letters
2. Copies of past checks

341. Value of Food Stamps/Housing Subsidy

Review and verify this element for all appropriate AFDC-related cases.

States that choose the AFDC State plan option of counting food stamps and housing subsidies as income must reduce the amount of the flat grant to the extent that the value of food stamps or housing subsidies duplicates the flat grant amount. The reduction is made according to the methodologies specified in the AFDC State plan.

342. Contributions/Income In-Kind

Verify this element for all groups of beneficiaries reviewed.

Primary Sources

1. Contribution check
2. Statement of person or organization making contribution or payment
3. Cancelled checks of person making payments to beneficiary
4. Receipts of contribution

Secondary Sources

1. Beneficiary's statement of receipt
2. Statement as to the value of the income in-kind received

343. Deemed Income

Verify any deemed income to which a money value is given. Applicable income disregards must be applied.

344. Public Assistance or General Assistance

This element is applicable to State agency PA or GA payments made to the assistance unit.

Primary Sources

1. Most recent check
2. Financial aid statement
3. Notice approving application of PA or GA
4. Statement from government agency

Secondary Sources

1. Beneficiary's statement.
2. Copies of past checks
3. Statement from institution where check is cashed

345. Education Grants/Scholarships/Loans

Verify this element for all necessary groups.

Verify by the contract or with the originator of the grant, scholarship, or loan whether its use for current living cost is precluded, the beneficiary is an undergraduate student, the grant or loan is for educational purposes, and the loan or grant is made or insured under a program administered by the Department of Education.

346. Other Income

Verify this element for all beneficiaries who have income not already recorded on the worksheets, e.g., other information obtained under the IEVS.

42 CFR 435.603 requires, as a condition of eligibility, that applicants and beneficiaries must take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled unless they can show good cause for not doing so. Failure to apply when so entitled constitutes grounds for termination or denial of benefits.

If the individual appears to be eligible for benefits for which he/she has not applied, verify the actual eligibility and the amount of such benefits. If MEQC believes a beneficiary is eligible for benefits for which he/she has not applied, verify this potential eligibility in order to positively establish or disprove this potential. Contact the potential payer and verify that eligibility would have existed had application been made, and verify the benefit amount. If the MEQC review discloses eligibility for a payment for which the beneficiary has not applied, add the amount of these benefits to the individual or family's income. Code these errors on the IRS using the appropriate income element and nature code. Before citing an error, however, determine if good cause for failure to apply for benefits exists, as discussed in 42 CFR 435.603. Use the resultant aggregate income to determine whether any liability or eligibility error exists.

If you cannot substantiate eligibility or ineligibility for the benefit, complete the MEQC review anyway. However, if you cannot establish entitlement to such benefits, do not cite an eligibility, liability, or technical error.

Verify whether any income not previously considered under the above income items is actually received, and, if so, determine the correct amount for inclusion in the computations. This refers to other cash income such as income received on a recurring basis from rental property, farm produce, boarders/lodgers, interest income, etc.

350. Support Payments Made to Child Support Agency

The Child Support Enforcement Agency (CSEA) (title IV-D) collects monthly support obligations from absent parents. MEQC must verify amounts passed along to the beneficiary by CSEA in the review month. The first $50 is exempt.

Primary Source

The report from the title IV-D agency to the title IV-A agency itemizing the monthly amounts collected and passed on to the beneficiary.

361. Standard Deduction

Do not complete this element for the MEQC review.

362. Unearned Income Deduction

| Verify appropriate unearned income deduction when allowed.

363. Shelter Deduction

Do not complete this element for the MEQC review.

364. Standard Utility Allowance

Do not complete this element for the MEQC review.

365. Medical Deductions

Do not complete this element for the MEQC review.

371. Combined Gross Income

Review and verify this element for all beneficiaries who have income. Specifically, in this element, compute gross income from the income verified under the 300 Income elements.

372. Combined Net Income

Review and verify this element for all beneficiaries who have income.

Derive net countable income by applying State designated allowable deductions to the combined gross income computed under element 371.

7269.4 Other Medicaid Coverage Requirements (400).--Review these elements of eligibility, which apply only to certain groups of Medicaid beneficiaries, when required by the State plan. Base the evaluation of these elements on State agency requirements for establishing basic budgetary need. These elements pertain to those standard basic need items such as food, clothing, shelter, fuel and/or utilities, etc., for which allowances have either been established, are conditioned on an actual (as paid) cost, or are included in the budget based on all basic budgetary allowances combined (consolidated standard/flat grant).

Determine whether the amount for the standard basic need items to which each beneficiary is entitled was included in the budget in the manner prescribed by the State agency. Apply the appropriate policies to the case member(s') circumstances.

411. Shelter Only

412. Other Basic Budgetary Allowance (Food, Clothing, etc.)

413. All Basic Budgetary Allowances (Combined)

Determine the dollar amounts for each of the case member's basic budgetary allowances using the primary sources listed below relevant to the type of budget (flat or actual expense).

Primary Sources

1. Rent receipts
2. Recipient's landlord
3. Copy of the lease
4. Property grantor - real estate agent
5. Copy of the current tax statement
6. Tax Assessor
7. Utility bills
8. Utility company
9. Water and sewage bills
10. Court house - property records
11. Home insurance policies
12. Mortgage payment receipts
13. Financial institution holding mortgage
14. Sales agreement or purchase contract
15. Public Housing Authority

Secondary Sources

1. Home repair bills
2. Refuse disposal receipt
3. Room and board receipt

420. Special Circumstances Allowance

Review and verify this element for all AFDC-related beneficiaries for whom Medicaid eligibility is based on potential cash eligibility in States allowing special needs as part of the computation. Generally this element is not completed in States utilizing a flat grant approach.

Identify the need for and determine the correct amount of an allowance for special circumstance needs in accordance with State provisions. This may include the following:

521 Child care
522 Transportation
523 Work-related expenses
524 Personal care and other; e.g., a housekeeping service, laundry
525 Other special needs

Determine the appropriateness and correctness of the dollar amount of any special needs allowance(s) which was included in the review month assistance payment.

Primary Sources

1. Doctor's or druggist's statement of special diet need
2. Pregnancy statement from doctor
3. Statement from institution re: special needs
4. Receipts for compensable supplies or services
5. Eviction or relocation notice
6. Car payment record
7. Receipts of transportation costs
8. Employment search cost statement
9. Bureau of Employment Security or WIN agency
10. Institution or agency requesting or supplying services
11. Laundry receipts
12. Telephone bills
13. Housekeeping service charges

Secondary Sources

1. Vendor supply services receipt
2. Telephone company records

7269.5 Computations Of Financial Eligibility (500).--Complete elements in this program area for all beneficiaries. Verify the accuracy of the computations on which financial eligibility for Medicaid is based.

Document in this section computations of potential cash benefits eligibility when that is the basis for Medicaid eligibility. Once the AFDC-related need and payment requirements (elements 411-420) or the SSI FBR (elements 140 and 170) have been established and income amounts have been verified, utilize program area 500 to determine potential cash assistance eligibility. When these computations are required, the State should utilize its own AFDC budget form or, if available, its own SSI budget form.

510. Proper Persons in Budget

Complete this element for all beneficiaries, as appropriate.

520. Arithmetic Computation

Verify this element for all beneficiaries when financial eligibility for Medicaid must be computed.

530. Beneficiary Liability Determination

Review and verify this element for all beneficiaries for whom Medicaid eligibility is based on the case members' liability to apply excess income to an equal amount of incurred medical expenses, e.g., the medically needy and individuals in 209(b) States who are permitted spenddown to become categorically needy.

Also complete this element in determining post eligibility determinations for beneficiary contributions to the cost of care.

For medically needy cases, obtain proof of medical expenses used to obtain eligibility. Copies of bills are usually obtained by the local agency and filed in the case record. However, if documentation is lacking, it may be necessary to secure substantiation of incurred medical expenses. The beneficiary's word is not sufficient. Obtain copies of receipts, bills, written provider statements, or other proof of incurred medical expenses.

Verify that the agency correctly computed medical expenses utilized to offset excess income and that the case had met its liability as computed prior to being certified by the agency. Use an appropriate State form to document these computations.

Also determine if any of the incurred medical expenses were paid by a third party and not by the beneficiary. Do not use medical expenses paid by a third party to offset excess income when determining eligibility and/or liability status. If time requirements prohibit determining whether medical expenses were paid by a third party, count these expenses toward the individual's spenddown.

Determine excess income by subtracting the State's allowable income level from the case's countable income.

After verifying beneficiary income, determining the correct State allowable maintenance level, and reviewing the incurred expenses used by the agency to offset excess income, record the computations of case liability in the QC Computation column of the worksheet. If the computations differ from the agency's computations, either a case liability understated or a case liability overstated error exists.

Record the bases for the computations including a description of the types, dollar amount, and dates of services incurred to offset excess income documented in agency records. Also record the reasons for any case liability errors.

If unable to verify from agency records or the beneficiary(s) during the field investigation whether a case subject to liability requirements had incurred the appropriate dollar amount of medical expenses as of the date of certification, code the case liability error (element 530). Complete only the QC Computation column of the case liability worksheet.

540. Grandfathered Coverage Provisions

Grandfathered provisions apply to beneficiaries for whom Medicaid eligibility is based upon their status as of December 1973, August 1972, or April 1977. Complete this section to summarize findings when agency or reviewer decisions are based on these requirements.

550. Other State Medicaid Coverage Criteria

Complete this element when eligibility requirements not included on the worksheets apply. Examples include:

- Assignment of rights to third party payments for medical services.

- Authorization for QMB coverage no earlier than the month after the determination decision. The determination decision is defined as the earliest record in the case file or automated files that verifies that the State has established eligibility for QMB.

560. Monthly Reporting

Review this element if appropriate. Code errors in this element as technical errors. (See §7309.) States may use monthly or less periodic reports for Medicaid.

7272. VERIFICATION GUIDE

The eligibility elements requiring verification vary depending upon Medicaid eligibility coverage requirements. The Verification Guide, used during the eligibility review, indicates which elements on the worksheets must be verified for each Medicaid coverage group. Prior to beginning reviews become familiar with the State plan, and check the appropriate columns in the Verification Guide to identify the coverage requirements that apply. Following this guide generally assures proper documentation of all eligibility requirements. Occasionally, additional verification may be necessary.

For a specific eligibility coverage requirement under review, verify every applicable element as indicated in the Verification Guide for the review month and/or other time periods if specified. This applies even if an element is in error prior to the completion of all elements. If you find other errors, report them on the IRS. The IRS provides for reporting the total number of errors identified during the review. Identify and report all errors to base subsequent corrective action on complete information which existed during the review month.

Use coverage code (CC) 98 to indicate valid coverage groups which are not included in the SMM.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
Choice of 01 or 03	Individuals who receive SSI basic payments where the State determines Medicaid eligibility using SSI criteria.	1. Complete element 140 to verify State residency, if applicable. 2. Complete elements 211-255 to verify the value of a Medicaid Qualifying Trust (if any). Also verify for transfer of assets. 3. Verify that the recipient received an SSI basic payment (and/or mandatory State supplement (SSP) if provided) during the review month, and record amount under element 333. 4. Document the assignment of rights to medical support/third party payments and, if applicable, the death of the beneficiary in element 550.

NOTE: Use coverage code (CC) 01 also for individuals who meet the above eligibility requirement and who, in addition, receive home and community-based services. Likewise, for other individuals whose eligibility is based on a CC already included in the SMM but who also receive home or community-based services, use the CC under which they qualify but also review for eligibility for home or community-based services provided.

For those whose eligibility is based on a home or community-based waiver, use CC 29 and review accordingly.

Use CC 01 or 03 for individuals who meet the definition of §1619(a) of the Act. 209(b) States must verify individuals covered under §1619(a) of the Act using the instructions under CC 16 of this section.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
02	OASDI recipients who became ineligible for any reason but who would again be eligible for SSI/SSP if any OASDI cost of living increases they received following loss of SSI/SSP after April 1977 were deducted from countable income.	1. Complete element 110 or 185 to verify SSI categorical relationship as of the review month. 2. Complete element 331 to verify OASDI payment for the review month. Also verify element 540 to establish loss of SSI/SSP after April 1977 and that beneficiary was receiving OASDI when he/she lost SSI/SSP. 3. Complete elements 120-150, 170, 211-225, 311-372, and 520 as appropriate to establish whether: a. Beneficiary meets all SSI/SSP eligibility requirements except for income, and b. Beneficiary would again be eligible for SSI/SSP if any OASDI cost of living increases received after April 1977 were deducted from countable income.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
Choice of 01 or 03	Individuals who are aged, blind, or disabled and the State determines Medicaid eligibility using criteria more stringent than SSI requirements.	1. Complete elements 110 to 185, as applicable, to verify categorical relationship. 2. Complete elements 211-225, 311-372, and 520-550, as appropriate, to verify financial eligibility. Use element 530 if the beneficiary gained eligibility through spenddown.

42 CFR 435.130 Coverage Code (Mandatory Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
04		Beneficiaries who receive mandatory supplement payments only and the State administers the supplement.	1. Complete elements 110 or 185 to verify SSI categorical relationship as of the review month. 2. Complete elements 140 to verify residency and 540 to verify that the beneficiary received a mandatory payment for the review month. 3. Complete elements 120, 150, 211-225, 311-372, and 520 to verify eligibility for a mandatory supplement.

42 CFR 435.134 Coverage Code (Mandatory Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
05		1. entitled to title II (OASDI) in August 1972 and: a. were receiving cash assistance under title I, X, XIV, or XVI in August 1972; or b. Would have been eligible for cash assistance had he/she applied and the Medicaid plan covered this group; or c. would have been eligible for cash assistance in August 1972 if they were not in a medical institution or intermediate care facility. d. They would currently be eligible for SSI or SSP except for the 20-percent increase in OASDI provided for by Public Law 92-336.	1. Complete element 540 to verify entitlement to title II benefits in August 1972, or: 2. a. Complete element 540 to verify actual receipt of title I, X, XIV, or XVI in August 1972. b. On a separate set of worksheets complete elements 120, 130, 140, 150, 211-225, 311-372, and 520 to verify potential cash assistance eligibility as of August 1972 except for lack of application or institutionalization, and document that finding under element 540 on the set of worksheets completed for the review month. 3. Complete elements 110 and 185 to verify SSI categorical relationship as of the review month. 4. Complete elements 211-225, 311-372, and 520 to verify eligibility for SSI ignoring the amount of the August 1972 title II increase (element 331) when doing computations.

42 CFR 435.131 Coverage Code (Mandatory Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
06		Persons who were eligible for Medicaid in December 1973 as an "essential spouse" of a cash assistance beneficiary and who continue to meet December 1973 criteria.	1. a. Complete element 540 to verify actual status of the beneficiary as an essential spouse in December 1973. b. On a separate set of worksheets complete program areas 110-150, 211-372 and 520-530 to verify potential status of the beneficiary as an essential spouse in December 1973, and document that finding under element 540 on the set of worksheets completed for the review month. 2. Complete elements 120, 130, and 150 to verify that the beneficiary was an essential spouse during the review month. 3. Complete element 540 to verify that conditions of eligibility prescribed at 42 CFR 435.131 are met.

42 CFR 435.132 Coverage Code (Mandatory Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
07		eligible for Medicaid in December 1973 as institutionalized, who remain appropriately institutionalized and who continue to meet December 1973 criteria in each month since then.	1. Complete element 150 to document institutionalization since December 1973. 2. a. Complete element 540 to verify that the beneficiary was certified eligible for Medicaid in December 1973. b. Complete elements 110 or 185, 120, 130, 140, 150, 211-225, 311-372, and 520-530 on separate worksheets to verify eligibility for Medicaid in December 1973, and for each month since then, and document that finding under element 540 on the set of worksheets completed for the review month. 3. Complete elements 110 and 185 to verify SSI categorical relationship as of the review month. 4. On the separate worksheet, complete elements 120-150, 211-225, 311-372, and 520 to verify eligibility for Medicaid as of the review month based on December 1973 criteria. 5. Verify in element 540 that the institutionalization requirement was met as required by 42 CFR 435.132.

42 CFR 435.133 Coverage Code (Mandatory Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
08		Persons who were eligible for Medicaid in December 1973 as blind or disabled and who continue to meet December 1973 criteria.	1. On a separate worksheet complete elements 130, 140, 150, 185, 211-225, 311-372, and 520 to verify that the beneficiary meets December 1973 eligibility criteria for each month since then up to and including the review month. 2. Complete elements 130-150, 211-225, 311-372, and 520 to verify financial eligibility for Medicaid based on current criteria as of the review month. 3. Verify in element 540 that eligibility requirements for Medicaid based on December 1973 criteria were met each month since then in accordance with 42 CFR 435.133.

42 CFR 435.122 Coverage Code (Mandatory Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
09		would except for an eligibility condition or requirement which is specifically prohibited under title XIX be eligible for SSI or an optional State supplement.	1. Complete elements 110 or 185 as appropriate to verify categorical relationship ignoring conditions or requirements specifically prohibited by Title XIX. 2. Complete elements 211-225, 311-372, and 520 to verify program requirements as well as financial eligibility for SSI or an optional supplement.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
10	Disabled widows and widowers who are deemed to be SSI recipients under COBRA.	1. Verify entitlement to title II benefits for December 1983 (element 186). 2. Complete elements 120-150, 211-225, 311-372, and 520-560 as appropriate to establish: a. Entitlement to widows or widower's disability benefits under §202(e) or (f) of the Act for January 1984. b. Ineligibility for SSI or a mandatory or optional State supplement due to increase in widow's or widower's benefits resulting from elimination of the reduction factor under Public Law 98-21. (Record in element 540.) c. Continuous eligibility for the increase in item 2.b since the time of increase. d. Eligibility for SSI or a mandatory or an optional State supplement if this increase and any other subsequent cost of living adjustment in widow's or widower's benefits under §215(i) were deducted from countable income.

NOTE: Medicaid coverage is available only to individuals who filed a written application for Medicaid benefits before July 1, 1988. Eligibility may not begin before July 1, 1986.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
11	Individuals who are qualified Medicare beneficiaries (QMB) are individuals: 1. Who are entitled to hospital insurance benefits under Medicare Part A; 2. Who, except for QMB coverage, are not otherwise eligible for medical assistance under the plan; 3. Whose income does not exceed the income level (established at an amount up to 100 percent of the official Federal poverty line) specified in the State plan; and 4. Whose resources do not exceed twice the maximum amount allowed under SSI.	1. Complete element 186 to verify entitlement for Medicare Part A. 2. Complete elements 130-140 and 170 to verify other categorical requirements. (See note.) 3. Complete elements 120, 150, 211-225, 311-372, 520, and 550 to verify financial eligibility. (See note.) 4. Complete element 550 to verify assignment of rights to third party payments for medical services and that authorization for QMB is no earlier than the month after all eligibility criteria are met and no earlier than the month after application.

