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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

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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?

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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

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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

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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

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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

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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

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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

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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.

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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:

o Savings bonds,

o Promissory notes,

o Stocks and bonds,

o Certificates of deposit,

o Mutual funds,

o Bank accounts, or

o 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:

o The name of the financial institution(s),

o Address,

o Type of account,

o Type of ownership,

o Account number,

o Balance, and

o 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.

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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:

o Antiques,

o Art work,

o Heirlooms,

o Silver,

o Collections,

o Farm equipment (not used in farming), and

o 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:

o Type of ownership (sole or shared),

o Right of disposition (full, limited, none),

o Description of property (size and construction),

o Existence of mortgage (amount of equity), and

o 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

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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:

o Name of the insurance company,

o Date of issue,

o Policy number,

o Ownership,

o Beneficiary,

o Face value, and

o Cash surrender value.

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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.

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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)

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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

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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.

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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.**

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12-85 REVIEW PROCESS 7269.3 (Cont.)

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

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7269.3 (Cont.) REVIEW PROCESS 12-85

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

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12-85 REVIEW PROCESS 7269.3 (Cont.)

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.

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7269.3 (Cont.) REVIEW PROCESS 12-85

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.

7-3-48 Rev. 32

04-94 REVIEW PROCESS 7269.3 (Cont.)

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.

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7269.3 (Cont.) REVIEW PROCESS 04-94

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.

7-3-50 Rev. 51

10-94 REVIEW PROCESS 7269.4 (Cont.)

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

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7269.5 REVIEW PROCESS 10-94

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.

7-3-52 Rev. 52

09-92 REVIEW PROCESS 7269.5 (Cont.)

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.

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7269.5 (Cont.) REVIEW PROCESS 09-92

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:

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

o 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.

7-3-54 Rev. 46

09-92 REVIEW PROCESS 7272 (Cont.)

Coverage Code

(Mandatory

Coverage)

Choice of

01 or 03

Medicaid Eligibility

Coverage Requirement

Individuals who receive SSI basic payments where the State determines Medicaid eligibility using SSI criteria.

Verification Instructions

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.

Rev. 46 7-3-55

10-94 REVIEW PROCESS 7272 (Cont.)

Coverage Code

(Mandatory Medicaid Eligibility

Coverage) 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.

Rev. 52 7-3-57

7272 (Cont.) REVIEW PROCESS 10-94

Coverage Code

(Mandatory Medicaid Eligibility

Coverage) 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.

7-3-58 Rev. 52

12-86 REVIEW PROCESS 7272 (Cont.)

|  |  |  |  |
| --- | --- | --- | --- |
| 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. |

Rev. 34 7-3-59

7272 (Cont.) REVIEW PROCESS 12-86

|  |  |  |  |
| --- | --- | --- | --- |
| 42 CFR 435.134  Coverage Code  (Mandatory  Coverage) | State Plan  Reference | Medicaid Eligibility  Coverage Requirement | Verification Instructions |
| 05 |  | 1. Individuals who were 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. |

7-3-60 Rev. 34

12-85 REVIEW PROCESS 7272 (Cont.)

|  |  |  |  |
| --- | --- | --- | --- |
| 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. |

Rev. 32 7-3-61

7272 (Cont.) REVIEW PROCESS 12-85

|  |  |  |  |
| --- | --- | --- | --- |
| 42 CFR 435.132  Coverage Code  (Mandatory  Coverage) | State Plan  Reference | Medicaid Eligibility  Coverage Requirement | Verification Instructions |
| 07 |  | Persons who were 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. |

7-3-62 Rev. 32

12-85 REVIEW PROCESS 7272 (Cont.)

|  |  |  |  |
| --- | --- | --- | --- |
| 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. |
|  |  |  |  |

Rev. 32 7-3-63

7272 (Cont.) REVIEW PROCESS 12-85

|  |  |  |  |
| --- | --- | --- | --- |
| 42 CFR 435.122  Coverage Code  (Mandatory  Coverage) | State Plan  Reference | Medicaid Eligibility  Coverage Requirement | Verification Instructions |
| 09 |  | All individuals who 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. |

7-3-64 Rev. 32

11-93 REVIEW PROCESS 7272 (Cont.)

Coverage Code

(Mandatory

Coverage)

10

Medicaid Eligibility

Coverage Requirement

Disabled widows and widowers who are deemed to be SSI recipients under COBRA.

Verification Instructions

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.

Rev. 49 7-3-64.1

7272 (Cont.) REVIEW PROCESS 11-93

Coverage Code

(Mandatory

Coverage)

11

Medicaid Eligibility

Coverage Requirement

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.

Verification Instructions

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.

7-3-64.2 Rev. 49

11-93 REVIEW PROCESS 7272 (Cont.)

Coverage Code

(Mandatory

Coverage)

12

Medicaid Eligibility

Coverage Requirement

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.

