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100.01 HISTORY AND LEGAL BASE

Title XIX of the Social Security Act, enacted in 1965, provides authority for states to establish Medicaid programs to provide medical assistance to needy individuals. The program is jointly financed by federal and state governments and administered by states. Within broad federal rules, each state decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the state to the providers that furnish the services.

Background

Enabling legislation for the Medicaid program in Mississippi was enacted during a special session of the legislature in 1969. Funds were appropriated and the Mississippi Medicaid Commission was designated as the single state agency to administer the program. State statutes governing Medicaid may be found in Sections 43-l3-l0l et. seq. of the Mississippi Code of 1972.

From 1969 to 1973, the determination of Medicaid eligibility was the responsibility of the State Department of Public Welfare (DPW). During this time period, DPW authorized money payments for the aged, blind and disabled and dependent children.

SSI Program

The passage of Public Law 92-603 amended Title XVI of the Social Security Act and established the Supplemental Security Income (SSI) Program for the aged, blind and disabled. State statutes were amended to specify that DPW would no longer determine eligibility for a monthly payment for the aged, blind and disabled.

PL 92-603 allowed States an option to either grant Medicaid to all persons receiving SSI (known as Section 1634) or to grant Medicaid to persons who met more restrictive criteria set by States (known as 209b). The Mississippi Legislature voted to limit Medicaid eligibility to persons who met more restrictive criteria and to designate the DPW as the certifying agency for Medicaid.

History and Legal Base Continued)

During the l980 session of the Mississippi Legislature, Senate Bill 2118 changed the Medicaid eligibility criteria to 1634 status whereby Medicaid would be granted to all individuals receiving SSI. In addition, SSI criteria would be used to determine eligibility for all aged, blind and disabled individuals. During the 1981 Legislative Session, Senate Bill 2478 authorized the Mississippi Medicaid Commission to make its own Medicaid determinations for aged, blind and disabled individuals. Regional Medicaid offices were opened in July, 1981, for the purpose of certifying the eligibility of aged, blind and disabled individuals who did not receive SSI cash assistance.

Current Structure

Senate Bill 3050, entitled the "Mississippi Administrative Reorganization Act of 1984," transferred the powers and responsibilities of the Mississippi Medicaid Commission to the Division of Medicaid in the Office of the Governor. The Division of Medicaid is the single state agency designed to administer the Medicaid Program.

The Mississippi Department of Human Services (MDHS, formerly known as DPW) continued to determine eligibility for the Medicaid Programs for children and families as authorized under Section 43-13-115 of the Mississippi Code of 1972, Annotated, and later adding determination of eligibility for Children's Health Insurance Program (CHIP) in 1999 under Section 41-86-15.

During the 2004 Session of the Mississippi Legislature, House Bill 1434 made significant changes to Section 43-13-115 of the Mississippi Code of 1972. While retaining all Medicaid coverage groups and CHIP (Section 41-86-1 and so forth), the Division of Medicaid was given the responsibility for determining initial and ongoing eligibility for all children, families, and pregnant women. The transition of the Families, Children and CHIP (FCC) programs from MDHS to Division of Medicaid was effective January 1, 2005.

History and Legal Base (Continued)

During the 2012 Session of the Mississippi Legislature, House Bill 316 transferred the existing contract for insurance services for the Children's Health Insurance Program (CHIP) from the State and School Employees Health Insurance Management Board to the Division of Medicaid effective January 1, 2013. The Division of Medicaid has all authority set forth in 43-13-101 et seq. in administering the Children's Health Insurance Program (CHIP).

DHS remained the certifying agency for children under Title IV-E services and other related custody and adoption assistance and those eligible for Medicaid coverage under the Refugee Resettlement grant program until the creation of the MS Department of Child Protection Services with the passage of Senate Bill 2179 during the 2016 Legislative Session. MDCPS is now the lead child welfare agency and effective July 1, 2016 became responsible for Medicaid certifications for children in the custody of MDCPS who qualify for Medicaid and all IV-E foster children and adoption assistance children and the refugees qualifying for Medicaid under the Refugee Resettlement Grant.

During the 2018 legislative session, the passage of Senate Bill 2675 made the Department of Child Protection Services a sub-agency independent of, though housed within, the Department of Human Services. The restructuring included the sharing of resources between the two agencies, such as systems support and other related administrative supports, to enhance efficiency.

100.02 AGENCY DUTIES

100.02.01 DUTIES OF THE DIVISION OF MEDICAID (DOM)

The duties of the Division of Medicaid as set out by State and Federal legislation and the approved State Plan include, but are not limited to:

- Setting regulations and standards for the administration of the Medicaid programs, with approval of the Governor and in accordance with the Administrative Procedures Law.
- Providing Medicaid coverage to all qualified beneficiaries under the provisions of state law and within appropriated funds.
- Establishing reasonable fees, charges and rates for medical services, drugs, equipment and supplies.
- Fair and impartial hearings.
- Safeguards for preserving the confidentiality of records.
- Detecting, investigating and processing alleged violations, fraudulent practices and abuses of the program.
- Receiving and expending funds for the program
- Submitting a state plan for Medicaid in accordance with state and federal regulations.
- Preparing and distribution of required reports to the state and federal government.
- Defining and determining the scope, duration, and amount of Medicaid coverage.
- Cooperating and contracting with other state agencies for the purpose of administering the Medicaid program.
- Bringing suit in its own name.
- Recovering incorrect beneficiary or provider payments including recovery of beneficiary or provider state tax refunds of beneficiaries or providers.
- Establishing and providing methods of administration for the operation of the Medicaid program.
- Contracting with the federal government to provide Medicaid to certain refugees.
- Entering into an agreement with the federal health insurance marketplace as necessary to fulfill the requirements of federal healthcare laws relating to insurance affordability programs that include Medicaid, CHIP and subsidies for insurance coverage through a federal marketplace, effective January 1, 2014.

100.02.02 DUTIES OF THE DEPARTMENT OF CHILD PROTECTIVE SERVICES (DCPS)

The duties of DCPS with regard to Medicaid include:

- Providing the opportunity for persons to apply for Medicaid benefits through all foster care and refugee programs.
- Determining time-limited Medicaid eligibility for certain refugees under the Refugee Resettlement Grant administered by MCPS.
- Determining eligibility for foster children and adoption assistance-related Medicaid applicants and certifying them as eligible, notifying them of eligibility and determining retroactive eligibility, when appropriate.
- Renewing foster care and adoption assistance Medicaid eligibility at required intervals.
- Providing the opportunity for filing appeals and conducting hearings for eligibility certifications that MCPS certifies.
- Identifying and reporting third party resources for foster care and adoption assistance recipients.