NOTE: Documentation of receipt of SSI is acceptable verification for SSI income, resources, and categorical requirements.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
12	Individuals who are dually eligible as qualified Medicare beneficiaries (QMB) and under non-QMB coverage are individuals: 1. Who are entitled to insurance benefits under Medicare Part A; 2. Who are also eligible for medical assistance under another coverage group other than AFDC cash; 3. Whose income does not exceed the income level (established at an amount up to 100 percent of the official Federal poverty line) specified in the State plan; and 4. Whose resources do not exceed twice the maximum amount allowed under SSI.	1. Complete elements indicated for coverage group 11 to verify eligibility for QMB. 2. Complete elements indicated for the other Medicaid coverage group to verify dual eligibility.

NOTE: Documentation of receipt of SSI is acceptable verification for SSI income, resources, and categorical requirements.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
14	Elderly/disabled poor: 1. Who are age 65 or older or are disabled; 2. Whose resources do not exceed the SSI resource level or, at State option, the State's medically needy resource level or QMB resource level; and 3. Whose income does not exceed 100 percent of Federal poverty guidelines (refer to State plan).	1. Complete applicable elements 110-186 to verify that age and categorical requirements are met. 2. Complete applicable elements 211-225 to verify that resources are within defined limits. 3. Complete applicable elements 311-372 to verify that countable income is within defined limits. 4. Complete applicable elements 510-550 to verify additional Medicaid eligibility requirements.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
15	Disabled widows and widowers between the ages of 60-64 who would be eligible for SSI except for the increase in their widow/widower's insurance benefits and who are deemed, for purposes of title XIX, to be SSI recipients under §1634(b) of the Act, effective July 1, 1988. Disabled widows, widowers, or surviving disabled divorced spouses between the age of 50 and 64 who become ineligible for SSI or Federally administered State supplement payments due to receipt of title II disability benefits are deemed to be SSI recipients for Medicaid purposes under §5103 of the OBRA 90, effective January 1, 1991.	1. Complete elements 110, 130, 140, 170, and 186 to verify categorical requirements and application for Medicaid by July 1, 1988. (This filing date may be later in 209(b) States.) 2. Complete elements 211-225 to verify resources. 3. Complete elements 311-322 and 331-372 to verify income, to verify eligibility for RSDI for December 1983 to verify eligibility for widow/widower's insurance benefit based on disability for January, 1984, and to verify loss of SSI in the first month of an increase in the widow's/widower's insurance benefit.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
16	Qualified severely impaired individuals as defined in §1905(q)(1) of the Act who continue to be blind or disabled and, except for earnings, continue to meet all nondisability related SSI eligibility requirements. These are individuals eligible for Medicaid under §1619(b) of the Act in June 1987.	209(b) States: 1. Verify that in the month prior to the month the beneficiary entered §1619 status (s)he had been determined eligible for Medicaid by the State agency. 2. Verify that the beneficiary was in §1619 status as of the review month.

NOTE: In §1634 and SSI criteria States, this coverage group is considered to be receiving SSI cash payments.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
17	Blind or disabled individuals who: 1. Are at least 18 years of age; 2. Were receiving SSI on the basis of blindness or disability which began before the age of 22; and 3. Lost SSI eligibility because they became entitled on or after July 1, 1987, to OASDI child's benefits under §202(d) of the Act or became entitled to an increase in these benefits. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their child's insurance benefits or such increases.	1. Complete elements 110 to verify age, 140 to verify residency, 185-192 for other categorical requirements, 211-225 for resources including transfer of resources, and 311-372 for income verification. 2. Complete element 550 to verify loss of SSI due to receipt of or an increase in OASDI benefits on or after July 1, 1987. Also verify that blindness or disability began prior to age 22.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
18	A qualified disabled and working individual (QDWI) is an individual: a. Who loses entitlement to premium free Medicare Part A coverage due to earnings from substantial gainful activity (SGA); b. Who is entitled to enroll in Medicare Part A; c. Whose income does not exceed 200 percent of the official poverty line; d. Whose resources do not exceed twice the SSI level; and e. Who is not otherwise eligible for Medicaid.	1. Verify that the individual is not eligible for any other Medicaid coverage. 2. Complete element 186 to verify that the individual is entitled to enroll in Medicare Part A and is engaged in substantial gainful activity. 3. Complete elements 130, 140, 150, 170, 185, and 550 to verify programmatic eligibility for Medicaid. 4. Complete elements 211-225 and 311-372 to verify financial eligibility. 5. Document premium payments in element 550 if the individual is required under the State plan to pay a percentage of the Part A premium.

42 CFR 435.230 Coverage Code (Optional Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
21		Individuals who receive State optional supplement payments only where the state determines Medicaid eligibility using SSI criteria.	1. Verify that the beneficiary received only an SSI optional supplement during the review month and record that amount under element 333. 2. Complete elements 110 or 185 as applicable to verify SSI categorical relationship. 3. Complete elements 120-170, 211-225, 311-372, and 520 to verify programmatic and financial eligibility requirements are met.

42 CFR 435.230 Coverage Code (Optional Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
22		State optional supplement payments where the State determines Medicaid eligibility using criteria which are more stringent than SSI requirements.	1. Verify that the beneficiary received only an optional State supplement during the review month and record that amount under element 333. 2. Complete elements 110 or 185 to verify categorical relationship utilizing state-set requirements. 3. Complete elements 120-150, 211-225, 311-372, and 520 to verify programmatic requirements are met and financial eligibility for Medicaid is established based on State-set financial criteria. 4. For any State-set requirements not covered above verify under element 186.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
23	Persons who are eligible for SSI payments or a State's supplement payment only but are not receiving payments.	Complete elements 110 or 185, 120, 130, 140, 150, 211-225, 311-372, and 520 for the review month to verify that the beneficiary would have been eligible for an SSI basic payment or a State supplement only, had the beneficiary applied.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
24	Individuals for whom a notice of ineligibility for SSI benefits is received after the 10th of the month and who are eligible for coverage through the end of the following month.	Complete element 186 to document notification of termination from SSI after the 10th of month before the review month.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
25	Individuals residing in medical institutions with income sufficient for personal needs while in the institution but who would be eligible for SSI or a State supplement payment if not living in the institution.	1. Complete element 150 to verify institutionalization during the review month. 2. Complete element 110 or 185 to verify SSI categorical relationship as of the review month. 3. Complete element 530 for beneficiary liability determination. 4. Complete elements 120-140, 170, 211-225, 311-372, and 520 to verify eligibility for an SSI basic payment or State supplement payment assuming the beneficiary was not living in the institution. Use the SSI budget worksheet if required.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
26	Individuals whose eligibility for Medicaid has otherwise ceased but who are still overcoming the condition(s) upon which their eligibility was predicated.	1. Complete element 550 to document that the review month is no more than 2 months after the month in which the recipient's Medicaid eligibility would have been terminated (document date of SSI/SSP or AFDC termination if applicable). 2. Complete element 185 to verify that the beneficiary is overcoming the condititon of Medicaid eligibility during the review month.

42 CFR 435.301 Coverage Code (Optional Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
27		Individuals who would be eligible for any of the SSI categorically needy groups listed above except for excess income and/or resources and whose income is insufficient to meet medical expenses (use only for medically needy).	1. Complete elements 110 or 185 as applicable to verify SSI categorical relationship as of the review month. 2. Complete elements 120-170, 211-225, 311-372, and 520 to verify programmatic and financial eligibility for Medicaid except for excess income (program area 300). 3. Complete element 530.

42 CFR 435.231 Coverage Code (Optional Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
28		individuals in institutions who are eligible under a special income level.	1. Complete elements 110 or 185 as applicable to verify categorical relationship as of the review month. 2. Complete elements 120-170, 211-225, 311-372, and 520 to verify programmatic and financial eligibility for Medicaid. 3. Complete element 530.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
29	Individuals receiving home and community-based services and other waiver services who are eligible under a special income level.	1. Complete element 110 or 185, as applicable, to verify categorical relationship as of the review month. 2. Complete elements 120-150, 170, 211-225, 311-372, and 520 to verify programmatic and financial eligibility for Medicaid. 3. Complete element 530 for liability determination. 4. Review against State plan and other applicable waiver materials to confirm proper waiver placement and document findings in element 550.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
30	Institutionalized member of a couple (whose spouse remains in the community) who: a. Receives SSI cash in a State which determines Medicaid eligibility using criteria more stringent than SSI requirements; or b. Has income sufficient for personal needs while in the institution but who would be eligible for SSI or State supplemental payment if not living at the medical institution. (At State option, this may apply to a member of a couple who receives home and community-based services.); or c. Is eligible under a special income level.	1. Complete element 120 to verify legal marriage under State law to community spouse. 2. Complete element 110 or 185, as applicable, to verify SSI categorical relationship as of the review month. 3. Complete element 186 to determine date of onset of most recent period of institutionalization. 4. Complete elements 130-140, 170, 211-225, and 311-350 to verify programmatic and financial eligibility for Medicaid: o Review both spouses for transfers of assets as prescribed in the State plan, and o Review the original application to determine if the recipient was resource eligible when certified eligible for Medicaid. 5. Complete elements 411-420 to verify calculation of community spouse/family member monthly income allowances.

Coverage Code Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
30 (Cont.)		6. Complete element 530 to document that the spousal allowance which was deducted from the institutionalized spouse's income was actually made available to (or for the benefit of) the community spouse. 7. Complete elements 520 and 530 to verify calculation of the patient liability. If the review month is the last (reconciliation) month of a projected period of eligibility, verify that actual income and expenses in each of the months of the projected budget period were correctly reconciled at the end of the period. 8. Complete element 550 to verify compliance with assignment of rights to medical support/third party payments.

NOTE: The resource determination for spousal cases described in coverage codes 30 and 31 is a two-step process. First, find the couple resource eligible (by combining the couple's resources and subtracting the protected resource amount for the community spouse and comparing the remaining resources to the Medicaid limit for an individual) for ANY 1-month period between the month of application and the review month. Second, the resources attributed to the institutionalized spouse (IS) must be equal to or below the Medicaid resource limit for an individual in the review month in order to code the case eligible. If the IS resources are above the State's resource limit, the case is ineligible.

Depending on the case, it may be easier for you to review from the review month backward to the first month of Medicaid eligibility. In new Medicaid cases, reviewers may prefer to use the first month of eligibility. Regardless of which month is used to establish eligibility for MEQC purposes, you must use the protected spousal resource amount established at the initial resource assessment to determine eligibility under the first step of the process. You must also examine the initial assessment to verify the correctness of all mathematical calculations.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
31	Institutional individuals who are in a medical institution or nursing facility or, at State option, in a home and community-based services waiver arrangement, and have spouses who live in the community. These are individuals who would be eligible for any of the SSI categorically needy groups listed above except for excess income and/or expenses and whose income is insufficient to meet medical expenses.	1. Complete element 120 to verify legal marriage under State law to community spouse. 2. Complete elements 110 or 185, as applicable, to verify SSI categorical relationship as of the review month. 3. Complete element 186 to determine date of onset of most recent period of institutionalization. 4. Complete elements 130-140, 170, 211-225, and 311-350 to verify programmatic and financial eligibility for Medicaid: o Review both spouses for transfers of assets as prescribed in the State plan, and o Review the original application to determine if the recipient was resource eligible when certified eligible for Medicaid. 5. Complete elements 411-420 to verify calculation of community spouse/family member monthly income allowances.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
31 (Cont.)		6. Complete element 530 to document that the spousal allowance which was deducted from the institutionalized spouse's income was actually made available to (or for the benefit of) the community spouse. 7. Complete elements 520 and 530 to verify calculation of the patient liability. If review month is the last (reconciliation) month of a projected period of eligibility, verify that actual income and expenses in each of the months of the projected budget period were correctly reconciled at the end of the period. 8. Complete element 550 to verify compliance with assignment of rights to medical support/third party payments.

NOTE: The resource determination for spousal cases described in coverage codes 30 and 31 is a two-step process. First, find the couple resource eligible (by combining the couple's resources and subtracting the protected resource amount for the community spouse, and comparing the remaining resources to the Medicaid limit for an individual) for ANY 1-month period between the month of application and the review month. Second, the resources attributed to the institutionalized spouse (IS) must be equal to or below the Medicaid resource limit for an individual in the review month in order to code the case eligible. If the IS resources are above the State's resource limit, the case is ineligible.

Depending on the case, it may be easier for you to review from the review month backward to the first month of Medicaid eligibility. In new Medicaid cases, reviewers may prefer to use the first month of eligibility. Regardless of which month is used to establish eligibility for MEQC purposes, you must use the protected spousal resource amount established at the initial resource assessment to determine eligibility under the first step of the process. You must also examine the initial assessment to verify the correctness of all mathematical calculations.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
32	Qualified pregnant women who are eligible on the basis of income and resource requirements for payments under the AFDC State plan.	1. Complete element 186 to verify pregnancy and elements 130-170, as applicable, to verify programmatic eligibility. 2. Complete elements 211-225 and 311-372 to verify AFDC-related financial eligibility. Use AFDC income and resource standards for two or the appropriate number of family members considered to determine financial eligibility. 3. Complete applicable elements 411-520 and 550 to verify eligibility under remaining coverage provisions.

Coverage Code (Mandatory) Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
33	Qualified family members who are eligible for time limited AFDC unemployed parents (UP) benefits.	1. Complete elements 110-151 and 170 to verify programmatic eligibility. 2. Verify element 184 to verify eligibility of principal earner for AFDC/UP payments. 3. Complete elements 211-225 and 311-372 to verify AFDC-related financial eligibility.

NOTE: This coverage group expires on October 1, 1998, and does not include qualified pregnant women and children.

States that had a UP program in effect on September 28, 1988, cannot limit UP payments. This coverage group is effective only in those States that may opt to limit UP payments (minimum 6 months).

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instruction
34	Qualified children born after September 30, 1983, or such earlier date as the State designates) who have not obtained age 19 and who meet AFDC income and resource standards.	1. Complete elements 110, 130, 140, 150, and 170 to verify age, citizenship, residency, living arrangements, and enumeration requirements. 2. Complete elements 211-225, 311-372, 411-420, 520, and 550 to verify financial eligibility for Medicaid.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
35	Children born to women who are eligible for and receiving Medicaid at the time of the child's birth. These children are deemed eligible for 1 year from birth as long as the mother remains eligible (or would remain eligible if pregnant) and the child remains in the household with the mother.	1. Verify element 110 for the child. Verify elements 120, 130, 140 and 170 for basic categorical requirements for the mother and child. 2. Verify that the child's mother was receiving Medicaid at the time she gave birth. 3. If the State has elected to consider resources for purposes of Medicaid eligibility, verify that the child's mother remained eligible or would be eligible if she was pregnant (regardless of category of coverage) through the review month, by completing applicable elements 211-225.

NOTE: Changes in income do not affect coverage of an otherwise eligible pregnant woman or infant born after January 1, 1991.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
36	Individuals who are dually eligible as specified low-income Medicare beneficiaries (SLMB) and under non-SLMB coverage are individuals: 1. Who are entitled to insurance benefits under Medicare Part A; 2. Who are also eligible for medical assistance under another coverage group other than AFDC cash; 3. Whose income exceeds 100% of the official Federal poverty level but is less than the income level specified in the State plan; and 4. Whose resources do not exceed twice the maximum amount allowed under SSI.	1. Complete element 186 to verify entitlement for Medicare Part A. 2. Complete elements 130-140 and 170 to verify other categorical requirements. 3. Complete elements 120, 150, 211-225, 311-372, 520, and 550 to verify financial eligibility. 4. Complete element 550 to verify assignment of rights to third party payments for medical services.

NOTE: Income levels for SLMB are:
- o 110% of Federal poverty level for CY 1993 and 1994; and
- o 120% of Federal poverty level for CY 1995 and thereafter.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
37	Specified low-income Medicare beneficiaries are individuals: 1. Who are entitled to hospital insurance benefits under Part A; 2. Who except for SLMB coverage are not otherwise eligible for medical assistance under the plan; 3. Whose income exceeds 100% of the official Federal poverty level but is less than the income level specified in the State plan; and 4. Whose resources do not exceed twice the maximum amount allowed under SSI.	1. Complete element 186 to verify entitlement for Medicare Part A. 2. Complete elements 130-140 and 170 to verify other categorical requirements. 3. Complete elements 120, 150, 211-225, 311-372, 520, and 550 to verify financial eligibility. 4. Complete element 550 to verify assignment of rights to third party payments for medical services.

NOTE: Income levels for SLMB are:
- o 110% of Federal poverty level for CY 1993 and 1994; and
- o 120% of Federal poverty level for CY 1995 and thereafter.

Coverage Code	Medicaid Eligibility Coverage Requirement	Verification Instructions
38	Reserved for future use.	

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
39	Certain disabled children age 18 or under who are living at home and who would be eligible, if in a medical institution, for SSI or a supplemental payment under title XVI of the Act, and therefore for Medicaid under the plan, and for whom the State has made a determination as required under §1902(e)(3)(B) of the Act.	1. Complete categorical elements 110 for age and 185 for disability. 2. Complete other categorical elements 120-184 as appropriate for other requirements. 3. Complete elements 211-225, 311-372, and 510-550 as appropriate for financial eligibility verification.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
40	Families whose receipt of AFDC was terminated due to receipt of child support income. These families are covered for Medicaid assistance for a maximum of 4 months beginning with the first month of ineligibility for AFDC.	1. Complete elements 311-323 and 342 to document ineligibility for AFDC due to receipt of child support income. 2. Complete element 140 to verify residence in the review month and during prior months in the extended period. 3. Complete element 186 to verify that the month of AFDC ineligibility is appropriate. 4. Complete element 186 to verify actual receipt of AFDC cash payments in at least 3 of the 6 months prior to AFDC ineligibility as appropriate.

Coverage Code	Medicaid Eligibility Coverage Requirement	Verification Instructions
41	Reserved for future use.	

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
42	Pregnant women who are aliens who are banned from receiving AFDC for 5 years but who can receive limited Medicaid services. These are pregnant women who are not aged, blind, disabled, Cuban-Haitian entrants or are not under 18 years of age but who are in a lawful temporary or permanent resident status.	Complete elements 110-184, 211-225, 311-372, and 520 to verify that the beneficiary is eligible for Medicaid.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
43	Work transition provision requires States to provide 6-month extension of Medicaid coverage to families who received and were eligible for AFDC benefits in 3 of the 6 months prior to the family becoming ineligible for AFDC due to employment of the caretaker relative because of an increase in hours, income, or loss of the $30 and one-third, or $30 income disregards by a family member. Requires States to offer an additional 6-month extension to families who received Medicaid coverage during the entire initial 6-month extension period and who meet the reporting requirements. When a family is ineligible for Medicaid under this coverage, the State cannot terminate a child until the State determines that the child is not eligible under any other coverage group.	Initial 6-Month Period 1. Complete elements 311-323 to document ineligibility for AFDC because of hours of, or income from, employment of the caretaker relative, or loss of $30 and 1/3 or $30 earned income disregard by a family member. 2. Complete elements 110, 120, and 150 to verify that there is a child living in the home in the review month and during prior months in the extended period. 3. Complete element 140 to verify residence in the review month and during prior months. 4. Document element 186 that the caretaker relative has made application for his/her employer's health plan when this is a condition of eligibility under the State plan. 5. Complete element 186 to verify that the first month of AFDC ineligibility is appropriate. 6. Complete element 186 to verify actual receipt of AFDC cash payments in at least 3 of the 6 months prior to the first month of AFDC ineligibility as appropriate.

