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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:

o Mandatory categorically needy,

o Optional categorically needy, and

o 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:

o Individuals who are deemed to be recipients of title IV-A benefits (Aid to Families with Dependent Children (AFDC)).

o Qualified pregnant women and children.

o 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.

o 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.

o 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.

o 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.

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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

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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 non liquid 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 re-determinations, 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:

o Was ineligible for the review month or, if full month coverage is not provided, was ineligible at the time services were received;

o Had not properly met beneficiary liability prior to receiving Medicaid services; or

o 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.

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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.

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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.

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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:

o 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);

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

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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.

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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:

o Analyzing the case record and recording the analysis on the worksheets;

o Conducting field investigations, including an in-person interview with the beneficiary or the beneficiary's representative to determine eligibility for all MAO stratum cases;

o Verifying the elements of eligibility through collateral contacts as required, and recording the information on worksheets;

o Determining the eligibility status of each case member;

o 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;

o Associating dollar values with eligibility errors; and

o 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

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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:

o Whether there is beneficiary liability that must be met;

o If beneficiary liability was met prior to being certified eligible for Medicaid;

o If the monthly amount of the beneficiary's liability was computed correctly;

o If the monthly amount of nursing home or home and community-based services liability was computed correctly;

o Type of eligibility error(s);

o Total amount by which resources exceed the State allowable limit; and

o 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

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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:

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

o 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;

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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.

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