100.03 RIGHTS OF APPLICANTS AND RECIPIENTS

Any individual applying for and/or receiving assistance has certain rights relating to receipt of Medicaid benefits, which are addressed in this section.

100.03.01 OPPPORTUNITY TO APPLY

Any individual who requests assistance, including those who are clearly ineligible, must be allowed to apply immediately. Medicaid Specialists must make a reasonable effort to assist the applicant in establishing eligibility.

100.03.02 CIVIL RIGHTS AND NON-DISCRIMINATION

The Division of Medicaid complies with all state and federal policies which prohibit discrimination on the basis of race, age, sex, national origin, handicap or disability as defined through the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973 and the Civil Rights Act of 1964. All complaints of discrimination will be investigated in accordance with state and federal laws and regulations.

100.03.03 ACCESS TO INFORMATION

The applicant, recipient or his authorized/designated representative may have access to information in the eligibility case record to either review the file or request copies of information from the file, in certain situations and under specified conditions as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Act. The privacy restrictions for protected health information (PHI) under HIPAA laws are very specific regarding disclosure of information to and on behalf of a Medicaid applicant or beneficiary. For a complete discussion of privacy policies and privacy procedures for all disclosures and the authorizations forms required prior to releasing case record information, refer to HIPAA Privacy Policies and HIPAA Privacy Procedures located on the DOM website.

HIPAA Privacy Procedures outline the requirements for the release of information, with or without the consent of the beneficiary, and the type and amount of information that is allowed to be released to or for:

ACCESS TO INFORMATION (Continued)

- A Medicaid applicant or recipient, referred to as a beneficiary,
- A personal or legal representative of a beneficiary,
- A parent or guardian of a minor beneficiary,
- Law enforcement agencies or officials,
- Public authorities,
- A judicial or administrative hearing,
- Federal/state agencies,
- Audits or compliance reviews,
- Legislators or elected officials,
- Providers and their contractors.

100.03.04 CONFIDENTIALITY OF INFORMATION

All individuals have the right to a confidential relationship with the Division of Medicaid. All information maintained on recipients, former recipients and denied applicants is confidential and must be safeguarded.

The Division of Medicaid (DOM) will adhere to state laws and federal regulations on the protection of the confidentiality of information about applicants/recipients. Protected information may only be disclosed without the individual's authorization for purposes directly connected with the administration of the program.

This includes:

- Establishing eligibility,
- Determining amount of medical assistance,
- Providing services for recipients, and
- Conducting or assisting an investigation, prosecution and civil or criminal proceeding related to the program.

The Division of Medicaid will also adhere to the Health Insurance Portability and Accountability Act (HIPAA) as it relates to confidentiality of information about applicants/recipients. It is DOM's policy that a valid authorization be obtained for all disclosures that are not for treatment, payment or healthcare operations, to the individual or their representative, to persons involved with the individual's care, to business associates in their legitimate duties or as required by law.

The agency has specified the agencies, persons and circumstances under which applicant or recipient information may be released with or without a recipient's consent. Any other exceptions are subject to prior approval of the DOM Executive Director or the Eligibility Deputy Administrator and DOM's Privacy Officer. Refer to DOM HIPAA Privacy Procedures for a complete discussion of disclosure rules.

100.03.05 PROTECTED INFORMATION

Protected information is of two general types: eligibility/financial and medical. It includes, but is not limited to, the following information:

1. **Eligibility information**

   - Name and address of applicants/recipients;
   - Social and economic conditions or circumstances;
   - Evaluation of personal information such as financial status, citizenship, residence, age and other demographic characteristics;
   - Information received in connection with the identification of legally liable third-party resources;
   - Information received for verifying income eligibility and benefit level.

   NOTE: Income information verifying income eligibility and benefit level received from the Social Security Administration, the Internal Revenue Service, the Veteran's Administration, State Retirement Board or Medicare must be safeguarded according to the requirements of the agency that furnished the data.

2. **Medical information**

   Medical data, including diagnosis and past history of disease or disability;

   - Medical services provided;
   - Medical status, psycho behavioral status, and functional ability;
   - Results of laboratory tests;
   - Medication records.

For a complete and detailed listing of information considered protected health information (PHI) refer to HIPAA Privacy Policies on the DOM website.

100.03.06 RELEASE OF PROGRAM INFORMATION

No Medicaid data regarding recipients, providers or services may be released without prior approval of the Executive Director, unless an established exception applies. The following program information constitutes the only established exceptions which do not require prior approval of the Executive Director:

- The annual report of the Division of Medicaid, published pursuant to state law, containing the total number of recipients, the total amount paid for medical assistance and care; the total number of applications, the total number of applications approved and denied, and similar data.
- Pamphlets, brochures and other documents prepared for distribution to the public.
- Information exchanged with other state or federal agencies pursuant to a contract or written agreement.

If requests for information are received, including requests for large quantities of pamphlets, brochures and other public information, the regional office should forward them to the Office of Eligibility for further action. Requests will be considered pursuant to the Access to Public Records Act, as applicable.

100.03.07 SAFEGUARDING CONFIDENTIAL INFORMATION

The privacy rule protects electronic records, paper records and oral communication. Therefore, employees of the agency are responsible for safeguarding the confidentiality of recipient information in all forms to prevent unauthorized disclosure. In practical terms, this includes:

- Following password and other security procedures for systems;
- Securing cases in filing cabinets rather than leaving them in open view when not in use; and
- Discussing cases or recipients only as necessary for legitimate job-related purposes and in confidential office settings.

SAFEGUARDING CONFIDENTIAL INFORMATION (Continued)

Failure to abide by the policies and procedures regarding confidentiality of recipient and applicant information, either intentionally or unintentionally, can result in disciplinary action. Group offenses are discussed in the DOM Employee Manual under Discipline and Grievance Policies. In addition, any violation of privacy and security policies and procedures may be referred to state or federal agencies for prosecution.

100.03.08 SAFEGUARD AWARENESS TRAINING

Training on the security standards for data provided by the Internal Revenue Service (IRS), the U.S. Citizenship and Immigration Services (USCIS) within the Department of Homeland Security (DHS) and the Social Security Administration (SSA) must be conducted annually for eligibility staff in each regional office. During the training employees are instructed in office security procedures to ensure security of the data and are issued a copy of the federal penalties for unauthorized disclosure of IRS, DHS and SSA information.