MEQC determines if the increase in earned income (or hours of employment or loss of the disregards) would have resulted in loss of AFDC eligibility if all other factors in the case remained the same. If so, the family is eligible for extended Medicaid benefits. Verify the increase in income with documentation, i.e., pay stubs, contact with the employer.

If the increase in earned income alone does not cause ineligibility, the family still might be eligible for extended Medicaid. If, without using the increase in earned income (or hours of employment or loss of the disregards) the other changes in circumstances could cause ineligibility, then the increase in earned income does not cause or contribute to ineligibility and the family is not eligible for extended coverage. However, if the other changes could not cause ineligibility unless combined with the increase in earned income, then eligibility for extended coverage exists.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
43 (Cont.)		Second 6-Month Extension

Verify all the conditions in the initial 6-month period AND the following:

7. Document element 186 to determine that the family submitted reports of earnings and child care costs by the 21st day of the 4th month of the initial 6-month extension and in the first and fourth months of the second 6-month extension.

8. Document in elements 311-314, 323, and 520 for each of the 3 preceding months (prior to the 1st and 4th months):

   - The family's average gross monthly earnings, less the cost of child care necessary for employment of the caretaker relative (must not exceed 185 percent of the Federal poverty level for the same size family);
   - The necessary cost for child care for the caretaker relative; and
   - That the caretaker relative was employed during the appropriate months.

     If the caretaker relative had no earnings in one or more of the appropriate 3 months, document that the lack of earnings was due to involuntary loss of employment; or due to illness; or other good cause.

9. Document premium payments in element 550 if required under State plan.

Coverage Code (Mandatory Coverage	Medicaid Eligibility Coverage Requirement	Verification Instructions
44	1. Individuals who were entitled to OASDI in August 1972 and: a. were receiving AFDC cash assistance; or b. would have been eligible for AFDC had they applied, and the Medicaid plan covered this optional group; or c. they would have been eligible for AFDC if they were not in a medical institution or intermediate care facility and the Medicaid plan covered this optional group. d. They would currently be eligible for AFDC except the increase in OASDI under P.L. 92-336 raised income over the limit allowed under AFDC.	1. Complete element 540 to verify entitlement to title II benefits in August 1972 and actual receipt of AFDC if applicable. 2. Complete elements 110-184, 211-225, 311-372, and 520 to verify eligibility for AFDC (ignoring the August 1972 OASDI income increase (element 331) when doing computations) for the review month, or: 3. On a separate set of worksheets complete elements 110-284, 211-225, 311-372, 411-420, and 520 to verify potential eligibility for AFDC as of August 1972 except for lack of application or institutionalization and document that finding in element 540 on the worksheets completed for the review month.

42 CFR 435.110 Coverage Code (Mandatory Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
45		Members of AFDC families who receive cash payments.	Elements of eligibility will have been verified by AFDC-QC for eligible cases. Cases found to be ineligible for cash payment should be checked for eligibility under other coverage codes.

42 CFR 435.113 Coverage Code (Mandatory Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
46		All individuals who would except for an eligibility condition or requirement which is specifically prohibited under title XIX be eligible for AFDC.	1. Complete elements 110-184 to verify AFDC catergorical relationship ignoring conditions or requirements specifically prohibited by title XIX. 2. Complete elements 211-225, 311-372, 411-420, and 520 for the review month to verify financial eligibilty for AFDC.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
47	Pregnant women who, while pregnant, were eligible for, had applied for, and received Medicaid and who, on the date pregnancy ends, are Medicaid eligible can receive pregnancy-related and post partum services for a period beginning with the date pregnancy ends and extending through the end of the month in which the 60th days falls.	1. Verify receipt of Medicaid on the day pregnancy ends. 2. Confirm that the post partum period has not expired.

NOTE: The 60-day post partum period extends to the end of the month in which the 60th day falls.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
48	Reserved for future use.	

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
49	Pregnant women and infants up to 1 year of age whose income is between 133 and 185 percent of the poverty level.	1. Complete elements 110-184 to verify categorical requirements were met (including pregnancy verification if appropriate.) 2. Verify applicable elements 211-225 to confirm that the resource limitation is met, unless the State has opted to have no resource requirements. 3. Complete applicable elements 311-372 to verify that income did not exceed the level specified in the State plan. (See note.)

NOTE: Effective January 1, 1991, income changes do not affect coverage (including the 60-day post partum period) of an otherwise eligible pregnant woman or infant born after January 1, 1991.

Infants who lose eligibility because they attain age 1 and who are inpatients remain eligible until the end of the inpatient episode.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
50	Pregnant women and infants up to 1 year of age whose income is either at or below 133 percent of the Federal poverty level or at a higher level, up to 185 percent, if mandatory for the State).	1. Complete elements 110-184 to verify categorical requirements were met (including pregnancy verification if appropriate.) 2. Verify applicable elements 221-225 to confirm that the resource limitation is met if applicable. 3. Complete applicable elements 311-372 to verify that income does not exceed the level specified in the State plan. (See note.)

| NOTE: Effective January 1, 1991, income changes do not affect coverage (including the 60-day post partum period) of an otherwise eligible pregnant woman or infant born after January 1, 1991.

Infants who lose eligibility because they attain age 1 and who are inpatients remain eligible until the end of the inpatient episode.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
51	Children born after September 30, 1983 from age 6 through age 19 whose income is up to 100 percent of the poverty level.	1. Complete elements 110-180 to verify categorical requirements. 2. Complete elements 211-225 to verify resources if applicable. 3. Complete elements 311-372 to verify that income does not exceed the level specified in the State plan.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
52	Children between age 1 year and up to age 6 whose income is at or below 133 percent of the poverty level.	1. Complete elements 110-180 to verify categorical requirements. 2. Complete elements 211-225 to verify resources if applicable. 3. Complete elements 311-372 to verify that income did not exceed the level specified in the State plan.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
53	Reserved for future use.	

42 CFR 435.231 Coverage Code (Optional Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
60		AFDC-related individuals in institutions who are eligible under a special income level.	1. Complete elements 110-184, as appropriate, verify AFDC categorical relationship and programmatic requirements are met as of the review month. 2. Complete elements 211-225, 311-372, 411-420, and 520 to verify eligibility for Medicaid. 3. Complete element 530.

42 CFR 435.110 Coverage Code (Mandatory Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
61		Beneficiaries who are receiving AFDC pay-ments under special program provisions which are not covered by the existing AFDC-QC system: AFDC Emergency Assistance.	1. Verify that the beneficiary received an AFDC Emergency Assistance payment in the review month, and document inelement 336. 2. Verify AFDC categorical relationship in elements 110-184. 3. Verify financial eligibility for Medicaid in elements 211-225, 311-372, 411-420, and 520.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
62	Reserved for future use.	

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
63	Caretaker relatives who: 1. Meet the definition of a specified relative in 45 CFR 233.90(c)(1)(V)(A); and 2. Have in their care an individual who is determined to be dependent, as specified in 42 CFR 435.510.	1. Complete element 150 to verify living arrangement of child with caretaker. 2. Complete elements 110-186 to verify AFDC categorical relationship and programmatic requirements. 3. Complete elements 211-225, 311-372, 411-420, and 510-570 for the review month to verify financial eligibility for AFDC.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
64	Persons who would be eligible for AFDC benefits but are not receiving payments.	Complete elements 110-186, 211-225, 311-372, 411-420, and 510-570 to verify that the beneficiary would have been eligible for an AFDC payment during the review month but was not receiving benefits. Also, verify any applicable, unique Medicaid requirements.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
65	Individuals who would be eligible for AFDC payments if they did not receive child care services through the agency but would have to pay for child care costs from earnings.	1. Verify that child care was received from the agency during the review month and verify the cost of the service received in element 420. 2. Complete elements 110-186, 211-225, 311-372, 411-420, and 510-570 to verify that the beneficiary would have been eligible for an AFDC payment during the review month if the estimated cost of child care services received (element 420) was treated as an income deduction in element 323. 3. Verify that the AFDC plan allows the deduction for work related child care costs.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
66	Persons who would be eligible for AFDC payments if the State's AFDC program were as broad as allowed under title IV-A of the Act.	1. In element 550, list the State established AFDC eligibility requirements which are more restrictive or in addition to those in title IV-A of the Act and which are not used in Medicaid eligibility determinations. 2. Complete elements 110-186, 211-225, 311-372, 411-420, and 550-570 to verify potential AFDC eligibility during the review month. For each requirement listed in element 550, utilize the eligibility requirement as specified in the Act as the basis for the eligibility determination.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
67	Individual residing in a medical institution with income sufficient for personal needs while in the institution but who would be eligible for AFDC if he/she were not living in the institution.	1. Complete element 150 to verify institutionalization during the review month. 2. Complete elements 110-186 to verify AFDC categorical relationship and programmatic requirements as of the review month. 3. Complete elements 211-225, 311-372, 411-420, and 510-570 to verify eligibility for AFDC assuming the beneficiary was not living in the institution. 4. Complete element 530 for beneficiary liability determination.

42 CFR 435.1004 Coverage Code (Optional Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
68		Individuals whose eligibility for Medicaid has otherwise ceased but who are still overcoming the effects of their AFDC eligibility condition.	1. Complete element 550 to document termination from AFDC within 2 months prior to the review month. 2. Complete elements 181-185 to verify that the beneficiary is overcoming the condition which resulted in Medicaid eligibility during the review month.

42 CFR 435.301 Coverage Code (Optional Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
69		Individual who would be eligible for any of the AFDC categorically needy groups listed above except for excess income and/or resources and whose income is insufficient to meet medical expenses (medically needy).	1. Complete sections 110 or 184 to verify AFDC categorical relationship as of the review month. 2. Complete elements 120-170, 211-225, 311-372, 411-420, and 520 to verify programmatic requirements and financial eligibility for Medicaid except for excess income (program area 300). 3. Complete element 530 to verify that the beneficiary had incurred appropriate medical expenses at the time of eligibility certification.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
71	Individuals who are denied an AFDC cash payment solely because the amount would be less than $10 but who must be deemed eligible for Medicaid.	1. Complete elements 110-186 to verify AFDC categorical relationship as of the review month. 2. Complete elements 211-225, 311-372, 411-420, and 510-570 to verify financial eligibility for an AFDC payment of less than $10.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
73	Pregnant women who, except for income and resources, would be eligible for Medicaid in any categorically needy group listed above and whose income is insufficient to meet medical expenses.	1. Complete elements 130-150 and 170-186 to verify AFDC categorical relationship and programmatic requirements. Verify element 110 or 185 to verify SSI categorical relationship. 2. Complete element 186 to verify pregnancy. 3. Complete elements 221-225, 311-372, 411-420, and 510-570 to verify financial eligibility for Medicaid except for excess income (program area 300). 4. Complete element 530 to verify that the beneficiary has incurred appropriate medical expenses at the time of eligibility certification.

Coverage Code (Mandatory Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
74	Individuals deemed eligible for Medicaid who are participating in an AFDC work supplementation program, any child or relative of the participant, or other individuals living in the same household as the participant who would be eligible for AFDC if the individual were not participating in the work supplementation program.	1. Complete elements 110-186 to verify AFDC categorical relationship as of the review month. 2. Complete elements 211-225, 311-372, 411-420, and 510-570 to verify financial eligibility for AFDC if the individual were not participating in the work supplementation program.

Coverage Code (Optional Coverage)	Medicaid Eligibility Coverage Requirement	Verification Instructions
81	All individuals under age 21 (or, at State option, age 20, 19, or 18) or approved reasonable classification thereof who meet the AFDC income and resource limits.	1. Complete elements 110, 130, 140, and 150 to verify age, citizenship, residency, and living arrangements. 2. Complete element 186 (if required) to verify that the child is in a State approved classification (and element 336 to verify a foster care payment was made for the review month (if applicable). 3. Complete elements 211-225, 311-372, 411-420, and 510-570 to verify financial eligibility for Medicaid.

Coverage Code (Optional Coverage)	State Plan Reference	Medical Eligibility Coverage Requirement	Verification Instructions
82		Individuals who would be eligible for Medicaid as a needy individual under 21 (or at State option age 20, 19, or 18) except for excess income and whose income is insufficient to meet medical expenses.	1. Complete elements 110, 130, 140, and 150 to verifiy age, citizenship, residency, and living arrangements. 2. Complete section 186 (if required) to verify that the child is in a State approved classification (and element 336 to verify a foster care payment was made for the review month, if applicable). 3. Complete elements 211-225, 311-372, and 520-530 to verify financial eligibility for Medicaid except for excess income (program area 300). 4. Complete element 530 to verify that the beneficiary had incurred appropriate medical expenses at the time of certification.

Ref. COBRA §9529(b) and 1902(a)(10)(A)(ii)(VIII) of the Act Coverage Code (Optional Coverage)	State Plan Reference	Medicaid Eligibility Coverage Requirement	Verification Instructions
	83	Children under 21 who have special medical or rehabilitative needs and who are under State adoption assistance agreements other than title IV-E agreements.	1. Verify that the child had a pre-existing special medical or rehabilitative need. 2. Refer to the State plan/procedure manual to determine additional necessary verification.

7275. INSTRUCTIONS FOR INTEGRATED REVIEW SCHEDULE (IRS) - Form HCFA 301

An IRS is required for each MEQC sampled case. (This includes each case in the AFDC stratum including drops.) The worksheets must contain documentation for the information entered on the IRS. Refer to The Integrated Manual for AFDC, Adult, Food Stamp, and Medicaid Eligibility Quality Control Reviews for detailed completion instructions.

Following the eligibility review, complete Form HCFA 301, except for the dollar amount, under Detailed Error Findings and the Payment Review Information-Medicaid.

Following the payment review, complete the dollar amount under Detailed Error Findings and the Payment Review Information-Medicaid sections.

Code technical errors (discussed in §7309) at the bottom of the Detailed Error Findings section. Do not code any dollars for these errors. Circle each detailed error and line through the dollar amount.

7278. ADMINISTRATIVE PERIOD

Quality control procedures provide for a reasonable period of time for States to reflect changes in the circumstances of the assistance group. MEQC refers to this period of time as the administrative period. For MEQC purposes, the administrative period is the review month and month prior to the review month. However, a State plan may impose a more restrictive period. The administrative period is designed to include all periods for advance notice, client reporting, agency investigation, and agency imposed time allowances for client action. Therefore, the administrative period provides for all such time allowances.

When an eligibility error is occasioned solely by the failure of case record data as of the review month to reflect changes in an assistance group's circumstances which occurred (a) during the review month (calendar or fiscal) or the month immediately preceding the review month, or (b) during the State's more restrictive administrative period, no case eligibility error exists (unless the medical assistance eligibility as of the review month was adjusted incorrectly). If the eligibility status of the assistance group was incorrect as of the review month and would still be incorrect disregarding the change in circumstances that occurred during the administrative period or applicable portion thereof, a case eligibility error exists. Use the case status for the review month in determining the type and amount of error if an error would exist even with application of the administrative period. The administrative period does not apply to State policy changes.

The change in circumstances is defined as the point at which a change causes the case to be in error (or to become correct). For example, if a beneficiary becomes employed in late February but earnings do not exceed the income limit until March, the change in circumstances for this case occurs in March. A change in circumstances must occur in the review month or month prior to be disregarded in the MEQC process.

In the concept of the administrative period, the date of action is the date on which the State Agency responds to a beneficiary's change in circumstances by revising his/her eligibility/liability status. In applications and redeterminations, the date the State Agency inputs the change into the eligibility system is considered to be the date of action.

If the State agency takes an incorrect action during the administrative period, MEQC must report that error. For example, if a beneficiary reports an increase in income and the State agency incorrectly acts upon that change, that action is subject to MEQC error citation.

As it applies to initial eligibility determinations, the administrative period may be affected by the date the case is approved for Medicaid (approval date) and the date the State agency enters the case into the system (systems action date) for Medicaid eligibles. If a change in circumstances occurs prior to the application date, the administrative period to reflect that change does not apply. For example, assume an application date is January 15, the approval date is January 25, and the systems action date is February 1. If a change in circumstances occurs January 14, the administrative period does not apply. However, if the change occurred January 25 or later, it applies.

Apply the administrative period to each program area. A program area has been defined as a program element of eligibility, e.g., Bank Accounts or Cash on Hand (211), Other Liquid Assets and Personal Property (213), and Real Property (221).

If there are two errors within one program element and one occurred prior to the administrative period while the other occurred within the administrative period, both are countable. However, if they are not within the same program element, i.e., 211 and 221, but the dates of errors exist as above, only the earlier one is countable because the elements are not the same and the second occurred within the administrative period.

The administrative period includes all changes of circumstances which affect beneficiary eligibility/liability.

An exception to MEQC looking first at the review month in determining eligibility occurs in cases when the beneficiary died in the month prior to the review month. In such cases, determine eligibility as of the date of death. If the case was in error as of that point and throughout the prior part of the administrative period, the case is in error regardless of what occurred subsequent to the beneficiary's death.

Note that the administrative period does not apply to retrospective budgeting.

7300. CLASSIFICATION OF ERRORS

The MEQC process may result in the following types of errors.

A. Eligibility Errors.--An eligibility error exists when a beneficiary and/or case does not meet all elements of eligibility.

B. Not Eligible for Services Received Errors.--This is applicable in States which cover more services for the categorically needy than for the medically needy and in States which provide home or community-based waiver services.

C. Liability Error.--A liability error exists when an individual case has its spenddown, amount of cost sharing, or contribution toward the cost of long term care incorrectly determined.

Report the total amount of all errors. However, do not report understated liability errors which total less than $5 in both the eligibility review and the payment review. See 42 CFR 431.804 for specific information on how to determine the erroneous payment amount from various errors.

D. MEQC Findings Which Are Not Eligibility Errors.--Examples of these findings are as follows:

o Ineligibility in periods other than the review month. An ineligible individual who dies in the month prior to the review month is considered ineligible in the review month;

o Incorrect agency administrative procedures which do not affect eligibility; and

o Technical errors.

While this information does not contribute to the MEQC findings regarding eligibility of cases during the review month, refer information to the appropriate administrative or program unit for further investigation.

7303. ELIGIBILITY ERRORS

An eligibility error during the review month exists when the case or a beneficiary in the case fails to qualify for any Medicaid eligibility coverage specified in the State plan as of the review month. For example, ineligibility exists when the case has no categorical relationship during the review month. An eligibility error also exists when a case does not meet a Medicaid coverage requirement during a specified period of the review month when, according to a State's eligibility plan, eligibility for a day does not mean eligibility for the entire month.