Verification Instructions

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.

Rev. 49 7-3-64.3

7272 (Cont.) REVIEW PROCESS 11-93

Coverage Code

(Optional

Coverage)

14

Medicaid Eligibility

Coverage Requirement

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).

Verification Instructions

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.

7-3-64.4 Rev. 49

09-92 REVIEW PROCESS 7272 (Cont.)

Coverage Code

(Optional

Coverage)

15

Medicaid Eligibility

Coverage Requirement

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.

Verification Instructions

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.

Rev. 46 7-3-64.5

7272 (Cont.) REVIEW PROCESS 09-92

Coverage Code

(Mandatory

Coverage)

16

Medicaid Eligibility

Coverage Requirement

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.

Verification Instructions

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.

7-3-64.6 Rev. 46

10-94 REVIEW PROCESS 7272 (Cont.)

Coverage Code

(Mandatory Medicaid Eligibility

Coverage) 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

1. 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.

Rev. 52 7-3-64.7

7272 (Cont.) REVIEW PROCESS 10-94

Coverage Code

(Mandatory Medicaid Eligibility

Coverage) 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.

7-3-64.8 Rev. 52

12-85 REVIEW PROCESS 7272 (Cont.)

|  |  |  |  |
| --- | --- | --- | --- |
| 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. |

Rev. 32 7-3-65

7272 (Cont.) REVIEW PROCESS 12-85

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| --- | --- | --- | --- |
| 42 CFR 435.230  Coverage Code  (Optional  Coverage) | State Plan  Reference | Medicaid Eligibility  Coverage Requirement | Verification Instructions |
| 22 |  | Individuals who receive 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. |

7-3-66 Rev. 32

09-92 REVIEW PROCESS 7272 (Cont.)

Coverage Code

(Optional

Coverage)

23

Medicaid Eligibility

Coverage Requirement

Persons who are eligible for SSI payments or a State's supplement payment only but are not receiving payments.

Verification Instructions

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.

Rev. 46 7-3-67

7272 (Cont.) REVIEW PROCESS 09-92

Coverage Code

(Mandatory

Coverage)

24

Medicaid Eligibility

Coverage Requirement

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.

Verification Instructions

Complete element 186 to document notification of termination from SSI after the 10th of month before the review month.

7-3-68 Rev. 46

10-94 REVIEW PROCESS 7272 (Cont.)

Coverage Code

(Optional Medicaid Eligibility

Coverage) 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.

Rev. 52 7-3-69

7272 (Cont.) REVIEW PROCESS 10-94

Coverage Code

(Optional Medicaid Eligibility

Coverage) 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 condition of Medicaid eligibility during the review month.

7-3-70 Rev. 52

12-85 REVIEW PROCESS 7272 (Cont.)

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| --- | --- | --- | --- |
| 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. |

Rev. 32 7-3-71

7272 (Cont.) REVIEW PROCESS 12-85

|  |  |  |  |
| --- | --- | --- | --- |
| 42 CFR 435.231  Coverage Code  (Optional  Coverage) | State Plan  Reference | Medicaid Eligibility  Coverage Requirement | Verification Instructions |
| 28 |  | Aged, blind, or disabled 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. |

7-3-72 Rev. 32

10-94 REVIEW PROCESS 7272 (Cont.)

Coverage Code

(Optional

Coverage)

29

Medicaid Eligibility

Coverage Requirement

Individuals receiving home and community-based services and other waiver services who are eligible under a special income level.

Verification Instructions

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.

Rev. 52 7-3-73

7272 (Cont.) REVIEW PROCESS 10-94

Coverage Code

(Optional Medicaid Eligibility

Coverage) 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

1. 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.

7-3-73.1 Rev. 52

04-94 REVIEW PROCESS 7272 (Cont.)

Coverage Code

Optional Medicaid Eligibility

Coverage) 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.

Rev. 51 7-3-73.2

7272 (Cont.) REVIEW PROCESS 04-94

Coverage Code

(Optional Medicaid Eligibility

Coverage) 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.

7-3-73.3 Rev. 51

10-94 REVIEW PROCESS 7272 (Cont.)

Coverage Code

(Optional Medicaid Eligibility

Coverage) 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.

Rev. 52 7-3-73.4

7272 (Cont.) REVIEW PROCESS 10-94

Coverage Code

(Mandatory

Coverage)

32

Medicaid Eligibility

Coverage Requirement

Qualified pregnant women who are eligible on the basis of income and resource requirements for payments under the AFDC State plan.

Verification Instructions

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.

7-3-74 Rev. 52

11-93 REVIEW PROCESS 7272 (Cont.)

Coverage Code

(Mandatory)

Coverage)

33

Medicaid Eligibility

Coverage Requirement

Qualified family members who are eligible for time limited AFDC unemployed parents (UP) benefits.

Verification Instructions

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).

Rev. 49 7-3-75