A confidentiality statement for each type of data is signed by employees. The employee receiving the training must sign and date the confidentiality statements to certify receipt of security training for each agency's data. The signed and certified statements are forwarded to state office, where they are maintained to document compliance with each agency's safeguard training requirements.

100.04 ELIGIBILITY APPEALS AND FAIR HEARINGS

At the time of any action affecting an applicant or recipient's claim for assistance, the applicant or recipient or his representative (collectively referred to below as the "individual") must be:

- Informed of his right to a fair hearing and right to request an expedited fair hearing;
- Notified of the methods by which he may obtain a hearing; and
- Informed of his right to represent himself at the hearing or to be represented by an authorized person such as an attorney, relative, friend or other spokesperson;
- Notified of the time frames in which the agency must take final administrative action.

The agency must grant the opportunity for a fair hearing to any individual who requests it because his claim for medical assistance is denied or not acted upon with reasonable promptness or because he believes that the agency has taken an action erroneously. Fair hearings must be accessible to individuals who are limited English proficient and to individuals with disabilities. ***A hearing request made in connection with a rebuttal prior to any adverse action being taken will not be accepted***. NOTE: The agency need not grant a hearing when the sole issue is a federal or state law requiring an automatic change which adversely affects some or all recipients.

Notification Regarding Appeal Rights

If an interview is conducted, the right to appeal must be discussed with the individual. In addition, individuals are notified of appeal rights by statements included on the ABD and MAGI application forms and on all notices. A hearings pamphlet is included with adverse action notices informing individuals of the right to appeal and other information about the hearings process. These pamphlets are also available for distribution in regional offices.

100.04.01 THE HEARING PROCESS

Hearings Defined

A fair hearing is an orderly, but informal meeting in which an individual is afforded an opportunity to address an impartial hearing officer for the purpose of presenting oral testimony and/or evidence of his entitlement to medical assistance and services. The individual has the right of confrontation and cross-examination as described further in this section. A fair hearing is a *de novo hearing* which means it starts over from the beginning. A new determination of eligibility is made based on all the evidence that can be secured, without regard to whether the evidence was available at the time the regional office took action. Thus, the process is not essentially different from a determination of eligibility.

Types of Hearings

The individual may request to present an appeal through a local-level standard or expedited hearing, a state-level standard or expedited hearing, or both. In an attempt to resolve issues at the lowest level possible, offices should encourage individuals to request a local hearing first. The only exception to requesting a local hearing is when the issue under appeal involves disability, blindness or level of care. Therefore, the actions below which involve medical decisions cannot be addressed in a local hearing. A state hearing must be requested for:

- A disability or blindness denial or termination, or
- A level of care denial or termination for a Disabled Child Living at Home.

Hearing Methods

Local and/or state level hearings (standard or expedited) will be held by telephone unless, at the discretion of the hearing officer, it is determined that an in-person hearing is necessary.

Regional Office Handling Local Hearing Request

An appeal will ordinarily be filed in the regional office responsible for the adverse decision or delay in action. If the applicant or recipient has moved to another regional office's jurisdiction at the time the appeal is made, it is possible for the regional office serving the current county of residence to act for the former regional office. However, the hearing officer may request the participation of staff in the regional office where the action was originally taken if necessary or advisable.

Representation

The request for a state or local standard or expedited hearing can be made in any of the following ways: in person, via mail, by telephone, or through other commonly accepted electronic means, i.e., fax, e-mail, or online through common web portal.

"*Legal representative*" includes an authorized representative, an attorney retained to represent the applicant or recipient, a paralegal representative with a legal aid service, the parent of a minor child (if the applicant or recipient is a child), a legal guardian or conservator or an individual with power of attorney for the applicant or recipient. All legal representatives must be designated in writing using the appropriate DOM authorization form.

The applicant or recipient may be represented by anyone he designates. If the applicant or recipient elects to be represented by someone other than an authorized, designated or legal representative, he must designate the person in writing using the appropriate DOM authorization form. If a person, other than a legal representative, states that an applicant or recipient has designated him as a representative and the applicant or recipient has not provided written verification to this effect, the regional office will ask the person to obtain written designation from the applicant or recipient using the appropriate DOM authorization form.

Telephone Hearing Requests

An oral request for a hearing made by telephone must be documented in written form by staff handling the call. The specialist will complete the appropriate hearing request form, i.e., DOM 350, Request for Local Hearing, or DOM 352, Request for State Hearing, and sign the form to begin the appeal process via the telephone request.

Written Hearing Requests

When a written request is received electronically or through mail, the specialist will complete the appropriate hearing request form, DOM 350 Request for Local Hearing or DOM 352 Request for State Hearing, and sign the form to begin the appeal process. Any written request received from the client will be attached to the DOM 350 or DOM 352. The request may be submitted to the regional or central office by mail, in-person or by fax or by electronic means. An original signature is not required to be a valid hearing request. If the hearing request does not specify the type of hearing desired, the specialist will contact the person making the request to determine whether a local or a state hearing is being requested. If contact cannot be made within three (3) days of receipt of the hearing request, the regional office will assume a local standard hearing is requested and schedule accordingly.

However, if the hearing involves a medical decision, which requires that a state hearing be held or if a state hearing is requested, the request will be forwarded to the Office of Administrative Appeals in the Central Office for assignment to a hearing officer.

Hearing Requests Made In Person

The individual may come to the regional office or meet with a specialist in person to request a hearing. The specialist must first determine what level of hearing, local or state, is desired. If a state level hearing is *required* because the hearing request is based on a medical decision, this will be explained to the individual. Otherwise, if the individual is unsure of the type hearing desired, the specialist will explain the difference between the two levels of appeal and types of hearings, standard or expedited and explain a state hearing may still be available if the local hearing decision is not favorable. The specialist will assist the individual in completing the appropriate form, DOM-350 or DOM 352, whichever is applicable. If a state hearing is required or requested, the specialist can assist in submitting the request to the central office or the individual may choose to submit it himself.

Appeal By Both Members Of A Couple

When both members of an eligible couple wish to dispute the action or inaction of the regional office that affects both applications and cases similarly and arose from the same issue, one or both members may file the request for a hearing. The couple will be assured that both may present evidence at the hearing and that the agency's decision will be applicable to both. If both file a hearing request, two hearings will be registered, but they will be conducted on the same day and in the same place, either consecutively or jointly, according to the wishes of the couple. If it is their wish for only one of them to attend the hearing, this is permissible.