Evaluate changes in situations which have occurred since the last agency determination as they affect eligibility coverage requirements as of the review month. For example, an AFDC categorically related beneficiary may have been determined as eligible for Medicaid based in part on deprivation due to the father's absence from the home. The reviewer finds that the father returned to the home, but the deprivation element still exists due to the disability of the father as of the review month. Change in the deprivation element does not affect the basic eligibility of the beneficiary under the coverage requirement in question.

Actions taken subsequent to the review month and their effect on the beneficiary's eligibility and payment status fall outside the scope of MEQC. As such, they do not affect the MEQC review findings.

7306. REPORTING OF ELIGIBILITY ERRORS

An eligibility error must relate to an element(s) of eligibility on the worksheet which causes the case to be ineligible or have an incorrect liability amount. When coding errors on the IRS, record each individual error in the Detailed Error Findings section. If there is more than one error in an element, code each one.

This also applies to beneficiaries who are dually eligible QMB/non-QMB individuals when the MEQC eligibility findings are different for the coverage categories. (See §7343 for QMB error coding.)

The error category known as "eligible with ineligible services" is applicable in States which provide more services for the categorically needy than for the medically needy, in States which have home or community-based waiver provisions, and States which supply emergency services to illegal aliens.

Report eligibility review findings to the State or local unit, as appropriate, using the State's established process. These units are expected to follow up on MEQC review information and take action which is consistent with the State plan.

7309. TECHNICAL ERRORS

Regulations implementing the MEQC provisions of §1903(u) of the Act define technical errors as those "errors in eligibility conditions which, if corrected, would not result in a difference in the amount of medical assistance paid." These paperwork eligibility errors are to be excluded from the computation of the MEQC payment error rate. Do not code dollar error amounts on the IRS for technical errors.

Technical errors for MEQC purposes include the following:

- Work incentive program requirements,
- Assignment of social security numbers (enumeration requirements),
- Requirements for a separate Medicaid application,
- Monthly reporting requirements,
- Assignment of rights to third party benefits as a condition of eligibility for Medicaid,
- Failure to apply for benefits for which the family or individual is eligible,
- Failure to locate a case record when available evidence shows that an application was filed,
- Failure to record proper verification of pregnancy if later documentation established pregnancy in the review month,
- Failure to submit required reports for work transition Medicaid coverage, and
- Failure to obtain a written declaration by a beneficiary stating whether (s)he is a citizen or national of the United States.

Additional potential technical error situations may arise. Refer them to supervisory personnel for contact with the RO for instructions. The RO then contacts CO for a determination. Only those additional technical errors approved by HCFA can be excluded in determining error rates.

While technical errors are not included in the error rate, they are to be identified in completing the MEQC review and coded on the IRS. Code them after all other errors and place them at the bottom of the Detailed Error Findings. Circle the line(s) on which these errors are coded and line through the dollar amount. Do not code dollar amounts for technical errors.

7310. HIERARCHY OF MEQC ERRORS

In completing the Detailed Error Findings section of the IRS for non-QMB or QMB only, cite errors in the following order to properly associate erroneous payments with eligibility and liability errors:

- o Eligibility errors other than for excess resources and technical errors,
- o Eligibility errors because of excess resources,
- o Liability errors,
- o Eligible with ineligible service errors, and
- o Technical errors (erroneous payments not applicable).

Ineligible service errors for dually eligible QMB/non-QMB individuals are eligibility errors and, therefore, are included in the first category of the hierarchy of errors.

In the above hierarchy, associate dollars with the errors in the order given. Thus, in any case with an eligibility error (other than for excess resources and technical errors), associate all dollars with that error and no dollars with any remaining errors. In a case with an eligibility error because of excess resources (but no other eligibility errors), code the lesser of the amount of paid claims or excess resources as the dollar error. If this same case also had a liability error, assign that error any dollars not already assigned to the excess resource eligibility error (a case with an eligibility error other than for excess resources or technical errors already has had all dollars coded to that error and therefore has no dollars remaining with which to associate the liability error). If a case has no eligibility errors but does have a liability error, assign dollar values to the error(s) per current procedures as indicated in §7318. As previously stated, do not associate dollars with technical errors.

7312. ELIGIBLE WITH INELIGIBLE SERVICES

The explanation below is applicable for cases that are not dually eligible as QMB/non-QMB or SLMB/non-SLMB.

The regulation implementing §1903(u) of the Act established an error category known as eligible with ineligible services. This type of error occurs in States which provide more services for the categorically needy than for the medically needy. In such States, a medically needy case which the State agency had incorrectly certified as categorically needy may receive services which would not have been provided had the case been correctly certified as medically needy. This case is eligible for Medicaid but not for the particular categorically needy service received.

Affected States must review all claims for services received in the review month for every type of case in the sample identified below to determine if any ineligible services were received by any case member(s).

Note that we are speaking of ineligible services received solely due to an incorrect eligibility determination, i.e., categorically needy only services received by an individual/case which is really medically needy but was incor- rectly certified by the State Agency as categorically needy. If the case is correctly coded in the system as medically needy but a categorically needy only service is paid by Medicaid, it is a claims processing error and is not coded as an eligibility error.

A. Types of Cases Which Require Review.--The following cases require review.

o Cases found eligible by MEQC as medically needy which were certified by the State agency as categorically needy,

o Medically needy cases with liability understated or overstated errors which were certified by the State agency as categorically needy,

o Medically needy cases with excess resources less than the total amount of review month claims which were certified by the State agency as categorically needy,

o Categorically needy individuals receiving services for which they are not eligible, i.e., home and community-based waiver beneficiaries who received services not allowed by the waiver, and

o Illegal aliens eligible to receive only emergency services.

If a State's policy is to pay for a beneficiary's Medicare Part B premium, then Part B coverage is assumed to be available to the beneficiary. Thus, if a beneficiary fails or refuses to enroll in Part B under these circumstances, he/she is ineligible for services that otherwise would have been covered under Part B.

These errors can only be found during the payment review. They cannot be found in the initial eligibility review. Four possible findings result from receipt of a service for which the case or case member was not eligible: eligible with ineligible services, liability overstated with ineligible services, liability understated with ineligible services, or ineligible.

For cases or individuals found eligible with ineligible services, code the case as such on the IRS. The dollar error is the amount of payments for which the case or individual(s) was ineligible, i.e., the total amount of claims paid for noncovered services or, for cases found ineligible for the categorically needy program due to excess resources, the lesser of the amount of noncovered services or the amount of resources in excess of the categorically needy level.

If the case finding is liability understated with ineligible services, code the case liability understated with ineligible members on the IRS. The element and nature codes are 550 and 113 respectively. The liability error takes precedence over the ineligible service error(s) in determining the amount of misspent dollars to apply to each error. Thus, code the liability error first.

B. Rules For Determining Amounts Cited For Different Errors.--

1. Determine the chronological sequence of services received to be applied to the review month.

2. Apply the liability error to the first claims of the month, in order of date of service, assuming that if the beneficiary had not erroneously received a Medicaid card he/she would have met his spenddown chronologically. This applies whether the claim is for a covered service as long as it meets the definition of an expense which can be used to meet spenddown. The full amount of the unmet liability as of the review month is the misspent total for that error in every instance.

3. Only those claims not used to meet the spenddown as described above can be cited for the ineligible service error(s).

EXAMPLE (One-month spenddown):

Date of service	10/1	10/4	10/10	10/21
Amount of correct claims paid for services received on those dates	$21	$12	$53	-
Ineligible services received	-	$17	-	$37

There is $36 in unmet liability in this case as of the review month. Twenty one dollars would have been met on October 1 if the beneficiary had not erroneously received a Medicaid card, leaving an unmet liability of $36 less $21, or $15. On October 4, the beneficiary received two services, one for which he/she is eligible and one for which he/she is not. The spenddown is applied first to the service for which he/she is <u>not</u> eligible. All of the $15 liability is met with $2 of the ineligible services remaining.

Thirty six dollars are considered misspent due to the liability error (this error is coded first on the IRS) and $39 due to the ineligible services ($2 from October 4 plus the $37 claim for the ineligible service received October 21). The total erroneous payment in this case is $36 plus $39, or $75.

If the case finding is liability overstated with ineligible services, code the case liability overstated with ineligible members on the IRS. The element and nature codes are 550 and 113 respectively. The dollar error for the ineligible services is the full total of ineligible services for the month.

A fourth finding of ineligible is possible for cases with excess resources, the amount of which is less that the full amount of paid claims for the review month, who have also received services for which they are ineligible.

Code this type of case ineligible on the IRS. Again, the element and nature codes for the ineligible service error(s) are 550 and 113 respectively. The full amount of the excess resource (the amount by which the resources exceed the standard) is coded as the dollars in error for that element. The ineligible services error are coded next. The amount of that error cannot exceed the difference between the excess resource error and the amount of paid claims for review month services.

Use the logic applied in computing payment errors for liability understated cases with ineligible services cited above in computing final liability error amounts for cases where paid and denied claims or billed amounts from prior months in the spenddown period are used to offset liability.

7315. ERRONEOUS PAYMENT COMPUTATION

When dollar errors are cited in more than one element during a case review, the total dollar error cannot exceed the amount of paid claims. This includes all eligibility, understated liability, and ineligible service errors. When computing the final dollar amounts of these errors, keep in mind the error hierarchy as discussed in §7309.

For erroneous payment computation purposes resulting from ineligibility or understated liability, the amount of error is the lesser of:

- The amount of payments made on behalf of the family or individual for the review month, or
- The difference between the correct amount of beneficiary liability and the amount of beneficiary liability met by the individual or family for the review month.

Code these errors as discussed in §7318.

For erroneous payments resulting from excess resources the amount of error is the lesser of:

- The amount of claims payments made on behalf of the family or individual for the review month, or
- The difference between the actual amount of countable resources of the family or individual for the review month and the State's applicable resource standard in the approved State plan.

For erroneous payments due to an eligibility error resulting from other than excess resources or failure to properly meet beneficiary liability, the amount of error is the total amount of medical assistance payments made for the individual or family under review for the review month. Cite these erroneous payments as eligibility errors. In completing the IRS for excess resource cases, cite the lesser amount of excess resources or paid claims.

7316. DOLLAR AMOUNT OF CASE ELIGIBILITY ERRORS

The only amount of dollar error computed during the eligibility review phase is the dollar amount of overstated or understated liability and for cases ineligible due to resources the dollar amount by which resource(s) exceeds the State's allowable limit. The following chart shows the eligibility error and the dollar amount of the error to be cited on the eligibility review.

For coding of errors on cases involving those who are dually eligible as QMB/non-QMB individuals, see §7343. The explanation below is applicable to cases other than those involving beneficiaries who are dually eligible QMB/non-QMB individuals.

Type of Error	Dollar Amount of Case Error for Eligibility Review
Case is ineligible during part or all of the review month due to elements other than the resource elements (200).	Zero dollar amount.
Case is ineligible during part or all of the review month due to excess resources (elements 200).	The dollar amount by which the resource(s) exceeds the State's allowable limit. (Code in section V, item 65 of the IRS.)
Case eligible during review month with ineligible case members due to elements other than the resource elements.	Zero dollar amount.
Case eligible during review month with ineligible case members due to excess resources (elements 200).	The dollar amount by which the resource(s) exceeds the State's allowable limit.
Case liability understated.	The full understated case liability amount. (Item 64 of the IRS.)
Case liability overstated.	The full overstated case liability amount. (Item 64 of the IRS.)

When the type of error is eligible with ineligible services by itself or in combination with any of the above, do not note any additional dollar amount of error for the eligibility review. Assign ineligible service dollar amounts at the time of payment review.

Note that the final amount of misspent Medicaid funds cannot be determined during the eligibility review. Associating misspent dollar amounts with these eligibility errors must await identification of paid claims for services rendered which are credited to the review month (payment review).

For reviews which have multiple liability errors, the overall liability error amount is the net effect of all errors.

7318. COMPUTATION OF LIABILITY ERRORS

Use this section for cases involving Medicaid coverage categories other than QMB. For cases involving beneficiaries who are dually eligible as QMB/Medicaid individuals, refer to §7343 for explanation as to how to use this section.

For cases with excess income (subject to spenddown), code an error finding liability understated, not ineligible. This finding is subject to change during the payment review.

In any case found to have excess income, thoroughly examine the case record to see if it contains evidence of incurred medical expenses not used by the agency in computing beneficiary liability. Explore with the beneficiary during the home visit any additional documented incurred expenses which can be used to offset excess income. Determine if any of the incurred medical expenses used by the agency and additional incurred expenses not used by the agency were subject to payment by a third party. Medical expenses subject to payment by a third party cannot be used to offset excess income.

1. Case Failed to Meet Liability as Computed.--If a beneficiary fails to meet liability as computed prior to certification, do not consider the case ineligible during the eligibility review. Undertake a complete review of case circumstances. If the beneficiary has an unmet liability in the review month, code the error as liability understated in the full amount of the understatement.

2. Case on Eligibility File Subsequent to Expiration of Certification Period.--If a case remains on the eligibility file and is selected for review in a month subsequent to expiration of the beneficiary's certification period, examine it to determine eligibility. Assume that a new spenddown period would have begun at the end of the prior certification period unless the end of the prior certification period preceded the review month by more than the State's prescribed spenddown period. If so, the review month then becomes the first month of a hypothetical spenddown period. If excess income is found, code the error as liability understated.

3. Ineligible AFDC Cash Assistance Case.--Cases or individuals found ineligible for cash assistance by AFDC-QC due to excess income may be eligible for medical assistance with a spenddown if coverage code 43, extended benefits,

is not applicable. In those States which allow spenddown by AFDC-related MEQC cases, treat an AFDC case with income in excess of the medically needy income level (MNIL) as any other case with unmet liability. Construct a spenddown period using the review month as the first month of the period. Calculate the amount of excess income and code the error as liability understated. Note, however, that an AFDC case found to have income in excess of the AFDC cash assistance standard but less than the State MNIL is eligible for medical assistance under coverage code 69 with no liability to be met.

4. MAO Case Receiving Benefits Under Extended Coverage Provision.--For MAO cases receiving benefits under the extended coverage provision (code 43) and for which the review month is any month subsequent to the final month of continued eligibility, construct a spenddown period beginning with the next month if the case has excess income. If, however, that month precedes the review month by more than the State's prescribed spenddown period, the review month becomes month one of the spenddown period. The case must be reviewed for eligibility under a coverage code other than 43 because extended benefits no longer apply.

5. MAO Case Found Eligible Only With Spenddown.--For MAO cases found eligible by quality control only with spenddown but found eligible by the State agency with no spenddown, use the spenddown period used by the State agency to compute liability (even if no liability amount was found). If the State agency did not use a spenddown period to compute liability, begin the period with the month of the last redetermination/application preceding the review month unless the date of the action preceded the review month by more than the State's prescribed spenddown period. In this event, the review month becomes month one of the spenddown period.

EXAMPLE: If, in a 6-month spenddown State, the last redetermination was no more than 5 months prior to the review month, the month of last redetermination is the first month of the spenddown period constructed by quality control. If the month of the last redetermination had preceded the review month by 7 months the review month becomes month one of a hypothetical spenddown period. Assume, for example, that the review month is June and the latest redetermination was in January. January is the first month of the spenddown period constructed by MEQC. However, if the review month was June and the latest redetermination was made in the previous September, then June becomes month one of the hypothetical spenddown period.

6. States Which Begin a New Spenddown Period When an Income Change Causes a Change in Beneficiary Liability.--If a State automatically begins a new spenddown period when an income change causes a change in liability, begin the spenddown period with the month of the last redetermination/application if the income change occurred prior to that date. If the date of that action preceded the review month by more than the State's prescribed spenddown period, the review month then becomes month one of the quality control spenddown period. If the income change occurred subsequent to the last redetermination/application date, the month of the change becomes the first month of the spenddown period unless it too precedes the review month by more than the State's prescribed spenddown period. In this case, the review month becomes month one of the spenddown period.

7. Liability Understated With Ineligible Services.--See §7312.

7319. REVIEW MONTH INCOME PROJECTED FORWARD THROUGHOUT SPENDDOWN PERIOD

MEQC looks at all months of the spenddown period up to and including the review month. If the MEQC review month liability is different from the agency projection, recompute the liability for the entire spenddown period projecting the review month income forward. (For those States which utilize a spenddown period of more than one month, liability computation for the review month is NOT reviewed in isolation.) Although MEQC may know the actual income available for the entire spenddown period, focus the review on the circumstances as of the review month, since this is, at most, the information that would have been available to the agency. Therefore, project only the review month income throughout the remaining spenddown period.

7321. IDENTIFICATION OF CLAIMS FOR SERVICES

Following the eligibility review for all completed cases, all claims paid for services received in or applied to the review month for all case members must be identified. A claim is defined as a specific line item on a provider voucher for which there is a fee charged. For crossover claims and inpatient hospital claims, a number of different services may be included. These are normally treated as single line items. Occasionally, the only information available is from tape to tape billing or from other electronic media. When these billings contain Part B services, it may be necessary to access intermediary records to determine which services were received in the review month. Identification may be by use of beneficiary profiles, claims histories, or invoices. Use these or other sources which best provide the information needed. Crossover claims are to be treated as other claims for purposes of claims collection. When adjustments have been made, use the adjustment in computing the total dollar amount of claims. Do not verify the correctness of the adjustment. Adjustments to claims may only be considered during the administrative period, which for paid claims is the month the claim was paid and the following month. See §7126 for additional information on claims collection. HMO premiums and Medicare buy-ins are considered claims for the month of medical care which they cover.

7324. ROUNDING TO NEAREST DOLLAR

When determining the total dollar amount of claims, add the amount of all claims and do not round until a final sum is reached. Then round to the nearest dollar. If the final cents amount is $.50, round up to the next dollar. This is MEQC policy for all situations in the manual which require rounding.

7327. DETERMINING FINAL MISSPENT DOLLAR AMOUNTS OF CASES CONTAINING INITIAL ELIGIBILITY ERRORS

Use this section for cases involving Medicaid coverage categories other than dually eligible QMBs. For cases involving QMB/Medicaid beneficiaries, see §7343.

The worksheets provide documentation of the eligibility errors. The paid claims or profiles allow the reviewer to associate dollar amounts with eligibility errors. Sections 7303ff present the procedures to determine if a case is in error. In the following sections, the procedures for associating misspent dollar values with eligibility errors are described.

At this stage in the MEQC review, determine the following from the eligibility QC worksheets:

- o The eligibility status of each beneficiary in a case; and
- o The element(s) of eligibility that was found to be in error and the nature of the errors.

These constitute the primary information needed for computing and reporting the dollar value of eligibility errors. In addition, have available the dollar amount of paid claims for each beneficiary for services received during the review month. A major purpose of the MEQC system is to measure misspent Medicaid funds.

Therefore, if a case is found to be ineligible during the review month but had no paid claims for services received during that month, no Medicaid funds have been inappropriately expended, i.e., if there are no review month claims for a case, the value of an eligibility error is 0 (zero).