Time Limit For Filing A Hearing Request

The individual has 30 days from the date the appropriate notice is issued to request either a local or state hearing (standard or expedited). This 30-day filing period may be extended if the individual can show good cause for not filing within 30 days. Good cause includes, but may not be limited to, illness, failure to receive the notice, being out of state, or some other reasonable explanation. If good cause can be shown, a late hearing request may be accepted, provided the facts in the case remain the same.

Time Limit For Filing A Hearing Request (Continued)

However, if the individual's circumstances have changed or if good cause for filing a request beyond 30 days does not exist, a hearing request will not be accepted. If the individual wishes to have his eligibility reconsidered, he may reapply.

Timeframe for Entire Hearing Process (Local and/or State Hearings)

The Division of Medicaid must take final administrative action on standard hearings, whether state and/or local, within 90 days of the date of the initial request for a hearing. Although regulations allow 90 days, the agency will make every effort to hold hearings promptly and render decisions in a shorter timeframe.

The 90-day period for final administrative action must be met except in unusual circumstances when:

- The agency cannot reach a decision because the client requests a delay or fails to take a required action, or
- There is an administrative or other emergency beyond the agency's control.

All delays must be documented in the hearing record or case record, as appropriate.

Scheduling the Hearing

Upon receipt of a request for a hearing, the request will be acknowledged in writing and the hearing scheduled. If a local hearing is requested the regional office will notify the individual in writing of the time and date of the local hearing. A copy of the letter scheduling the local hearing will be filed in the case record. If a state hearing is requested, the hearing officer assigned to the case will notify the appropriate person in writing of the time and date of the state hearing. A request for an expedited hearing must be handled in accordance with 100.04.02, Expedited Hearings, described below.

The notice scheduling the time and date of a state or local standard hearing must be mailed to the individual at least five (5) days before the day the hearing is scheduled. A hearing pamphlet will be included with the letter scheduling either a local or state hearing. Expedited hearing must be scheduled, held and a decision reached within a 7-working day time period, as addressed in 100.04.02.

Attendance at the Hearing

A state or local standard or expedited hearing is not open to the public. All persons attending the hearing will attend for the purpose of giving information on behalf of the applicant or recipient or rendering him assistance in some other way, or for the purpose of representing the Division of Medicaid. All persons attending the hearing will be asked to give information pertinent to the issues under consideration.

Withdrawn or Abandoned Hearings

The hearing process is initiated by a documented request. The request for hearing can be withdrawn by the individual using any of the methods for requesting a hearing – in person, via mail, by telephone, or by other electronic means, i.e., fax, email, or online via common web portal. A state or local standard or expedited hearing request may be withdrawn at any time prior to the scheduled hearing or after the hearing is held, but before a decision is rendered.

For telephonic, online, and other electronic withdrawals, the agency must send the affected individual written confirmation via regular mail or electronic notification in accordance with the individual's communication preference election.

A hearing request will be considered abandoned if the appropriate individual fails to appear or is unavailable for a scheduled hearing without good cause. If no one is available for a hearing, the appropriate office will notify the individual in writing that the hearing is dismissed unless good cause is shown for not attending. Following failure to appear for a hearing, the proposed adverse action will be taken on the case if the action is not already in effect.

Rights of the Individual

The individual has the following rights in connection with a local or state hearing:

- The right to examine at a reasonable time before the date of the hearing and during the hearing the contents of the individual's case record.
- The right to have legal representation at the hearing and to bring witnesses.
- The right to produce documentary evidence and establish all pertinent facts and circumstances concerning eligibility.
- The right to present an argument without undue interference and to question or refute testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses.

Group Hearings

A group hearing can be held for a number of applicants or recipients under the following circumstances:

- The Division of Medicaid may consolidate the cases and conduct a single group standard hearing when the only issue involved is one of a single law or agency policy.
- The applicants or recipients may request a standard group hearing when there is one issue of agency policy common to all of them.

In all group hearings, whether initiated by the Division of Medicaid or by the applicants or recipients, the policies governing fair hearings must be followed. Each individual applicant or recipient in a group hearing must be permitted to present his own case and be represented by his own lawyer or representative or withdraw from the group hearing and have his appeal heard individually. As in individual hearings, the hearing will be conducted on the issue being appealed, and each applicant or recipient is expected to keep his testimony within a reasonable time as a matter of consideration to the others involved.

Medicaid Determinations Made by Other Agencies

Medicaid eligibility determinations that are made by the Social Security Administration (SSA) and certified to the Division of Medicaid are not subject to the administrative hearing procedures of DOM, but are subject to the administrative hearing procedures of SSA. Appeals of a SSI denial or termination must be filed with SSA since that is the agency that determined eligibility for both SSI and Medicaid for the SSI applicant/recipient. However, appeals of eligibility decisions made by the Department of Child Protective Services (DCPS) for foster children whose eligibility was certified by DCPS and appeals of eligibility decisions made by the State Department of Health for Breast and Cervical Cancer for women screened and diagnosed through the Health Department are handled by the Division of Medicaid as state level appeals.

100.04.02 EXPEDITED HEARINGS

An expedited hearing, either local or state, must be granted if the agency determines that the 90-day timeframe described in "Timeframe for the Entire Hearing Process (Local and/or State Hearings)" could jeopardize the individual's life, health or ability to attain, maintain or regain maximum function, i.e., the medical urgency of the individual's situation must be taken into consideration.

An expedited hearing must be granted if the individual attests to an immediate need for a health service or services that, if delayed, could jeopardize the individual's life or health. Take the following into consideration in making the decision to approve or deny a request for a local expedited hearing.

- Does the individual currently have health insurance. If the individual has current coverage, Medicaid and Medicare included, that provides major medical coverage that would cover the cost of an urgent medical procedure or treatment then an expedited hearing would not be granted.
- If the individual is a terminated recipient who requested continuation of benefits within 15 days of the adverse action notice and benefits are continued, an expedited hearing would not be granted.
- Does the individual have an urgent medical procedure or treatment scheduled, or an urgent procedure/treatment that needs to be scheduled that may indicate a need for an expedited hearing. For example, an uninsured high risk pregnant woman attesting to the need for urgent pre-natal care may qualify for an expedited hearing.
- If there is no medical urgency attested to in the request, an expedited hearing will not be granted. The hearing request will be handled as a standard hearing.
- Expedited hearings apply to both MAGI and ABD denied or terminated individuals. However, for ABD purposes, if disability or level of care for a disabled child is the issue under appeal, it must be handled as an expedited state hearing. Expedited appeal requests may be submitted in person, by mail, by electronic submission or orally, as described below.

A request for an expedited local hearing will be granted or denied by the regional office. A request for an expedited state hearing will be granted or denied by the Office of Appeals. If the regional office receives the request for an expedited state hearing, fax documentation of the request to the Office of Appeals upon receipt and follow up by mailing the written request to the Office of Appeals.

Requests for an Expedited Hearing

Due to the time constraints imposed for an expedited hearing and the medical urgency of such a request, prompt and timely action must be taken when the RO becomes aware an expedited appeal is requested. The date the request becomes known by whatever means is the date the expedited appeal request is received.

- If the expedited hearing is granted, the individual will be notified in writing by use of form DOM-351A, Notice of Decision on Request for Expedited Local Hearing that includes the date, time and specifics of the hearing. Use of DOM-350, Request for a Local Hearing, accommodates a request for an expedited hearing. An alternate form of written request can be accepted but must provide the reason an expedited hearing is needed, i.e., describe the medical urgency.
- If the expedited hearing request is denied, DOM-351A, Notice of Decision on Request for Expedited Local Hearing, is used to notify the individual of the negative decision and reason(s) for denial. It also advises the eligibility hearing request will be treated as a standard hearing with separate notification of date, time and location.
- If the regional office has already received a request for a hearing and the individual subsequently requests an expedited hearing, document the case with the date the expedited hearing was requested and how the expedited request was made - in person, via fax, by telephone, or other electronic means - and the reason the individual is requesting an expedited hearing.
    - If a local hearing has not been held, take action to grant or deny the local expedited decision as described above.
    - If a local hearing has already been held and the individual requests an expedited hearing, an additional local hearing is not required. DOM-351, Notice of Decision on Local Hearing, notifies the individual of the expedited hearing decision. The individual has the right to request a state hearing if the local hearing is adverse.

Notice to Grant or Deny a Request for an Expedited Hearing

If a local expedited hearing is requested, the regional office must notify the individual as expeditiously as possible of the decision to grant or deny the request. This is done by telephone or in-person contact. After oral contact is made or if attempts to contact are unsuccessful, the regional office must follow up with written notice of the decision by use of DOM-351A, Notice of Decision on Request for Expedited Local Hearing.

- If the expedited request is granted, the written notice will both approve the request and provide a date, time and specifics for the hearing. It is permissible to give the hearing date to the individual orally when advising that the expedited request has been granted, but a follow up written notice is also required. Allow adequate time for the individual to participate in the hearing while adhering to the 7-day timeframe allowed for the entire hearing process to be finalized.
- If the expedited request is denied because there is no medical urgency or no treatment or procedure needed that will not be covered by existing health coverage, there are no further appeal rights associated with an expedited hearing denial. A denial of a request for an expedited hearing results in the request for an expedited appeal being treated as a standard request for a local hearing. The notice advises that a local hearing will or has been scheduled.

If the regional office has already received a request for a standard hearing and the individual subsequently requests that the hearing be expedited, document the case with the date the expedited hearing was requested and how the request was made (in person, via fax, by telephone or other electronic means) and the reason the individual is requesting an expedited hearing.

Expedited Hearing and Hearing Decision

Expedited local hearings that are granted are held in the usual manner, in-person or by telephone. Granting an expedited hearing means the hearing is scheduled, conducted and a decision rendered expeditiously. It does not mean that any policy or procedures associated with the eligibility process are disregarded. All factors of eligibility must be met and all required verifications received as with all eligibility decisions.

Expedited Hearing and Hearing Decision (Continued)

Individuals granted an expedited local hearing must be issued a hearing decision no later than seven (7) working days from the date the initial request for an expedited hearing request was received. Any delays in meeting the 7-day timeframe must be due to failure on the part of the client to take a required action or an administrative or other emergency beyond the agency's control. All delays in reaching an expedited decision must be documented in the case record.

The expedited appeal decision is treated the same as standard local level hearing decisions as outlined in 100.04.06, Issuing the Local Hearing Decision. The individual has the right to request a state level appeal and has the right to request an expedited appeal. DOM-352, Request for a State Hearing, allows an individual to request a state hearing either after a local hearing or to request only a state hearing and includes the option for an expedited state hearing.

100.04.03 CONTINUATION OF BENEFITS

If a recipient or his representative requests a hearing within the advance notice period, benefits must be continued or reinstated to the benefit level in effect prior to the planned adverse action for both Medicaid and CHIP. Benefits will continue at the original or former level until a final hearing decision is rendered. As stated, if continuation of benefits is applicable, an expedited hearing request will not be granted.

NOTE: The override function in MEDS may be used to reinstate QMB benefits for prior months pending the outcome of a hearing.

Timely Request for Continuation of Benefits

To determine if the request for continuation of benefits is timely, the request must be received by the regional office within 15-days from the notice date. This 15-day period includes the 10-day adverse action period plus 5 days mailing time. Any hearing requested or dated after this period will not be accepted as a timely request for continuation of benefits, unless the individual presents valid evidence to support that the notice was not received within the 5-day mailing time.

Continuation of Benefits When Local Decision is Adverse

The recipient may request a state hearing if the local hearing is adverse. If benefits have been continued pending the local hearing, then benefits will continue pending a state hearing decision *provided* the request for the state hearing is made within 15 days of the date on the Notice of Local Hearing Decision. Local and state hearing procedures are discussed later in this section.

Agency Action Upheld in Final Hearing Decision

When the final hearing decision is adverse to the recipient, the specialist will terminate or reduce the continued benefits using the original reason for the adverse action. The supervisor will waive notice at authorization since a second Notice of Adverse Action is not required. In addition, the Division of Medicaid has the right to initiate recovery procedures against the recipient to recoup the cost of any medical services furnished the recipient under Medicaid and CHIP premiums paid by DOM on behalf of CHIP children, to the extent they were furnished solely based on the provision for continuation of benefits.