A. Computing Dollar Amount of Eligibility Errors.--For each beneficiary who has been found to be ineligible during the initial eligibility review, determine the primary error leading to the error finding. Enter the appropriate dollar amounts for the identified primary error in section VI of the IRS. For cases with excess resources, the amount of the error is the lesser of the review month claims or the amount of excess resources. When citing multiple errors, follow a hierarchy of error citation when completing the IRS. This is to properly associate misspent Medicaid funds with eligibility and liability errors. Assign dollar amounts to errors by element. If more than one element contributes to the total dollar error, specify how dollars are to be assigned to each element.

B. Order for Citing Errors.--Cite errors in the following order:

1. Eligibility errors other than for excess resources and technical errors,
2. Eligibility errors for excess resources,
3. Liability errors,
4. Eligible with ineligible services, and
5. Technical errors.

7330. DETERMINING FINAL MISSPENT DOLLAR AMOUNTS OF CASES CONTAINING INITIAL LIABILITY UNDERSTATED ERRORS

An initial finding of liability understated during the eligibility review is subject to modification during the payment review. In order to compare the actual eligibility

determined by the agency, the definition of incurred medical expenses (for MEQC purposes only) must include Medicaid paid claims (or billed amounts, if appropriate) for services received by case members during all months of the spenddown period including the review month. (NOTE: These instructions apply to all cases with an initial liability understated error. See §7318 for a definition of cases included in this error code. The procedures for determining the final misspent dollars for institutional cases are described in §7333.)

The beneficiary profiles will normally be requested at the beginning of the sixth month following the review month but may be requested as early as the fifth month. They will include claims for services rendered at any time in the spenddown period through the review month which are paid by the end of the fourth month after the review month. States which have permission to pull claims monthly may continue to do so.

If the agency had correctly computed liability and had not prematurely issued a Medicaid card to the case member(s), allowable medical expenses incurred by the recipient (as well as any expenses erroneously paid by Medicaid) would have been the case member's obligation and could have been used to meet liability. Therefore, these expenses must be used in the payment review to offset the initial beneficiary liability.

States may also search for and use in the payment review calculation any claims rejected for payment by Medicaid because they were for a noncovered service or were rendered by an uncertified provider but which would meet the definition of an allowable expense to meet a spenddown. These denied claims are to be chronologically applied along with paid claims when used to offset liability. Claims rejected for technical reasons are generally resubmitted for payment; e.g., provider ID number missing. Therefore these claims usually do not become the beneficiary's obligation and are not used to offset liability as an incurred expense.

States may also opt to use the total amount billed by the provider to offset the initial understated liability rather than the amount paid by Medicaid. If a recipient were incurring his/her own expenses the full amount incurred would have been allowed to meet liability. By applying this principle to the payment review calculations the billed amount would be used to offset beneficiary liability.

Paid claims (or billed amounts if the State so opts) prior to the review month can also be used to offset excess income. This can be done from the point at which the income causing the error became available to the case member(s) or from the first month of the spenddown period affecting the review month, whichever comes later.

When using billed amounts to offset liability first apply billed amounts for months up to the review month to determine the review month liability. Once the review month liability is determined utilize billed amounts to offset liability in the order incurred. This is important since only the dollars paid for the bills used to offset liability will be coded as misspent funds. (See Examples 14 and 15 for details.)

Note that misspent funds can never be greater than the review month paid claims regardless of the billed amount; e.g., a case with a $100 liability error, $150 in billed amounts for the review month, but only $20 in review month paid claims cannot have more than a $20 error.

States must notify the HCFA Regional Administrator (RA) of their choices on the options to use denied claims and/or billed amounts prior to commencing application of this policy. Once the choices have been submitted in writing and approved the State is required to conduct all reviews in the chosen manner. The choices are binding for at least one full sample period but may be revised at the end of each period. Submit any changes as a part of a State's sampling plan.

To determine the actual case status as of the review month and to compute misspent dollars obtain the following:

1. Eligibility findings and completed worksheets for all cases containing liability understated errors,

2. Any claims rejected for payment because they were for a noncovered service or because they were rendered by an uncertified provider but meet the State definition of an allowable expense to meet spenddown if a State elects this option,

3. Beneficiary profile relating to paid review month claims for all cases with understated liability, and

4. Beneficiary profiles of Medicaid paid claims (or actual claims in States which cannot produce beneficiary profiles) for services received by each case member during all other months of the spenddown period. If the liability error was caused by an income increase which occurred in a month other than the first month of the spenddown period obtain beneficiary profiles or claims for all services provided from the month of the increase through the review month. In States with a one-month spenddown period only review month claims must be obtained.

Paid claims (or billed amounts) as well as denied claims which meet the criteria above are used to offset the initial understated liability from the first month of the spenddown period or from the point within the period when increased income caused the computation

to be in error, whichever is later. Claims used during the payment review to offset the initial liability understated amount must be carefully cross-matched with medical expenses used by the agency or with any additional incurred medical expenses utilized during the eligibility review to reduce liability. Any paid claim which was found during the eligibility determination or eligibility review to be an incurred medical expense and used to offset beneficiary liability may not be considered again during the payment review to further reduce the liability understated error. In addition, do not use any review month claim(s) or portion of a claim found during the payment review to be the responsibility of a third party to reduce beneficiary liability.

Based on the preceding application of claims, one of the following will result.

1. If the sum of the Medicaid paid claims (or at State option billed amounts) for services received prior to the review month and (at State option) certain denied claims for services received prior to or during the review month is equal to or exceeds the initial liability understated amount the final case finding will change to eligible.

2. If liability is met during the review month the final case finding remains liability understated. (NOTE: The one exception to this involves the use of denied claims as described above.)

3. If liability is not met during the review month the final case finding will change to ineligible.

In certain cases an original finding of eligible is subject to change during the payment review to liability overstated/understated or ineligible. This occurs when liability is correctly computed by the agency but MEQC establishes during the payment review that a third party paid totally or in part for a service incurred by the recipient and used to offset initial beneficiary liability; e.g., that portion of a hospital bill used to offset liability is paid by a third party.

Retain copies of beneficiary profiles and/or claims collected for the spenddown period and used in the payment review computation in the MEQC file. Show the computation which determines the correct case eligibility status as of the review month and the amount of misspent funds, if any, in the MEQC file.

Examples 1-12 utilize paid claims to offset beneficiary liability rather than billed amounts. Examples 13 and 14 utilize billed amounts to offset beneficiary liability. The examples utilize only 6-month and one-month spenddown periods since the payment review process used in a 6-month spenddown State is identical to that which would be used in States having 2, 3, 4, or 5-month periods. Details on coding the review schedule are explained in the Integrated Review Manual.

E X A M P L E 1 - ORIGINAL FINDING OF LIABILITY UNDERSTATED CHANGES TO INELIGIBLE.

The agency computed a $100 spenddown for a beneficiary on January 1 which he immediately met and was thus certified eligible for medical assistance from January 1 through June 30 (6-month spenddown State). MEQC reviews the case for January and finds the beneficiary had more income in January which is expected to continue in subsequent months than the agency had used in its calculation and that the beneficiary had no additional expenses to offset the excess income. MEQC computes a spenddown of $300 and finds an initial liability understated error of $200.

$300	Correct Spenddown
- 100	Already Met
$200	Liability Understated Error

Claims collected for January are as follows:

Medicaid Claims	$50

If the beneficiary had not erroneously received a Medicaid card in January he would have been responsible for the $50 worth of services received in January leaving $150 of unmet liability. Thus, even had he not received a card in January, he would not have met his liability in that month. He is ineligible, and the full amount of Medicaid paid claims ($50) is misspent funds. The original finding of liability understated will be changed to ineligible in the payment review, and will show $50 of misspent eligibility funds.

E X A M P L E 2 - ORIGINAL FINDING OF LIABILITY UNDERSTATED $200 DECREASES TO LIABILITY UNDERSTATED $150.

Claims collected for January and February are as follows:

	January	February
Medicaid Claims	$50	$200

Had this same case been selected in February the final dollar error would have been $150 liability understated. Had the beneficiary not erroneously received a Medicaid card, February would be the month in which he would have met his liability and $150 would be the amount he would have incurred in that month; i.e., only $50 of the $200 claim would have been correctly paid by Medicaid. In this situation the error will always equal the amount of unmet liability in the review month.

E X A M P L E 3 - ORIGINAL FINDING OF LIABILITY UNDERSTATED CHANGES TO ELIGIBLE.

Claims collected for January, February, and March services are as follows:

	January	February	March
Medicaid Claims	$50	$200	$125

Had this same case been selected in March there would be no misspent funds. If the beneficiary had not erroneously received a Medicaid card in January $50 of the liability would have been met in January leaving $150 of unmet liability. This liability would have been met in February if the beneficiary had been held responsible for the first $150 of the $200 paid by Medicaid. Thus, $50 was correctly paid in February, but $150 was erroneously expended. By March the client would have legitimately been eligible for Medicaid had the agency correctly computed his liability. There are no misspent funds in March. Change the original liability understated error in the payment review to eligible.

Note that a case has an equal chance of being selected in any month of a spenddown period. As shown in the previous examples, the error finding will vary depending upon which month of the spenddown period is the review month.

E X A M P L E 4 - ORIGINAL FINDING OF LIABILITY UNDERSTATED $150; DECREASES TO LIABILITY UNDERSTATED $70; ONE INCOME CHANGE IN SPENDDOWN PERIOD.

In the preceding examples the excess income became available to the beneficiary at some point prior to January; thus Medicaid paid claims could be used to offset excess income beginning with January, the first month of the spenddown period. Examples 4 and 5 reflect income which becomes available to the recipient after the beginning of the spenddown period. (NOTE: These examples are not applicable to States which automatically begin a new spenddown period when income changes.)

	Jan.	Feb.	Mar.	Apr.	May	June (Review Month)
Medicaid Claims	$	$	$	$ 65	$ 15	$ 100
Actual Income found by MEQC	200	200	200	250	250	250
Income Used by Agency to Compute Liability	200	200	200	200	200	200

Agency Computation		MEQC Computation			
$ 200		Monthly	$ 200	Income	
	$ 250 Income				
x 6		Months	x 3	Months	(Jan.-Mar.)
	x 3 Months (Apr.-June)				
$ 1,200		Total Income	$ 600		
	$ 750				
- 1,000		Income Level			
$ 200		Excess Income			

(Case record contains documentation of correctly met spenddown prior to certification in mid-January)	$ 600	
	+ 750	
	$ 1,350	Total Income
	- 1,000	Income Level
	$ 350	Excess Income
	- 200	Previously Met
	$ 150	
	- 0	Additional Incurred Expenses
	$ 150	Unmet Liability

During the initial eligibility review this case would have been coded with a $150 liability understated error. In the payment review, claims/beneficiary profiles need only be obtained for the months of April, May, and June because the income increase causing an error in the spenddown computation did not occur until April. Had the beneficiary reported his increase in a timely fashion it is only in April that the agency would have suspended benefits and instructed the beneficiary to incur an additional $150 in medical expenses. Therefore, beginning in April the client is responsible for claims paid by Medicaid and will use those claims to offset unmet liability. In the example there is an unmet liability of $150; $65 is met in April, a total of $80 ($65 in April plus $15 in May) is met by the end of May, and the additional $70 is met in the review month. However, since Medicaid did pay $70 erroneously in June, the payment review finding shows a true eligibility dollar error (liability understated) of $70.

EXAMPLE 5 - ORIGINAL FINDING OF LIABILITY UNDERSTATED CHANGES TO ELIGIBLE; TWO INCOME CHANGES IN SPENDDOWN PERIOD.

	Jan.	Feb.	Mar.	Apr.	May	June (Review Month)
Medicaid Claims	$ 40	$ 200	$ 65	$ 100	$ 60	$ 25
Actual MEQC Income	210	210	210	250	250	250
Agency Income Figures	200	200	200	200	200	200

Agency Computation

$ 180	Private Pension
+ 20	VA
$ 200	Monthly Income
x 6	Months
$ 1,200	Total Income
- 1,000	Income Level
$ 200	Excess Income

$200 in medical expenses incurred prior to certification - verified in case record.

In order to correctly determine review month eligibility it is important to know that the VA error occurred prior to January and that the pension error first occurred in April.

MEQC Computation

First 3 Months		Last 3 Months	
$ 180	Pension	$ 220	Pension
+ 30	VA	+ 30	VA
$ 210	Income	$ 250	Income
x 3	Months	x 3	Months
$ 630		$ 750	
+ 750			
$ 1,380	Total Income		
- 1,000			
$ 380	Excess Income		
- 200	Previously Met		
$ 180			
- 0	Additional Incurred Expenses		
$ 180	Liability		

The initial eligibility finding would be a liability understated error of $180. Code both a private pension source error (element 346) and a VA source error (element 332).

The impact of the VA error alone on liability is computed in the payment review to determine the amount of unmet liability from January 1 through the end of March.

It is only that amount that the beneficiary would have been expected to meet prior to the pension increase in April. Thus collect claims for January through June which would result in the following computations:

VA Error Alone

$ 180	Pension
+ 30	VA
$ 210	
X 6	
$ 1,260	
- 1,000	Income Level
$ 260	Excess Income
- 200	Previously Met
$ 60	Unmet From January 1

Thus $40 paid for January services should have been the beneficiary's obligation leaving $20 which would have been met in February. In March there would be no misspent funds. Beginning in April the beneficiary would have been required to meet the additional $120 ($220 - 180 = $40; $40 x 3 months = $120) in liability caused by the pension increase. Of that, $100 would have been incurred in April and the remaining $20 met in May. By the review month of June the beneficiary is eligible; there is no error. Change the original State finding of liability understated to eligible in the payment review, and show no misspent funds in the payment review.

E X A M P L E 6 - ORIGINAL FINDING OF LIABILITY UNDERSTATED $50 INCREASES TO $115, CASE CHANGES TO INELIGIBLE: MEDICAL EXPENSES USED TO OFFSET ORIGINAL LIABILITY AMOUNT WERE PAID BY MEDICAID.

MEQC reviews a case for June and finds excess income of $115 for the spenddown period of January 1 through June 30 due to undercounted income in January and subsequent months. During the field investigation, however, the recipient produces three incurred medical bills of $15 (March service), $15 (May service) and $35 (June service) which were not available to be used by the agency at the time of application to offset excess income. Thus, MEQC must reduce the $115 liability understated error by $65 and the error amount in the eligibility review becomes $50 liability understated. When spenddown period paid claims are collected during the payment review all three of the medical expenses thought to have been incurred by the recipient are found to have been paid by Medicaid.

	Jan.	Feb.	Mar.	Apr.	May	June (Review Month)
Total Medicaid Paid Claims	$ 0	$ 0	$ 15	$ 0	$ 40	$ 50
Amount Previously Used to Offset Liability	0	0	15	0	15	35

In this case the March claim of $15, the May claim of $15, and the June claim of $35 previously used by MEQC to offset the initial liability understated amount, must be added to the initial liability amount of $50 to establish the actual liability understated amount for the spenddown period. The payment review computation is as follows:

$ 50	Liability Understated Amount
+ 65	Claims of $15, $15, and $25 Previously Counted
$ 115	Revised Liability Understated
- 15	March Paid Claims
$ 100	
- 40	May Paid Claims
$ 60	
- 50	June (Review Month) Paid Claims
$ 10	Liability (unmet) in Review Month

The case is ineligible, and the full amount of actual Medicaid paid claims in June ($50) is misspent funds. Change the original State finding of liability understated to ineligible, and change the payment review to show $50 in misspent funds.

Had the paid claims for the spenddown period not been matched with incurred medical expenses used to offset beneficiary liability, and had the overlap not been discovered, May is the month in which the $50 liability would appear to have been met. In the review month of June the case would have been erroneously found eligible with no misspent funds.

E X A M P L E 7 - ORIGINAL FINDING OF LIABILITY UNDERSTATED $50 INCREASES TO LIABILITY UNDERSTATED $60; MEDICAL EXPENSES USED TO OFFSET ORIGINAL LIABILITY AMOUNT WERE PAID BY MEDICAID.

	Jan.	Feb.	Mar.	Apr.	May	June (Review Month)
Total Medicaid Paid Claims	$ 0	$ 0	$ 15	$ 0	$ 40	$ 70
Amount Previously Used to Offset Liability	0	0	15	0	15	35

Assuming the case situation as shown in example 6, MEQC found an initial liability understated amount of $50. Claims for March, May, and June totaling $65, must be added back in to the initial liability amount since they were previously used by MEQC to reduce beneficiary liability. The payment review computation is as follows:

$ 50	Liability Understated Amount
+ 65	Claims of $15, $15, and $35 Previously Counted
$ 115	Revised Liability Understated
- 15	March Paid Claims
$ 100	
- 40	May Paid Claims
$ 60	
- 70	June (Review Month) Paid Claims
$ - 10	Liability Met in Review Month

If the beneficiary had not erroneously received a Medicaid card, June is the month in which he would have met his liability, and $60 is the amount he would have incurred himself. Only $10 of the $70 in claims would have been correctly paid by Medicaid. Therefore the case finding remains liability understated, and $60 is the unduplicated amount of misspent funds.

The situation is one in which the final dollar amount of misspent funds may exceed the liability understated amount coded during the eligibility review (when this understated amount is less then the amount of review month claims.) The original liability understated amount is increased during the payment review by adding back in those medical expenses thought to have been incurred by the recipient but actually found to have been paid by Medicaid. Note that although the amount of misspent funds for the review month may exceed the original liability amount they may never exceed the revised liability understated amount in the payment review (the sum of the original amount plus any paid claims which were also used to offset beneficiary liability).

E X A M P L E 8 - ORIGINAL FINDING OF LIABILITY UNDERSTATED $115 CHANGES TO ELIGIBLE; DENIED CLAIMS USED TO OFFSET EXCESS INCOME.

During the eligibility review the beneficiary may be unaware that he has incurred medical expenses. This situation can occur when Medicaid denies payment of a claim because it was for a noncovered service or was rendered by an uncertified provider; and it then becomes the beneficiary's obligation. If such denied claims are located by a State which has chosen the option of including denied claims during the payment review, and they meet the definition of an allowable expense to meet a spenddown, they should be considered in the payment review computation.

MEQC reviews a case for June and finds a liability understated error of $115 for the spenddown period of January 1 through June 30 due to undercounted income in January and subsequent months. When claims are collected during the payment review, three denied claims of $15, $20, and $10 for noncovered services are found. These claims are for services which meet the State's definition of allowable medical expenses for spenddown purposes and must be used in addition to the paid claims to reduce the initial liability understated amount.

	Jan.	Feb.	Mar.	Apr.	May	June (Review Month)
Medicaid Paid Claims	$ 0	$ 0	$ 50	$ 0	$ 20	$ 35
Allowable Denied Claims	0	15	0	20	10	0

In the example above the denied claims for February, April, and May must be used to reduce the initial liability amount in conjunction with the paid claims for March and May. The payment review computation is as follows:

$ 115	Liability Understated Amount
- 115	Denied Claims of $15, $20, and $10 plus March paid claims of $50 plus May paid claims of $20
$ 0	Liability Met Prior to Review Month

The case is eligible in the review month of June and there are no misspent funds. Change the original State finding of liability understated to eligible, and show no misspent funds in the payment review.