100.04.04 PREPARATION OF THE HEARING RECORD

A local hearing record is not needed since an applicant or recipient or his representative is entitled to examine the entire case record prior to or during the hearing; however, the regional office is responsible for preparing the hearing record to be used at a state hearing. The state hearing folder must be forwarded to the Office of Administrative Appeals in the Central Office no later than five (5) days after receipt of the request for a state hearing. The state hearing record will consist of all pertinent information relating to the issue under appeal, including:

- The documented hearing request submitted by the individual;
- A statement prepared by the specialist explaining the action taken on the case and the date of the action. In addition, there must be an explanation of any corrective action taken on the case subsequent to the hearing request;
- Copies of portions of the case record which constitute the basis for the action taken on the case. All hearing records will contain a copy of the application form and the letters and notice(s) (electronic or manual) related to the action under appeal;
- When applicable, a statement as to factors of eligibility not determined at the time of the denial or closure. For example, if the issue under appeal is a denial of disability but income was not established, a hearing on the disability factor will have limited value if the applicant or recipient was also ineligible on income or some other factor.

100.04.05 HOLDING THE LOCAL HEARING

The regional office is responsible for scheduling and rendering decisions on local hearings.

Purpose of a Local Hearing

The purpose of the local hearing is to provide an informal proceeding to allow the individual to:

- Present new or additional information;
- Question the action taken on the case, and
- Hear an explanation of eligibility requirements as they pertain to the individual's situation.

Scheduling the Local Hearing

When a request for a local hearing is received, the regional office will schedule the local hearing no later than 20 days after receipt of the request. The applicant or recipient will be allowed time to obtain additional information or request an attorney, relative or friend to attend the hearing and give evidence. The regional office may not schedule a local hearing without giving five (5) days advance notice to the individual unless the individual waives advance notice time. The case record will be documented if advance notice is waived.

Person Conducting the Local Hearing

The regional office staff member who conducts the hearing must be one who has not participated in determining eligibility or directed the decision. Although a supervisor may have officially authorized the eligibility decision, if he/she has not actually taken part in the eligibility decision the supervisor will hold the hearing. However, if the supervisor made the actual determination of eligibility on the case, he/she cannot hold the local hearing and another person must be designated to conduct the hearing.

Preparing a Summary of the Hearing

After a local hearing is held, the person who conducted the hearing will prepare a summary of the hearing procedure. The summary serves the same purpose as a transcript and is filed in the case record.

NOTE: The summary of the local hearing must be included as part of the state hearing record when a state hearing is requested after an adverse local hearing decision. The local hearing summary must contain sufficient information to enable the state hearing office to have a clear understanding of what transpired during the local hearing.

100.04.06 ISSUING THE LOCAL HEARING DECISION

The regional office staff member who held the hearing will carefully review and consider the facts presented during the local hearing in rendering the local hearing decision. When a decision has been reached, the individual must be notified of the decision via DOM-351, Notice of Decision on Local Hearing. This form must be used since it advises the individual of the right to request a state hearing.

The DOM-351 must clearly state the reason for the decision and the policy which governs the decision. Also, if the hearing is denied, the new effective date of closure or reduced benefits must be included on the form if continuation of benefits applied during the hearing process. The new effective date of closure or reduced benefits must include an effective date at the end of the 15-day advance notice period allowed via DOM-351. A second Notice of Adverse Action is not required; therefore, the second eligibility notice should be waived at authorization if benefits are terminated or reduced as a result of the local hearing decision.

However, if a state hearing is subsequently requested within the 15-day advance notice period and continuation of benefits is applicable, the regional office will reinstate the individual’s eligibility pending the outcome of the state hearing.

100.04.07 TAKING ACTION ON THE CASE

The regional office is responsible for taking any corrective action required as a result of a local or state hearing decision rendered in favor of the applicant or recipient or for processing the original planned action on the case which was the basis for the appeal if continuation of benefits applied pending the hearing decision.

100.04.08 STATE HEARING REQUESTED AFTER ADVERSE LOCAL DECISION

As indicated, the individual has the right to appeal a local hearing decision by requesting a state hearing; however, the state hearing request must be made within 15 days of the mailing date of the DOM-351. This means the state hearing request must be received by the regional or central office on or before the 15th day after the local hearing notice is mailed. The state hearing request may be submitted to the regional or central office by mail, in-person, by fax or by other commonly accepted electronic means, such as fax, email, or online through common web portal. An original signature is not required to be a valid state hearing request.

If benefits have been continued pending the local hearing decision, then benefits will continue throughout the 15-day advance notice period when the local hearing decision is adverse. If a state hearing is requested timely within the 15-day period, then benefits will continue pending the outcome of the state hearing.

State hearings requested after the 15-day advance notice period for the local hearing will not be accepted unless the 30-day period for filing a hearing request has not expired because the local hearing was held early in the 30-day period and there is time remaining.

100.04.09 STATE HEARINGS

When a request for a state hearing is received in the regional office, the request will be noted with the receipt date and forwarded to the central office. A copy of the state hearing request will be retained for the case record. The regional office will proceed with preparation of the state hearing folder. The folder must be mailed within five (5) days of receipt of the state hearing request.

If the request for a state hearing is submitted directly to state office, notification of the request will be forwarded to the appropriate regional office so the state hearing record can be prepared and sent in.

A state hearing is assigned to an impartial hearing officer. Impartial means the hearing officer has not been involved in any way with the action or decision under appeal.

100.04.10 REVIEW BY STATE HEARING OFFICER

Upon receipt of the state hearing folder, the hearing officer will review the material submitted. If the review shows an error was made in the action of the regional office or in the interpretation of policy or that there has been a change in policy, the hearing officer will discuss the issue with the Benefit Program Supervisor, over the regional office involved in the hearing and if appropriate, ask that an adjustment be made. The regional office will then discuss this matter with the individual. If the individual is agreeable to the adjustment of the claim, the state hearing request will be withdrawn.

Otherwise, if the action of the regional office is in order, the hearing officer will request any additional information from the case record that appears to be needed and will schedule the hearing.

100.04.11 HOLDING THE STATE HEARING

In conducting the hearing, the hearing officer will provide the following information to those present:

- The hearing will be digitally recorded. This information is made available to the individual upon request.

Holding The State Hearing (Continued)

- An explanation of the individual's rights during the hearing.
- That the purpose of the hearing is for the individual to question the agency's decision and present additional information or evidence.
- The reason for the hearing, i.e., the action taken by the regional office which prompted the appeal.
- That the case record is available for review by the individual during the hearing.

  NOTE: Even though the state hearing officer uses a hearing folder to conduct the hearing, the actual case record must be available for review by the individual before, during or after the state hearing.

- The final hearing decision will be rendered by the Executive Director of the Mississippi Division of Medicaid on the basis of the facts presented at the hearing and the case record material and that the individual will be notified by letter of the final decision.