Had the denied claims not been considered during the payment review computation only the $105 in paid claims would have been deducted from the unmet liability as of the review month. The case finding would have erroneously been ineligible, and there would have been $35 (paid review month claims) in misspent funds for the case.

E X A M P L E 9 - ORIGINAL FINDING OF LIABILITY UNDERSTATED $115 DECREASES TO LIABILITY UNDERSTATED $70; DENIED CLAIMS USED TO OFFSET EXCESS INCOME

In a one-month spenddown State MEQC reviews a case for June and finds a liability understated error of $115 due to undercounted income. When claims are collected during the payment review two denied claims of $25 and $20 for services rendered by an uncertified provider are found. These claims are for services which meet the State's definition of an allowable medical expense and must be used to offset beneficiary liability in addition to paid claims totaling $70. The payment review computation is as follows:

$ 115	Liability Understated Amount
- 115	Denied Claims of $45, plus paid claims of $70
$ 0	Liability Met During Review Month

If the beneficiary had not erroneously received a Medicaid card he would have met his liability in the review month of June by incurring medical expenses of $115. Therefore, the case finding remains liability understated, and $70 (the amount erroneously paid by Medicaid) is the amount of misspent funds.

Had the denied claims not been considered during the payment review computation only the $70 in paid claims would have been deducted from the unmet liability amount of $115. The beneficiary would still have had $45 unmet liability as of the review month, and the case would have erroneously been found ineligible. The amount of misspent funds would not have changed.

E X A M P L E 1 0 - ORIGINAL FINDING OF LIABILITY UNDERSTATED $200 CHANGES TO INELIGIBLE. ONE CLAIM FOUND TO BE THE RESPONSIBILITY OF A THIRD PARTY: NOT USED TO REDUCE BENEFICIARY LIABILITY

In a one-month spenddown State MEQC reviews a case for September and finds a liability understated error of $200 due to undercounted income. Three claims are paid for the review month of $110, $25 and $100. Review reveals that $80 of the $100 claim was the responsibility of a third party. Therefore, MEQC assumes that even if the beneficiary had not erroneously received a Medicaid card he/she would not have incurred the total claim for $100. Therefore, in the payment review computation only $20 of the $100 claim actually incurred by the beneficiary can be used to meet liability as follows:

$ 200	Liability Understated Amount
- 110	Paid Claim for September
$ 90	
- 25	Paid Claim for September
$ 65	
- 20	(September Claim of $100 less $80)
$ 45	Unmet Liability as of Review Month

The case is ineligible and the full amount of actual Medicaid paid claims in the review month ($235) is misspent. The original State finding of liability understated will be changed to ineligible and the payment review will show $235 in misspent funds.

If the total claim of $100 had been used during the payment review to offset beneficiary liability rather than only the $20 not the responsibility of a third party, liability would have been met during the review month and the finding would have erroneously remained liability understated with $200 in misspent funds.

E X A M P L E 1 1 - ORIGINAL FINDING OF ELIGIBLE CHANGES TO INELIGIBLE; THIRD PARTY PAID TOTAL HOSPITAL BILL

MEQC reviews an SSI-related case in a one-month spenddown State and finds that the agency correctly computed the beneficiary's liability ($250) for the review month of May. The case record indicates that the beneficiary came in to apply for Medicaid on May 1 and was informed that he must incur $250 in medical expenses to offset his excess income. The beneficiary was hospitalized from May 2 to 6. Upon release from the hospital he presented the hospital bill to the Medicaid agency and was informed that he was responsible for the first $250 (incurred May 2-3), and Medicaid would cover the remainder of the bill (incurred May 4-6). The MEQC file contained evidence that the beneficiary was covered by an insurance policy which may pay for the cost of hospitalization.

The potential for misspent Medicaid funds is carefully examined during the payment review since the portion of the hospital bill incurred after the beneficiary became eligible for Medicaid (May 4-6) was not paid by Medicaid. MEQC verifies that the third party paid the entire hospital bill and there were no other incurred medical expenses. The only paid review month claims were a physician's claim of $30 and four prescriptions totaling $40. The payment review computation is as follows:

$ 250	Actual Recipient Liability
- 30	Paid Physician's Claim
$ 220	
- 40	Four Paid Pharmacy Claims
$ 180	Unmet Liability as of Review Month

Since the correctly computed liability was not met during the review month the original State finding of eligible must be changed to ineligible, and the payment review will show $70 in misspent funds.

E X A M P L E 1 2 - ORIGINAL FINDING OF LIABILITY UNDERSTATED WITH INELIGIBLE MEMBERS CHANGES TO ELIGIBLE WITH INELIGIBLE MEMBERS

In a 6-month spenddown State MEQC reviews an AFDC-related case consisting of a mother and three children for October and finds that one of the children is ineligible. The child turned 21 in May. The mother and two children under 21 in the case are eligible as AFDC-related. MEQC establishes that the mother has $237.50 monthly income.

The date of application was June 5 and the original unit of four persons had excess income of $100 for the period of June-November which was offset immediately by dental expenses incurred by the mother during the first 4 days of June.

The case must be reevaluated by MEQC using the same spenddown period established by the agency to compute liability. Since the change in circumstances causing the error (child turning 21) occurred prior to the date of application liability for the three remaining case members must be established for this period. Due to a lower medically needy income level for three persons MEQC finds the beneficiary liability to be understated by $125. The computation is as follows:

$ 237.50	Monthly Income (mother and two children under 21)
- 200.00	Medically Needy Income Level - three persons
$ 37.50	Monthly Excess
x 6	Months
$ 225.00	Excess Income
- 100.00	Dental Expense Previously Incurred
$ 125.00	Actual Liability Understated Amount

When Medicaid paid claims are assembled for June-October services during the payment review MEQC finds that claims of $135 were paid for the mother and two children under 21 prior to the review month. Claims totaling $570 were paid for the ineligible child, $170 of which was paid during the review month of October.

	June	July	Aug.	Sept.	Oct. (Review Month)	Nov.
Medicaid Paid Claims for Mother and Two Children Under 21	$ 40	$ 50	$ 20	$ 25	$ 0	$ -
Medicaid Paid Claims for Ineligible Child	0	0	0	400	170	-

The payment review computation is as follows:

$ 125	Actual Liability Understated Amount (Mother and two children under 21)
- 40	June Paid Claim
$ 85	
- 50	July Paid Claim
$ 35	
- 20	August Paid Claim
$ 15	
- 25	September Paid Claim
$ - 10	Liability Met Prior to Review Month

Note that since the ineligible child was not included in the determination of liability his claims will not be used to offset liability.

If a Medicaid card had not erroneously been issued to the 4-person assistance group September is the month in which the mother and two children under 21 would have met their liability. By the review month of October the mother and two children under 21 would have legitimately been eligible for Medicaid. Thus, there are no misspent funds for this group in October. The original case finding of liability understated with ineligible members must be changed to eligible with ineligible members. The amount of misspent funds for the case is $170, the total amount of review month claims paid for the ineligible case member.

E X A M P L E 1 3 - BILLED AMOUNTS USED TO OFFSET LIABILITY; ONE CLAIM FOR REVIEW MONTH SERVICES

The agency computed a $400 spenddown for the beneficiary on June 1 which he immediately met and was certified eligible for June 1 - November 30 (6-month spenddown

State). MEQC reviews the case for June and finds that the beneficiary's income increased prior to June, and he has not incurred any additional expenses to offset the excess income. MEQC computes a spenddown of $500. Four hundred dollars of liability was met June 1 leaving liability understated error of $100.

$ 500	Actual Liability
- 400	Already Met
$ 100	Liability Understated Error

During the payment review MEQC finds that one claim was billed and paid for June services. MEQC uses the $90 billed amount to offset liability since this State chose the sampling plan option of utilizing billed amounts to offset excess income. The beneficiary would not have incurred sufficient medical expenses to offset the liability during the review month so the $100 liability understated finding is changed to ineligible in the payment review.

	June
Medicaid Billed Amount	$ 90
Medicaid Paid Claims	$ 80

The misspent dollars can never exceed the dollar amount of paid claims. In this case $90 was billed for review month services, and Medicaid paid $80 of the claim. Since the case is ineligible the dollar error is $80, the full amount of review month paid claims.

E X A M P L E 1 4 - BILLED AMOUNTS USED TO OFFSET LIABILITY; MULTIPLE CLAIMS FOR REVIEW MONTH SERVICES

Had this same example been selected in July the unmet liability for the July review month would have been $10.

$ 100	Liability Error
- 90	June Billed Amount
$ 10	Liability Unmet Prior to July Review Month

When MEQC collects claims they find that several claims were billed and paid for July services.

	June	July 1	July 15	July 29
Medicaid Billed Claims	90	8	10	30
Medicaid Paid Claims	80	6	9	25

MEQC must use the billed amount to offset excess income in the order incurred to determine the correct amounts of misspent dollars.

	Liability Still To Be Incurred	Billed Amount	Used to Offset Liability	Paid Amount	Dollar Error
July 1 Claim	$ 10	$ 8	$ 8	$ 6	$ 6
July 15 Claim	2	10	2	9	1
July 29 Claim	0	30	0	25	0
					7

If the agency had not erroneously issued a Medicaid card on June 1 the liability would have been met in July. The beneficiary would have been responsible for the $8 (July 1) claim. Since Medicaid paid $6 for this claim which was the full responsibility of the beneficiary, $6 was paid in error. The beneficiary would have been responsible for $2 of the $10 (July 15) claim at which point he would have become eligible for Medicaid. The provider could have billed Medicaid for the difference ($10-$2 beneficiary liability = $8). Since Medicaid paid $9 for the July 15 claim when no more than $8 should have been paid, $1 of the July 15 claim was paid in error. The final finding on this case is liability understated with a dollar error of $7.

NOTE: In States with reimbursement policies dictating a reasonable charge limitation (i.e., the provider cannot be reimbursed for more than the Medicaid rate including recipient liability), QC must review against this policy. In this example the dollar error for the $10 claim would have been $2 ($9 Medicaid reimbursement rate - $2 beneficiary liability = $7 correct amount; $9 Medicaid claim - $7 correct amount = $2 error). The total dollar error for the case would then be $8.

7333. DETERMINING FINAL MISSPENT DOLLAR AMOUNTS OF INSTITUTIONAL CASES

The review of institutional cases differs from noninstitutional cases because eligibility/liability is determined by a two-step process. The reviewer must first determine whether the beneficiary is eligible and then determine the amount to be applied to the cost of care. During the payment review the institutional billing must be reviewed to determine whether the appropriate amount was applied to the cost of care. The agency could incorrectly compute the patient's contribution towards his/her cost of care, and the institution could correctly adjust for the patient's contribution. In this situation the initial eligibility finding would be liability over- or understated, and the payment review finding would be eligible with no dollar error. Conversely, the agency may correctly compute the patient's contribution to the cost of care (i.e., the initial finding is eligible), and the nursing home may incorrectly adjust this amount when billing Medicaid. Thus,

Medicaid would pay an incorrect amount. In this situation the final case finding would be either liability understated (with a dollar error) or liability overstated (with no dollar error). Errors resulting from an incorrect institutional billing should be coded in element 550 (other State Medicaid criteria), nature code 097 (incorrect claims billing increased/decreased liability).

All policies described in §7330 apply to institutional cases with liability understated errors. These procedures also apply to institutional cases when the institutional billing is not present in the review month claims.

E X A M P L E 1 - ORIGINAL FINDING OF ELIGIBLE CHANGES TO LIABILITY UNDERSTATED: NURSING HOME BILLS INCORRECT AMOUNT AND MEDICAID PAYS THIS AMOUNT

MEQC reviews the institutional case and determines that the agency correctly computed the beneficiary's contribution toward his cost of care as $650. The initial MEQC finding is eligible. During the payment review MEQC finds that the nursing home cost was $1,000. The nursing home incorrectly applied only $600 of the beneficiary's income toward his cost of care. Medicaid was billed and paid $400 for the nursing home care.

Nursing Home Billing		MEQC Computation	
$ 1,000	Total Cost of Care	$ 1,000	Total Cost of Care
- 600	Applied to Cost of Care	- 650	Correct Contribution to Cost of Care
$ 400	Paid by Medicaid	$ 350	Amount Medicaid Should Have Paid

Correct Contribution to Cost of Care	$ 650
Contribution Applied to Cost of Care by Nursing Home	- 600
Liability Understated Error	$ 50

The initial finding of eligible is changed to liability understated and the dollar error is $50.

E X A M P L E 2 - ORIGINAL FINDING OF LIABILITY UNDERSTATED CHANGES TO ELIGIBLE: NURSING HOME CORRECTLY ADJUSTS LIABILITY

In this nursing home case MEQC finds, during the eligibility review, that the agency failed to adjust for an OASDI increase. The review month is October, and MEQC finds an initial liability understated error of $29. The beneficiary has not incurred any additional medical expenses.

Cost of Care Computation

	Agency	MEQC
OASDI Income	$ 550	$ 579
Personal Needs Allowance	- 25	- 25
Amount To Be Applied to Cost of Care	$ 525	$ 554

Liability Understated Amount = $29 ($554 MEQC computation - $525 agency computation)

During the payment review MEQC finds that the nursing home took into consideration the OASDI increase and correctly adjusted the amount to be applied toward the cost of care.

Nursing Home Billing

$ 1,000	Nursing Home Cost
- 554	Beneficiary's Income Applied To The Cost of Care
$ 446	Billed and Paid by Medicaid

Since the nursing home correctly adjusted the amount of the beneficiary's income to be applied to the cost of care the final finding is changed to eligible with no dollar error.

7336. IDENTIFYING THE PRIMARY ELIGIBILITY AND LIABILITY ERRORS

The MEQC review determines all the eligibility and liability errors occurring in a sampled case and records up to nine of these in section VI of the IRS. For each sampled case found to be ineligible or to have ineligible member(s) or to have a liability error, determine the error that contributed most substantially to the liability error or to the ineligibility. If the QC worksheets indicate that more than one error contributes to the ineligibility or inaccurate computation, select the primary error. Code errors in terms of the impact the error had on the case. Use the following criteria:

1. If all members of a case have both an eligibility and liability error the eligibility error is overriding.

a. If case liability has been computed incorrectly and each member of the case failed to meet an element of eligibility the case is ineligible and all claims paid for the case members during the review month were paid in error unless ineligibility is a result of excess resources. In those cases count the lesser amount of paid claims or excess resources. Classify the error as an eligibility error.

b. If case liability has been computed incorrectly and any case members are found ineligible all claims paid for the ineligible case member(s) during the review month were paid in error unless the ineligibility is caused by resources in which case the amount of claims paid in error could not exceed the amount of excess resources. For the remaining eligible member(s) all paid claims up to the final understated liability amount were paid in error.

2. If an understated or overstated liability case is found to have multiple errors the liability error listed first in section VI of the IRS is the primary error. Only one primary error can be associated with a case liability error.

If beneficiaries in a case are ineligible for different primary errors record these errors separately in section VI of the IRS in descending order with the greatest error dollar amount first. If the number of beneficiaries and the number of primary errors exceed nine, combine the error dollar amounts for the fifth and any additional beneficiaries into a single error dollar amount.

3. If the case is eligible but a member(s) of the case has received services for which he was not eligible it is considered an eligibility error rather than a claims collection error. See §7312 for a discussion of this type of error.

7339. DEFINITION OF MISSPENT DOLLAR AMOUNTS FOR CASES CONTAINING FINAL ELIGIBILITY OR LIABILITY ERRORS

The dollar amount of eligibility or liability errors is related to the dollar amount of the claims for services provided to ineligible members, to a case with a final finding of understated liability during the review month, or to eligible beneficiaries who have received ineligible services. Follow these instructions in determining the dollar amount of each type of error.

In cases with multiple errors the overall dollar amount of error is determined as follows.

1. If at least one error is an eligibility error (other than for excess resources) the dollar amount of error is the full amount of paid claims for the ineligible beneficiary(ies), or the amount of ineligible services received, as applicable.

2. In those cases where both eligibility and liability errors exist the case must be redefined and reevaluated. To reevaluate the case the reviewer first removes the ineligible case members from the case, then reevaluates the eligibility and, if appropriate, recomputes the liability of remaining case members. The total amount of misspent dollars will be calculated by combining the amount of dollars in error for ineligible beneficiaries and/or services with the amount of dollars determined to have been misspent because of the initial liability understated finding.

Record the dollar amount of eligibility and liability errors by primary type of error on the IRS. In cases with multiple beneficiaries with mixed eligibility findings compute the first dollar error amount paid on behalf of ineligible beneficiaries. List each element in error and the combined dollar error amounts for all ineligible beneficiaries having this same primary error. On the IRS code the eligibility and liability errors in separate blocks and then combine the dollar error amounts to show the total dollar error. If all beneficiaries in a case are found to be ineligible due to the same type of error record the overall case dollar eligibility error amount on the IRS as the dollar error amount recorded with the primary error for the case. Then record the primary liability error and the dollar amount.

Compute from these gross dollar amounts of eligibility and liability errors by primary type of error the total dollar amount of misspent funds by combining the dollar amounts of error for all ineligible recipients with the dollar amount of any misspent funds paid on behalf of the case members with a final finding of understated liability.

7342. COMPLETING THE UNDUPLICATED DOLLAR ERROR AMOUNT WORKSHEET (OPTIONAL)

Computations of final dollar errors may be completed on this worksheet for each case in which the original finding is subject to change. A sample worksheet is shown in §7342.1. Exhibit 4 allows the reviewer to record the following:

1. Case and beneficiary name(s),

2. Claim number and date of service provision (when utilizing paid claims to offset beneficiary liability errors arrange claims in order of dates of service),

3. Amount paid, and

4. Final payment review computation indicating whether beneficiary liability was met prior to the review month, during the review month, or not at all.

The use of the worksheet when computing the final dollar amount of eligibility/liability errors and determining the final case finding is optional. However, if this worksheet is not used record the same information on a form devised by the State or on plain paper and include in the MEQC file.

Exhibit 4
Unduplicated Dollar Error Amount Worksheet

Bene. Name	I.D. No.	(a) Elig. Errors Other Than For Excess Resources And Technical Errors	(b) Excess Resources Errors	(c) Understated Liability Error	(d) Overstated Liability Error	(e) Technical Error	(f) Eligible With Ineligible Services Error	(g) Gross Countable Error (add and unduplicate cols. a, b, c, d, and f)	(h) Paid Claims Amount	(i) Net Error Lesser of Col. g or h
TOTALS										

7343. COMPUTATION OF ERROR AMOUNTS FOR CASES INVOLVING BENEFICIARIES DUALLY ELIGIBLE FOR QMB AND NON-QMB COVERAGE GROUP

Beginning in January 1989, under §§1902(e)(8) and 1905(p)(1) of the Act, a single individual may be dually eligible for Medicaid as a QMB and under a non-QMB Medicaid eligibility coverage group at the same time. HCFA refers to these cases as QMB/non-QMB cases. When these cases are reviewed, MEQC may identify errors in either or both of these eligibility coverage groups. In addition, the types of errors may be the same for both coverage groups, i.e., both eligibility errors, or they may be different, i.e., one eligibility error and one liability error. To determine the dollar amount of any errors in these cases, the usual MEQC rules for error calculations are applicable for these dually eligible cases. This section provides examples of how these rules apply to dually eligible (QMB/non-QMB) cases.

When errors occur in an MEQC sampled QMB/non-QMB case, identify whether the paid claims are QMB covered only, non-QMB covered only, covered under both coverage groups, or unclassifiable. Only claims that can be covered under the group for which the client is eligible are eligible payments. Therefore, it is critical that the MEQC reviewer identify the coverage group(s) under which the claims for the MEQC review month are covered. In QMB/non-QMB error cases, determine the error amount using only the claims that cannot be covered under the eligible group. See examples 1.A. and 1.B. in §7343.5. If you cannot identify the coverage group(s) under which the individual claims can be covered, consider the unclassifiable claims to be paid under the group with the error. See example 1.C.

For the purpose of determining the eligibility group under which claims can be covered, some things are beyond the scope of the MEQC payment review for dually eligible QMB/non-QMB cases. These include:

- Errors in the amount of claims payment due to failure to use available third party coverage, such as incorrect payment in full of a hospital claim which could have been paid partially by Medicare Part A. Consider this claim a QMB-covered claim even though only the Medicare cost sharing amount should have been paid.

- Determination of whether a provider of a medical service on a dually QMB/non-QMB case is a Medicare/Medicaid provider or a Medicare only provider. Assume that the claims paid for any provider are covered under both coverage groups if the claims are (1) for services covered under the State plan for the Medicaid non-QMB coverage groups, and (2) for services eligible for payment under Medicare.

- Determination of correctness of amount of payment based on program (Medicare/Medicaid) participation of the provider.

7343.1 Coding of QMB/Non-QMB Cases on Integrated Review Schedule (IRS). Generally, the coding of QMB/non-QMB on the IRS follows the same guidelines as for other MEQC sampled cases. However, some of the National Integrated Quality Control System (NIQCS) edits have been deleted for QMB/non-QMB cases to allow coding of multiple types of errors and to allow changing of some previously reported initial coding when the MEQC payment review findings are reported. Use the directions in the IRS manual and the following guidelines for QMB/non-QMB cases.

If the MEQC initial findings indicate that the case is eligible for one of the groups but has an error other than total ineligibility for the other coverage group, use the coverage code for dual eligibility (12) at the end of the eligibility review. The coverage code may be changed at the end of the MEQC payment review, if necessary. See example 5 in §7343.5.

If there are distinctly different types of errors in QMB and the non-QMB group, use a summary code to define the eligibility status in the Initial Case Eligibility Status and Final Case Eligibility Status on the IRS. Separate the errors in the Detailed Error Findings of the IRS. The error finding codes may be different from the Initial or Final Case Eligibility Status. For example, if the case finding is ineligible under QMB and understated liability under non-QMB, the Initial Case Eligibility Status code indicates understated liability with ineligible services. The detailed error finding indicates an understated liability for the non-QMB error element and ineligible for the QMB error element.

If distinctly different types of errors are found in the same element for QMB and non-QMB, the same element number may be listed on multiple lines of the detailed error finding. For example, if the error from unreported income causes the case to be ineligible under QMB and also causes an understated liability under non-QMB, code the element number on two lines with a liability error indicated on one line and an eligibility error indicated on the other line.

Optional new codes have been added for program identifiers to allow you to specify whether the individual error occurred under QMB coverage or under non-QMB coverage on a dually eligible QMB/non-QMB case. Federal tables do not display these findings separately. However, they are available to develop State reports using this additional information for corrective action. For example, using the findings above, the State may choose to use the QMB program identifier for the eligibility error and use the non-QMB program indicator for the understated liability error, or continue to use the generic Medicaid program identifier for both errors. For the Federal 6 month summary reports, combine the separate program identifiers into the generic Medicaid program identifier.

7343.2 Dually Certified Cases - Ineligibility for One Coverage Group Due to Excess Resources.--When a dually eligible QMB/non-QMB benficiary is eligible for one of the coverage groups but ineligible for the other coverage group because of excess resources, determine the payment error amount by comparing the excess resources to the paid claims as described below and in §7315. Count as eligible those claims that can be identified as covered under the eligible coverage group. Determine the error amount as the lesser of (1) the excess resources, or (2) the amount of the claims that can be identified as covered ONLY under the ineligible group plus all the unclassified claims. (See §7343.5, example 3.)

7343.3 Ineligibility for Both Coverage Groups Due to Excess Resources.--When a dually eligible QMB/non-QMB beneficiary is ineligible due to excess resources for both QMB and the non-QMB coverage group, begin the determination of the error amount by identifying the coverage group under which the claims can be covered (i.e., QMB, non-QMB, or both).

Identify the coverage group that has the lower excess resource amount and designate it as Group A. If both groups have the same amount of excess resources, identify as Group A the one which has the larger amount of claims covered under that group. If these totals are the same, identify QMB as the A group.

Step 1: Determine the lesser amount of (1) the claims for Group A only plus the both claims, or (2) the excess resource amount for Group A.

Step 2: Determine the lesser amount of (1) the non-A group only claims plus the unclassifiable claims, or (2) the excess resource amount for the non-A group.

The final error amount is the lesser of the sum of the amounts in steps 1 and 2 or the higher amount of excess resources (non-A group).

7343.4 Understated Liability for Non-QMB Group.--When a dually eligible QMB/non-QMB beneficiary has an understated liability (UL) for the non-QMB coverage group, use these guidelines and those in §7330 to determine whether to reduce the initial UL amount. Determining whether QMB certification was correct during the spenddown period prior to the MEQC review month is beyond the scope of the MEQC review for purposes of applying prior month claims to the spenddown amount. Therefore, for all months of the spenddown period in which the recipient was certified as QMB, apply only non-QMB prior month claims to the UL. Furthermore, treat any unclassifiable claims as QMB-covered claims. For the months of the spenddown period in which the recipient was NOT certified for QMB, apply all claims to the outstanding liability during the spenddown period prior to the review month. (See examples 5.B and 6.B in §7343.5.)

If the initial UL amount is reduced to $0 by applying prior month claims, determine the dollar amount of the error as follows:

A. If the case is eligible as QMB for the MEQC review month, the dollar amount of the error is $0.

B. If the case is ineligible for QMB for the MEQC review month,

1. Count non-QMB claims as eligible, and

2. Count as ineligible those claims that can be covered ONLY under QMB, plus all unclassifiable claims. (See example 6.B in §7343.5.)

If the initial UL amount is not reduced to $0:

A. If the recipient is eligible for QMB for the review month, use the MEQC review month claims covered under QMB to establish the final status of the liability error according to §7330. (See example 5.B in §7343.5.)

B. If the recipient is ineligible for QMB for the MEQC review month due to a reason other than excess

resources, use all the MEQC review month claims to determine the final status of the liability error according to §7330. Apply the unmet liability to the review month claims in date of service order. For single dates of service with multiple claims, apply the unmet liability to QMB ONLY and unclassifiable claims first if these claims would be the recipient's responsibility if they were not eligible for payment under Medicaid.

1. If the revised initial UL amount is met in the review month, the maximum amount of the liability error is the revised initial UL amount for the review month. To unduplicate the error dollars and allot the dollar amount of final error to the proper error category:

(a) Determine the eligibility error amount to show on the IRS, in the final dollar amount of case eligibility errors, as the amount of claims that can be identified as covered ONLY under QMB plus the unclassifiable claims, and

(b) Determine the liability error amount, to show on the IRS, in the final dollar amount of case liability errors, as (1) the revised initial USL amount minus (2) the dollar amount of the QMB ONLY and unclassifiable claims used to offset the liability. This may reduce the UL to $0. (See §7343.5, example 6.B.)

2. If the revised initial USL amount is NOT met in the review month, determine the dollar amount of the eligibility error as the total amount of the paid claims for the review month. (See §7343.5, example 6.B.)

7343.5 Examples of Error Computations for Qualified Medicare Beneficiary Coverage.--The examples below demonstrating how to determine the coverage group(s) under which particular services are covered are for illustration only. Make these decisions based on coverage groups included in your State plan.

EXAMPLE 1: MEQC finding of eligible for QMB but ineligible under non-QMB coverage for a reason other than excess resources.

A. Some Paid Claims Can Be Covered Only Under The Non-QMB Coverage Group.-Determine the coverage group(s) to assign the review month claims.

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Physician crossover	$ 12		$12		
Dental	79	$79			
Drugs	96	96			
Medicare B buy-in for CN	27		27		
Medicare A buy-in	156			$156	
	$370	$175	$39	$156	0

Since the claims identified as QMB-covered claims are eligible for payment, determine the error amount as the amount of paid claims covered ONLY under the non-QMB group plus the unclassifiable claims.

Non-QMB only	$175
Unclassifiable claims	-0-
Total errors	$175

B. All Paid Claims Are QMB-Covered.--Determine the coverage group(s) to assign the review month claims.

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Physician crossover	$ 12		$12		
Medicare B buy-in for CN	27		27		
Medicare A buy-in	156			$156	
	$195	0	$39	$156	0

Since all the claims are identified as eligible for payment under the eligible QMB group, the dollar amount of the eligibility error is $0.

C. Claims Not Classified By Coverage Group.--Determine the coverage group(s) to assign review month claims.

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Claim A	$ 12				$ 12
Claim B		79			
79					
Claim C		96			
96					
Medicare buy-in	27		$27		
	$214	0	$27	0	$186

If you cannot distinguish the coverage group(s) under which some of the individual claims can be paid, assume that the unclassifiable claims were paid under the coverage group with the error. Determine the error amount as the amount of the paid claims for the ineligible non-QMB group plus the unclassifiable claims.

Non-QMB only claims	$ 0
Unclassifiable	187
Total error	$187

EXAMPLE 2: MEQC finding of ineligible for QMB for a reason other than excess resources but eligible under non-QMB coverage.

A. Paid Claims Covered Only Under QMB.--Determine the coverage group(s) to assign review month claims.

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Physician crossover	$ 30		$30		
Drugs	22	$22			
Medicare B buy-in for MN	27			$27	
	$ 79	$22	$30	$27	0

Since the non-QMB identified claims are eligible for payment, determine the error amount as the amount of the claims identified as covered only under QMB plus the unclassifiable claims as follows:

QMB only claims	$ 27
Unclassifiable	0
Total error	$ 27

B. QMB-Only Paid Claims.--Determine the coverage group(s) under which the MEQC review month claims can be covered

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Physician crossover	$ 30			$30	
Medicare B buy-in for CN	27		$27		
	$ 57	0	$27	$30	0

Since all the claims are identified as eligible for payment under the non-QMB coverage group, the dollar amount of the eligibility error is $0.

EXAMPLE 3: MEQC finding of eligible for QMB but ineligible under another non-QMB coverage group because of $150 excess resources.

A. Paid Claims For The Non-QMB Coverage Group Are Greater Than The Excess Resources.--Determine the coverage group(s) under which the MEQC review month claims can be covered.

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Physician crossover	$ 12		$12		
Dental	79	$ 79			
Drugs	96	96			
Medicare B buy-in for CN	$ 27		27		
	$214	$175	$39	0	0

Since the identified QMB-covered claims are eligible for payment, determine the error amount as the lesser of the (1) excess resources or (2) the non-QMB only claims plus the unclassifiable claims as follows:

Unclassifiable claims	$ 0	
Non-QMB only claims	175	
Total	$175	
Excess Resources	$150	= lesser amount

Note that the amount of error in this case is the lesser of excess resources or paid claims.

B. Paid Claims for the Non-QMB Coverage Group are Less Than the Excess Resources.--Determine the coverage group(s) to assign review month claims.

	Total Claims	Non QMB	Both	QMB	Unclassifiable
Physician crossover	$ 12		$12		
Dental	69	$ 69			
Drugs	41	41			
Medicare B buy-in for CN					

Since the identified QMB-covered claims are eligible for payment, determine the error amount as the lesser of (1) the excess resources or (2) the non-QMB only claims plus the unclassifiable claims as follows:

Unclassifiable claims	$ 0	
Non-QMB only claims	110	
Total	$110	(lesser amount)
Excess Resources	$150	

Since the amount of claims is less than the excess resources, the amount of error is $110.

C. All Paid Claims are QMB-Covered.--Determine the eligibility group(s) to assign review month claims.

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Physician crossover	$12		$12		
Medicare B buy-in for CN	27		27		
	$ 39	0	$39	0	0

Since all the claims are eligible for payment under the eligible QMB group, the dollar amount of the eligibility error is $0.

D. Some Claims are Unclassifiable.--Determine the eligibility group(s) to assign the review month claims.

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Claim A	$ 12				$12
Claim B		21			
21					
Medicare B buy-in for CN	27		$27		
Medicare A buy-in	156			$156	
	$216	0	$27	$156	$33

Since the QMB-covered claims are eligible, determine the error amount as the lesser of (1) the excess resources or (2) the non-QMB ONLY claims plus the unclassifiable claims as follows:

Non-QMB only claims	$ 0	
Unclassifiable claims	33	
Total	$ 33	lesser amount
Excess Resources	$150	

Since the amount of claims is less than the excess resources, the amount of the error is $33.

EXAMPLE 4: MEQC finding of ineligible for QMB due to excess resources and ineligible under another non-QMB coverage group due to excess resources.

A. QMB Excess Resources of $100 and Non-QMB Excess Resources of $500.--Determine the coverage group(s) to assign the review month claims.

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Physician crossover	$ 87		$ 87		
Drugs	40	$40			
Drugs	27		27		
Medicare B buy-in for CN	156			$156	
	$310	$40	$114	$156	0

Determine the coverage group which has the lower excess resources and designate that as group A.

QMB excess resources	$100	lesser amount (Group A)
Non-QMB excess resources	$500	

STEP 1: Determine the lesser amount of (1) the claims for Group A only plus the both claims or (2) the excess resource amount for Group A.

QMB only claims	$156	
Both claims	+114	
	$270	
QMB excess resources	$100	lesser amount

STEP 2: Determine the lesser amount of (1) the non-A group only claims plus the unclassifiable claims or (2) the excess resource amount for the non-A group.

Non-QMB only claims	$ 40	
Unclassifiable claims	0	
	$ 40	lesser amount
Non-QMB excess resources	$500	

Determine the final error amount as the lesser of (1) the lesser amount determined in Step 1 plus the lesser amount determined in Step 2 or (2) the higher amount of excess resources.

Step 1 lesser amount	$100	
Step 2 lesser amount	+40	
	$140	lesser amount
Higher excess resources	$500	

Since the Step 1 lesser amount plus Step 2 lesser amount is less than the higher excess resources, the amount of the error is $140.

B. QMB Excess Resources of $400 and Non-QMB Excess Resources of $200.--
Determine the coverage group(s) to assign the review month claims.

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Medicare B buy-in for MN	$ 27			$27	
Physician crossover	40		$40		
Dental	280	$280			
Drugs	160	160			
Claim A	100				$100
	$607	$440	$40	$27	$100

Determine the coverage group which has the lower excess resources and designate that as group A.

QMB excess resources.	$400	
Non-QMB excess resources.	$200	lesser amount (Group A)

Step 1: Determine the lesser amount of (1) the claims for Group A only plus the both claims or (2) the excess resource amount for Group A:

Non-QMB only claims	$440	
Both claims	+40	
	$480	
QMB excess resources	$200	lesser amount

Step 2: Determine the lesser amount of (1) the non-A group only claims plus the unclassifiable claims or (2) the excess resource amount for the non-A group.

QMB only claims	$ 27	
Unclassifiable claims	+100	
	$127	lesser amount
QMB excess resources	$400	

Determine the final error amount as the lesser of (1) the step 1 lesser amount plus the step 2 lesser amount or (2) the higher amount of excess resources.

Step 1 lesser amount	$200	
Step 2 lesser amount	127	
	$327	lesser amount
Higher excess resources	$400	

Since the step 1 lesser amount plus the step 2 lesser amount is less than the high excess resource, the amount of the error is $327.

C. QMB Excess Resources of $100 and Non-QMB Excess Resources of $500.--Determine the coverage group(s) to assign the review month claims.

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Medicare A buy-in	$ 156			$156	
Physician crossover	33		$ 33		
Medicare B buy-in for CN	27		27		
Hospital crossover	560		$560		
Drugs	670	$670			
	$1446	$670	$620	$156	0

Determine the coverage group which has the lower excess resources and designate that as group A.

QMB excess resources	$100
Non-QMB excess resources	$500

Step 1: Determine the lesser amount of (1) the claims for Group A only plus the both claims or (2) the excess resource amount for Group A:

QMB only claims	$156	
Both claims	620	
	$776	
QMB excess resources	$100	lesser amount

Step 2: Determine the lesser amount of (1) the non-A group only claims plus the unclassifiable claims or (2) the excess resource amount for the non-A group.

Non-QMB only claims	$670	
Unclassifiable claims		0
	$670	
Non-QMB excess resources	$500	lesser amount

Determine the final error amount as the lesser of (1) the Step 1 lesser amount plus the Step 2 lesser amount or (2) the higher amount of excess resources.

Step 1 lesser amount	$100	
Step 2 lesser amount	500	
	$600	
Higher excess resources	$500	lesser amount

Since the higher excess resource is less than the Step 1 lesser amount plus the Step 2 lesser amount, the amount of the error is $500.

EXAMPLE 5: Eligible for QMB and understated liability (UL) OF $100 for non-QMB eligibility group

A. All the Review Month Claims Can Be Covered Under QMB.--Determine the coverage groups to assign the review month claims.

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Physician crossover	$ 12		$12		
Medicare B buy-in for MN	27			$27	
Total	$ 39	0	$12	$27	0

Since all the review month claims are identified as covered under the eligible QMB group, the dollar amount of the error is $0.

B. Some of the Review Month Paid Claims Are Covered Only Under the Non-QMB Eligibility Group or are Unclassifiable.--Determine whether to reduce the initial liability error using instructions in §7330 and the following guidelines. For the prior months in the certification period (CP) for which QMB was certified, apply the UL review to claims identified as covered only under the non-QMB eligibility group. For the prior months in the CP for which QMB was not certified, apply the UL review to all the claims. Determination of the correctness of the QMB certification in the prior months of the CP is beyond the scope of the MEQC review.

For example, for a CP of August 1989 - January 1990 when the MEQC review month is October, 1989, reduce the initial UL of $100 as follows:

Month	Certified for	Paid Claims	Total Claims	Non-QMB	Both	QMB	For UL Review
8/89	Non-QMB only	Physician crossover	$ 15	$15			
9/89	Dual QMB and Non-QMB	Physician crossover	$ 25			$25	No
		Drugs	$ 18			$18	Yes
		Medicare B buy-in	$ 27		$27		No
		Drugs	$ 12	$12			Yes
Initial UL			$100				
Prior month claims			45				
Revised initial UL			$ 55				

C. If some of the review month claims are eligible for payment under QMB and non-QMB claims plus unclassifiable claims for the review month are greater than the revised initial UL of $55, then the status for the non-QMB group remains as UL.