During the hearing the individual will be allowed an opportunity to make a full statement concerning his appeal and will be assisted, if necessary, in disclosing all information on which the claim is based. All persons representing the applicant or recipient and those representing the regional office will have the opportunity to state all facts pertinent to the appeal. When all information has been presented, the hearing officer will close the hearing.

100.04.12 RECESSING OR CONTINUING A STATE HEARING

If additional information is determined to be needed during the state hearing, the hearing officer may recess or continue the hearing as follows:

- Recessing the Hearing
  If additional information is needed and this information is readily available, the hearing officer will recess the hearing for the time required to obtain the facts.

- Continuing the Hearing
  If the information needed is not readily available, the hearing officer will continue the hearing to a suitable later date. If the time at which the information will be obtained is known, the hearing officer, before adjourning the original hearing, will set the time and place for the continued hearing at the earliest possible date, notifying the principals that there will be no further notice. The hearing officer will reach an agreement with the applicant or recipient and any persons attending on his behalf about bringing the needed information to the continued hearing.

The hearing cannot be extended beyond the time limit for completion of a hearing.

100.04.13 CHANGES WHICH OCCUR DURING THE HEARING PROCESS

If the regional office becomes aware of a change in circumstances of the applicant or recipient which will result in an adverse action other than the issue currently under appeal, the individual must be notified in writing. Adverse action notice requirements (10-day notice plus 5 days mailing time) must be met and action taken as follows:

Change Discovered Prior to State Hearing

If the state hearing has not yet been held, the individual may choose to have the new adverse action issue incorporated into the current appeal; however, the individual must first request an appeal in the usual manner. If the new hearing request is filed in time for the issue to be considered in the current hearing process, the regional office will notify the hearing officer of the additional issue under appeal. In this instance, the hearing may have to be rescheduled to allow the individual time to prepare for the hearing.

Change Discovered During the State Hearing

If the change in circumstances is discovered during the actual hearing, the hearing officer will recess the hearing and notify the regional office to send an adverse action notice to the individual. The hearing will be reconvened after the adverse action notice is mailed and the advance notice period has expired. The individual may choose to include the new issue in the hearing when it is reconvened. The hearing will be reconvened following the usual procedure for setting the time and place.

100.04.14 REVIEW BY DDS STAFF

When the issue under appeal is disability or blindness, a review by DDS is required. After the hearing, the hearing officer will forward all medical information to the Disability Determination Service for reconsideration.

A review team consisting of medical staff who were not involved in any way with the original decision will review the medical information and hearing transcript and give a decision on the disability or blindness factor. The DDS decision is final and binding on the agency.

100.04.15 RECOMMENDATION OF THE STATE HEARING OFFICER

After the hearing, the final decision of the hearing officer must be based on oral and written evidence, testimony, exhibits and other supporting documents which were discussed at the hearing. The decision cannot be based on any material, oral or written, not available to and discussed with the individual.

Following the hearing, the hearing officer will make a written recommendation of the decision to be rendered as a result of the hearing. The recommendation, which becomes part of the state hearing record, will cite the appropriate policy which governs the recommendation.

100.04.16 DECISION OF THE AGENCY

The Executive Director of the Division of Medicaid, upon review of the recommendation, proceedings and the record may sustain the recommendation of the hearing officer, reject the recommendation or remand the matter to the hearing officer for additional testimony and evidence, in which case the hearing officer will submit a new recommendation to the Executive Director after the additional action has been taken.

As soon as possible after the hearing officer makes a recommendation, a written decision summarizing the facts and identifying the policies and regulations which support the decision will be prepared and mailed to individual, with a copy to the regional office, Bureau Director, Deputy, and the Deputy Administrator for Eligibility.

The decision letter will specify any action to be taken by the agency and any revised eligibility dates. If the decision is adverse and continuation of benefits is applicable, the individual will be notified of the new effective date of reduction or termination of benefits or services, which will be fifteen (15) days from the mailing date of the notice of decision.

The decision of the Executive Director of the Division of Medicaid is final and binding. The individual is entitled to seek judicial review in a court of appropriate jurisdiction. Should the individual file an appeal the second time without a change in circumstances or agency policy, the individual will be notified in writing by the appropriate office explaining that the appeal cannot be honored. If the individual's circumstances or agency policy have changed, the individual will be advised to file a new application.

100.04.17 REGIONAL OFFICE RESPONSIBILITIES IN THE HEARING PROCESS

Each Regional Office (RO) must have a system in place to track and monitor hearing requests from the date of receipt through the final appeal decision.

- Each RO must promptly identify and document all hearing requests received by the office and immediately route the request to the appropriate person in the office assigned to handle hearing requests. This person will review the case record to ensure:
    - The proper person is filing the request, i.e., the person with authority to act for the individual. If not, contact the appropriate person to determine if a hearing needs to be requested.
    - An expedited hearing request is handled appropriately, i.e., the request is granted or denied according to policy and DOM-351A is issued accordingly. If granted, the hearing must be held and a decision issued within the timeframe allowed, i.e., 7-working days.
    - The action taken on the case was correct and all needed verifications are present in the record. If not, immediate corrective action is needed and the individual so notified.
    - Continuation of benefits is authorized, if applicable.
    - That the case is assigned to the correct staff person who will schedule and hold the local hearing or that a state hearing request is correctly and promptly processed.
- Each regional office is responsible for all activities involved in the local hearing process and for taking appropriate action on the case at the end of the hearing process in a timely manner as outlined in the chart below.

100.04.18 TIMELINESS OF HEARING ACTIONS – RO RESPONSIBILITIES

Step 1. Determine timeliness of hearing request
o All hearing requests have **30 days** from date on the notice to request a hearing. o Terminations have **15 days** from date on notice to have benefits continue and **30 days** from the date on notice to request a hearing. o An expedited hearing request is subject to a 7-day timeframe for scheduling and holding the hearing and issuing a decision provided the request, oral or written, is received within 30-days from date on the notice. If continuation of benefits applies, an expedited hearing is not granted. o If hearing is not requested timely and there is no evidence to support the notice not being received within the advance notice period, issue written notice to the client that the hearing request will not be honored because time to request hearing expired. A new application would be required in order to appeal. o The agency has **90 days** from the date of the hearing request to schedule, conduct and finalize a hearing. RO's must handle hearing requests promptly, as soon as received, to ensure the hearing timelines described below are met.
Step 2. Determine the type of hearing requested or required.
o DDS and Level of Care denials require a state level hearing – handle as state hearing. o If request does not specify type and issue is not DDS or LOC denial, contact client. If no contact within **3 days**, assume a standard local hearing is needed and proceed. o If the request indicates medical urgency, evaluate whether an expedited local (or state if DDS or LOC at issue) is needed and handle accordingly.
Step 3. Re-examine action taken to determine if correct.
o If correct, proceed to Step 4. o If incorrect, take corrective action and notify client.
Step 4. Schedule local hearing, if appropriate.
o Local hearings must be scheduled no later than **20 days** after receipt of the request. o Schedule local hearing **5 days** in advance, in writing. o Expedited hearings must be held and a decision issued within 7-days of the request. Make telephone contact with individual to schedule hearing then follow up in writing via DOM-351A.