Determine the coverage group(s) to assign the review month claims.

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Physician crossover	$ 12		$12		
Dental	69	$ 69			
Drugs	81	81			
Medicare B buy-in for MN	27	27	$27		
	$189	$150	$39	$27	0

Since the identified QMB-covered claims are eligible for payment, determine whether the revised UL amount is met with the non-QMB only claims plus the unclassifiable claims for the MEQC review month per §7330.

Unclassifiable claims	$ 0	
Non-QMB only claims	150	
Total	$150	
Revised initial UL	$ 55	lesser

If the non-QMB only plus unclassifiable paid claims is greater than the revised UL, the final eligibility status of the non-QMB group is UL. The dollar amount of the liability error is the amount of the revised UL amount.

NOTE: The State may choose to use billed amounts and denied and noncovered claims as described in §7330.

D. If some of the review month claims are eligible for payment under QMB and non-QMB claims plus unclassifiable claims for the review month are less then the revised initial USL of $55, then the status for the non-QMB group changes to ineligible.

Assume the initial USL was reduced with prior month claims as shown in subsection B.

Determine the coverage group(s) to assign the review month claims.

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Physician crossover	$ 12		$12		
Drugs	30	$30			
Medicare B buy-in for MN	27			$27	
	$ 69	$30	$12	$27	0

Since the identified QMB-covered claims are eligible for payment, determine whether the revised initial UL amount is met with the non-QMB only plus unclassifiable claims for the MEQC review month per §7330.

Unclassifiable	$ 0	
Non-QMB only claims	30	
Total	$ 30	lesser amount
Revised initial UL	$ 55	

If the non-QMB only plus unclassifiable paid claims is less than the revised USL, determine the non-QMB group as ineligible and determine the dollar amount of the eligibility error as the amount of the non-QMB only plus unclassifiable claims. Change the final status to eligible with ineligible services for the MEQC review month and change the coverage code from dual eligibility to QMB only.

NOTE: The State may choose to use billed amounts and denied and noncovered claims as described in §7330.

E. Some claims are QMB-covered only with the initial UL reduced to $0 prior to the MEQC review month by the UL review. The final eligibility status of the non-QMB group is eligible.

For example, for CP August 1989 - January 1990 when the QC review month is October, reduce the initial UL of $100 as follows:

Month	Certified for Review	Total Paid Claims	Non-QMB Claims	QMB	For UL Both
8/89 Non-QMB only	Hospital crossover	$560	$560		Yes
	Physician crossover	20	20		Yes
9/89 Dual QMB and Non-QMB	Physician crossover	40		$40	No

Initial UL	$100
Prior months' claims	-580
Revised UL	0

Determine the eligibility group(s) to assign the review month claims.

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Physician crossover	$ 12		$12		
Medicare B buy-in for MN	27			$27	
	$ 39	0	$12	$27	0

Since the final eligibility status for both QMB and the non-QMB group is eligible, the dollar amount of error is $0.

EXAMPLE 6: Ineligible for QMB for a reason other than excess resources and UL of $100 for the Non-QMB coverage group.

A. All the Review Month Claims are Identified as Covered Only Under QMB.-Determine the coverage group(s) to assign the review month claims.

	Total Claims	Non-QMB	Both	QMB	Unclassified
Medicare A buy-in	$156			$156	
Medicare B buy-in for MN	27			27	
	$183	0	0	$183	0

Since all the review month claims are identified as covered only under the ineligible QMB group, the dollar amount of the eligibility error is the total amount of the claims.

B. Some of the MEQC Review Month Paid Claims are Covered Only Under the Non-QMB Coverage Group.--Determine whether the initial liability error can be reduced using instructions in §7330 and the following guidelines. For the prior months in the CP, apply the UL review to claims that are covered only under the non-QMB eligibility group. For the prior months in the CP for which QMB was not certified, apply the UL review to all the claims. Determination of the correctness of the QMB certification in the prior months of the CP is beyond the scope of the MEQC review.

For example, for a CP of August 1989 - January 1990, when the MEQC review month is October, reduce the initial UL of $100 as follows:

Month	Certified for QMB	Paid Claims	Total Claims	Non-QMB Claims	QMB	Use for Both
8/89	Non-QMB only	Physician crossover	$15	$15			Yes
9/89	Dual QMB and Non-QMB	Physician crossover	25		$25		No
		Drugs	18	18			Yes
		Medicare B buy-in	27			$27	No
		for MN	12	12			
		Dental	12	12			

Initial UL	$100
Prior months' claims	45
Revised initial UL	$ 55

C. Some claims are covered only under the ineligible QMB group and the total claims for the MEQC review month are greater than the revised initial UL of $55 the status for the non-QMB group remains as UL.

Determine the eligibility group(s) to assign the review month claims:

Date of Service	Claim	Total Claims	Non-QMB	Both	QMB	Unclassifiable
10-01	Medicare B buy-in	$ 27			27	
10-02	Drugs	10	10			
10-06	Claim A	8				$ 8
10-06	Physician crossover	5		$5		
10-18	Claim B	10				10
10-18	Dental	20	20			
10-20	Medicare A buy-in	156			156	
		$236	$30	$5	$183	$18

Since the claims that are identified as QMB-covered only and unclassifiable claims are ineligible for payment, determine whether the revised UL amount is met using all the claims for the MEQC review month in §7330. Apply the unmet liability to the review month claims in date of service order. For single dates of service with multiple claims, apply the QMB only and unclassifiable claims to the unmet liability first if these claims would be the client's responsibility if they were not eligible for payment under Medicaid.

Date of Service	Type of Coverage Used to Offset Liability	Liability Still to Be Met	Amount Paid	
10-01	QMB only	$ 55	$ 27	$ 27
10-02	Non-QMB	28	10	10
10-06	Unclassifiable	18	8	8
10-06	Both claim	10	5	5
10-18	Unclassifiable	5	10	5
10-18	Non-QMB	0	20	0
10-20	QMB only	0	156	0

NOTE: The State may choose to use the billed amounts and denied and uncovered claims as described in §7330.

If the paid claims are greater than the revised UL, the final eligibility status of the non-QMB group is UL. In order to unduplicate the error dollars, determine the dollar amount of the eligibility error as the total amount of the claims that can be covered only under QMB plus the unclassifiable claims. Determine the dollar amount of the liability error as the amount of the revised UL amount minus the dollar amount of the QMB only and unclassifiable claims that were used to offset the liability. If the amount of QMB only and unclassified claims used to offset the liability equals or exceeds the revised initial UL amount, the liability error amount is $0.

QMB only claims	$183	
Unclassifiable claims	+ 18	
	$201	eligibility error amount
Revised UL amount	$ 55	
QMB only used to offset liability	- 27	
Unclassifiable claims used to offset liability	- 13	
	$ 15	liability error amount

D. Some paid claims are identified as covered only under the ineligible QMB and the total for the MEQC review month is less than the revised initial USL of $55 the status for the non-QMB group changes to ineligible.

Assume the initial UL was reduced to $55 by the QC review month (as described in subsection B).

Determine the coverage group(s) to assign the review month claims.

Date of Service	Claims	Total Claims	Non-QMB	Both	QMB	Unclassifiable
10-08	Physician crossover	$ 12		$12		
10-01	Medicare B buy-in	27			$27	
		$ 39	0	$12	$27	0

Since the claims that are identified as QMB only and unclassifiable are ineligible for payment, determine whether the revised UL amount is met using all the claims for the MEQC review month following directions in §7330. Apply the unmet liability to the review month claims in date of service order. For single dates of service with multiple claims, first apply the QMB only and unclassified claims to the unmet liability.

Date of Service	Type of Coverage	Liability Still to Be Met	Paid Amount	Used to Offset Liability
10-01	QMB Only	$55	$27	$27
10-08	Both claims	28	12	12

If the paid claims are less than the revised UL, the eligibility status of the non-QMB group is ineligible. Determine the dollar amount of the eligibility error as the total amount of the paid claims. Change the final eligibility status to ineligible for the QC review month.

E. Some claims are identified as covered only under the ineligible QMB and the initial USL for the non-QMB coverage group is reduced to $0 prior to the MEQC review month by the UL review so the final eligibility status of the non-QMB group is eligible.

For example, for CP August 1989 - January 1990 when the QC review month is October, reduce the initial UL of $100 as follows:

Month	Certified for	Paid Claims	Total Claims	Non-QMB	Both	QMB	For UL Review	
8/89	Non-QMB only		Hospital crossover			$560		
	560		Yes					
		Physician crossover	20		20		Yes	
9/89	Dual QMB and		Physician crossover					40
			$40		No			
	Non-QMB							

Initial UL	$100
Prior months' claims	580
Revised UL	0

Determine the coverage groups to assign the review month claims.

	Total Claims	Non-QMB	Both	QMB	Unclassifiable
Physician crossover	$ 12		$12		
Medicare B buy-in for MN	27			$27	
	$ 39	0	$12	$27	0

Since the claims that can be identified as covered under the non-QMB group are eligible for payment because the UL was met with prior months' claims, determine the dollar amount of the eligibility error as the amount of the claims that can be covered only under the ineligible QMB plus the unclassifiable claims. Change the final eligibility status to eligible with ineligible services.

QMB only claims	$ 27	
Unclassifiable claims	+0	
	27	eligibility error amount

7350. FEDERAL MONITORING

To ensure that State MEQC systems are operating in accordance with Federal requirements and to assist each State agency in fully utilizing its MEQC system, Federal staff conducts ongoing appraisals of State operations. The Federal appraisal consists of:

- Management reviews of the administrative and operational aspects of the system on an as-needed basis;
- Ongoing monitoring of State activities in sampling, review, and corrective action; and
- Re-review of a subsample of State MEQC case reviews.

If Federal re-review determines that State case reviews have not been completed appropriately, HCFA may:

- Return an inappropriately dropped case(s) for full review;
- Complete an inappropriately dropped case(s) by Federal resources at State expense;
- Return a case(s) not containing required income and eligibility verification information and/or verification to request and verify appropriate information; or
- Obtain and verify required income and eligibility verification information by Federal resources at State expense.

HCFA conducts Federal re-reviews in compliance with the provisions of this manual and the Regional Office Manual.

If any of these or other Federal monitoring activities reveal that a State has failed to cooperate in completing a valid MEQC sample or individual reviews in a timely and appropriate fashion, HCFA establishes payment error rates based on:

- A special sample or audit;
- The Federal subsample; or
- Other arrangements as the HCFA Administrator may prescribe.

In addition, Federal MEQC staff assists HCFA by identifying State policy which conflicts with the approved State plan and State plan material that may have been incorrectly approved by the RO.

Section 7206 provides the appropriate instructions for reviewing all cases against the approved State plan. Federal MEQC brings matters of apparent conflict between State plans, State policy, and Federal regulation to the attention of the Medicaid policy staff for interpretation.

Whenever differences exist between you and Federal review findings for MEQC cases which are federally re-reviewed, you are notified by a Federal difference letter. You may agree with the Federal findings or state your reasons for not agreeing, and may request a conference. However, you must respond to all Federal differences in writing, whether you agree within 28 days of the date of the difference letter. If you disagree with Federal findings, you must provide all documentation to substantiate your position within 28 calendar days from the date of the difference letter. The 28-day difference response period may be shortened if determined to be necessary by the RO with CO concurrence. This shortened response period must not be less than 10 working days. You may also request a difference conference to discuss the case. If, after reviewing arguments, HCFA maintains the Federal finding to be correct, you may appeal the case to the HCFA Regional Administrator (RA). The final decision concerning the difference is made by the HCFA RA. This decision is to be reflected in your MEQC statistical reports.

7355. RECORD MAINTENANCE

For purposes of Federal re-review and audit of State MEQC programs, you must maintain your official MEQC records to permit their ready access and use. Official MEQC records consist of documents which support your actions in the following areas:

- The case selection process, including but not limited to the data and/or working papers used to determine each month's sample frame, interval determination, and case selection method and the sample list;

- The case review process, including but not limited to Forms HCFA 301 and HCFA 316 and supporting documents, including Federal difference letters for all completed and dropped reviews. You must maintain copies of paid claims or histories for sample cases with your MEQC records; and

- The reporting process, including but not limited to all final 6-month MEQC reports.

Maintain official MEQC records for a period of 3 years following the submission of the final 6-month report. Retain the records beyond the 3-year period if audit findings have not been resolved or if additional action may be necessary.

You must mail to HHS staff all records as requested within 10 working days of receipt of the request unless HCFA has approved an additional 3 working days as needed.

7500. INTRODUCTION

The primary objective of the Medicaid Eligibility Quality Control (MEQC) System is to eliminate or substantially reduce dollar losses resulting from eligibility errors. Information concerning a sample of Medicaid cases and the claims for services provided to members of those cases during selected review months is obtained, documented on worksheets, and summarized on the Integrated Review Schedule. (See §7599, Exhibit 1.)

Case findings are summarized on the review schedule and submitted in two parts: eligibility findings after completing the eligibility review and payment findings after completing the payment review. The Sample Completion Monitoring Subsystem section, Part X of the Integrated Quality Control Data Processing System (IQCDPS) Users Manual contains instructions for automatically generating eligibility findings. The Medicaid claims subsystem section, Part XIV of that manual, contains the instructions for generating payment findings.

The data link between IQCDPS and the HCFA Data Center was implemented in April 1987. Its purpose is to provide electronic transfer of Medicaid eligibility and payment findings which States record on the integrated review schedule and transmit through the IQCDPS. Findings transmitted to the IQCDPS are the official findings for MEQC error rate purposes. Manual disposition lists are no longer required.

ROs do not request subsample cases until paid claims findings or a disposition of dropped are submitted. As a general rule, once payment findings have been submitted in an acceptable form and have been subsampled by the RO, the findings may not be changed. Eligibility findings may be changed to correct data errors until payment findings or a disposition of dropped have been submitted and subjected to subsampling.

There are four exceptions. If you:

1. Initially report a case as dropped and the Federal reviewers are able to complete the case, then change your eligibility findings to reflect the Federal findings or complete your own eligibility review and report that finding. If the Federal reviewers return the dropped case to you for completion, take all necessary actions to complete it and report the finding.

2. Complete a case and submit a finding and the Federal re-review demonstrates that the case was listed in error, i.e., that the case was completed even though it was not within the scope of the survey, then revise your eligibility findings and drop the case.

3. Report an AFDC-QC case as eligible and inadvertently report the same case an ineligible for Medicaid, then revise that finding provided the error was a transcription error and not a review error.

4. Report an eligibility finding for a case which is subsequently overturned by a hearing decision issued by a State administrative law judge or hearing officer, then revise that original finding to reflect the decision.

For each exception, revise the payment findings, if necessary, to make them consistent with any changed eligibility findings. As an extension of this "no change" policy, the IQCDPS has certain protected fields which, once paid claims findings or a disposition of dropped are transmitted to the Kansas City

Computer Center (KCCC), may only be changed through intervention by the RO. The designated protected fields are disposition, initial case eligibility status, initial case liability error, final case eligibility status, dollar amount of paid claims, revised initial case liability error, final dollar amount of case liability error, and final dollar amount of case eligibility error. All other fields contained on the Review Schedule may be changed via retransmission to the KCCC.

The submission of Table V, Universe Data by Stratum and Substratum, is required to allow Federal processing of electronically transmitted State review findings. This table shows the number of Medicaid cases and dollars paid for Medicaid cases during each month of the review period. Table V is also used to report universe data concerning Medicaid payments to Supplemental Security Income (SSI) recipients in States where Medicaid eligibility determinations are made by the Federal government (1634 contract States) and Medicaid payments to individuals covered for foster care and adoption assistance under title IV-E of the Act. This additional payment universe information is used by HCFA to determine that portion of your Medicaid grant award which is not subject to adjustment of Federal financial participation (FFP) for withholding and/or disallowance purposes.

Submit Table V when available, but no later than 4 months after the close of each 6-month reporting period.

7505. ANALYSIS OF REPORTED DATA

The MEQC system is based on a review of a statistically valid sample of Medicaid cases. The data collected through the review process is organized, processed, and analyzed to provide a clear and concise picture of the operations of the Medicaid program.

Thorough and accurate analyses are the basis for formulating corrective actions to effectively reduce error rates and misspent dollars. The State personnel responsible for data analysis use technical formulae and computations in the data analysis process. The analysis is presented to program managers in a form that helps them decide among alternative approaches to corrective action. There is a wide range of data available for analysis through the MEQC system. States may use a number of statistical techniques which are available for data analysis such as correlation, hypothesis testing, and chi-square testing. However, since it is beyond the scope of this manual to describe use of such techniques in detail, see existing literature on these subjects.

7510. INSTRUCTIONS

Table V contains universe statistics used in weighting statistics and also provides payment universe information necessary to adjust FFP in the States' Medicaid grant awards.

7520. TABLE INSTRUCTIONS - TABLE V

Table V displays universe data for each month of the review period. These data are not accumulated from Review Schedules but are counts developed by the State from the Medicaid universe. Enter the total number of Medicaid cases in each stratum or substratum and the total dollars paid out each month for all Medicaid cases in each stratum. The dollars paid in each stratum or substratum are those paid in the reporting period months which are associated with cases in each of the designated stratum groups. Include adjustments made in the month in the total dollar amount, except for cost settlement adjustments not attributable to individual cases. This table must include QMB cases and payments for the appropriate strata. Case and payment totals for QMB only and MAO/QMB dual eligible cases are reported in the MAO stratum; AFDC/QMB cases are included in the AFDC stratum; and SSI/QMB cases are included in the SSI stratum.

The major stratum code designations are:

1 -- Medical Assistance Only
2 -- Aid to Families with Dependent Children
3 -- Optional
4 -- Supplemental Security Income (1634 contract States only)
5 -- Foster Care and Adoption Assistance (title IV-E)

Report strata 4 (in 1634 contract States only) and 5 to allow for elimination of associated proportions of Medicaid dollars from consideration in withholding and disallowance determinations. Do not use these universe data in weighting sample estimates.

THIS SPACE RESERVED FOR FORM HCFA 309
TABLE V
MEDICAID ELIGIBILITY QUALITY CONTROL
UNIVERSE DATA BY STRATUM OR SUBSTRATUM

THIS SPACE RESERVED FOR
INTEGRATED REVIEW SCHEDULE
EXHIBIT 1
PAGE 1

THIS SPACE RESERVED FOR
INTEGRATED REVIEW SCHEDULE
EXHIBIT 1 (CONT.)
PAGE 2

THIS SPACE RESERVED FOR
INTEGRATED REVIEW SCHEDULE
EXHIBIT 1 (CONT.)
PAGE 3

THIS SPACE RESERVED FOR
INTEGRATED REVIEW SCHEDULE
EXHIBIT 1 (CONT.)
PAGE 4