Step 5. Hold a local level hearing, if appropriate.

- Must be held by supervisor not directly involved with the eligibility decision.
- Expedited local hearing must be held as soon as possible to meet 7-day timeframe.
- Prepare a local hearing summary.
- Take action on local hearing decision – corrective action as needed or uphold original RO decision.
- If benefits have been continued pending the local hearing, continue benefits through advance notice period when local decision is adverse.
- Client has **15 days** from local hearing decision to request a state hearing whether benefits have continued or not. Exception is the original 30-day period for requesting a hearing has not expired which lengthens the time allowed.
- Request for expedited state hearing following adverse local hearing must be referred to Office of Appeals on date written request for state hearing is received.

Step 6. Prepare for state level hearing if applicable.

- Prepare a state level hearing folder within **5 days** of request for a state hearing:
  - 5-days from original hearing request (Step 1), or
  - 5-days from state hearing request following adverse local hearing.
  - If expedited state hearing is requested, hearing folder must be prepared and forwarded immediately upon receipt of the request to Office of Appeals.
  - Ensure hearing folder has all required material.
- Take action on state level hearing decision when received. No additional notices are issued by RO. Hearing decision letter addresses all issues under appeal.

Changes Which Occur During the Hearing Process

- A change that becomes known during the hearing process that is not related to issue under appeal is handled as a separate adverse action (requires 15-day notice).
- New adverse action can be combined with current issue under appeal if time allows.
- A change that becomes known during actual state hearing will result in a recess so that an adverse action notice may be issued by RO. New adverse action may be combined with state hearing when reconvened.

100.05 IMPROPER PAYMENTS

When Medicaid benefits are available to recipients improperly, the central and regional office must identify these situations and take corrective action. Improper payments occur when the Medicaid or CHIP coverage authorized by DOM either underpays or overpays a recipient's fee-for-service or managed care costs. An improper payment may be in the form of an underpayment or an overpayment. Corrective action includes recovering misspent funds directly from a recipient or from the recipient's state tax refund.

Improper payments situations include, but are not limited to, the following:

- Begin or end dates of eligibility are incorrect or total ineligibility exists.
- A category of eligibility is incorrectly assigned based on incorrect eligibility information entered in the system.
- Incorrect Medicaid Income is calculated due to over or under reported income.
- Policy is misapplied that impacts eligibility.
- A case is not reviewed timely or a change is not reported timely and the review or change results in benefits that should have been reduced or results in ineligibility.
- A transfer of assets is discovered after eligibility has been approved.
- An applicant willfully or unintentionally withheld information that impacted eligibility.

Underpayments

An underpayment occurs when Medicaid has not paid its full share of a recipient's medical expenses or managed care payments. All underpayments are to be corrected upon discovery.

If the underpayment resulted from agency error, the error may be corrected retroactively. Underpayments resulting from recipient errors are corrected, but they are not corrected retroactively. Necessary adjustments are made effective with the next month a change can be made. For further discussion, refer to the policy on reinstatements in Chapter 101.

Overpayments

An overpayment occurs because the recipient was actually ineligible for a period during which he received Medicaid or CHIP, or because Medicaid paid more than its correct share of medical expenses or managed care payments or more for institutional cost of care than it should have. An overpayment may result from the following:

- **Suspected Fraud**

  The ABD and MAGI application forms carry a warning about the penalty for giving false information, so that when the individual gives the information to complete the application and signs it, he has been put on notice about giving incorrect or incomplete information as well as the requirement to report changes.

  Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some benefit to which the individual is not entitled or to a benefit greater than that to which the individual is entitled. It includes any act that constitutes fraud under applicable federal or state law.

  Fraud is a serious charge to make and the results can be serious. As a result, the facts in such a case must be clearly and accurately stated. The Mississippi courts have ruled, "There is a presumption against fraud, dishonesty and bad motive, and evidence to overcome this presumption must be more than mere preponderance; it must be clear and convincing. "

<u>Overpayments</u> (Continued)

Although fraud is a question for courts to decide, the regional office must determine suspected fraud, i.e., whether there is a basis for belief that fraud may have been committed. In making this decision, the specialist must consider the individual's intent; and the individual's mental capacity.

Also, a clear distinction, based on verified facts, must be made between misrepresentation with intent to defraud and mis-statements due to misunderstanding of requirements or of the individual's responsibility to report information.

It is also important to distinguish between suspected fraud and omission, neglect or error by regional office staff in helping the applicant or recipient to understand his responsibilities and in securing and recording pertinent information.

An applicant or recipient may be suspected of fraud when the individual willfully and knowingly and with intent to deceive obtained Medicaid or CHIP by:

- Making a false statement or misrepresentation; or
- Failing to disclose a material fact; or
- Not reporting changes in income or other eligibility factors that affect the benefit; and
- As a result of the action or inaction, the individual obtains or continues to receive assistance. In other words, if the information had been known, it would have resulted in denial or reduction of benefits to the individual or would have resulted in a different amount of Medicaid Income.

- **Client Error**

In situations involving client error, there is no proof that individual (applicant, recipient or his authorized representative) acted willfully and intentionally to obtain more benefits than those he was entitled to receive. Instead, the individual gave incomplete, incorrect or misleading information because he misunderstood, was unable to comprehend the relationship of the facts about his situation to eligibility requirements or there was other inadvertent failure on the individual's part to supply the pertinent or complete facts affecting Medicaid or CHIP eligibility.

Overpayments (Continued)

The specialist must be alert to whether or not the individual understood that the information he gave or withheld had a bearing on his eligibility or the amount of his Medicaid Income.

- **Agency Error**

  Agency errors occur in instances such as the following:

  - The specialist misapplies policy or fails to follow procedures which would have resulted in denial or closure if the correct action had been taken.
  - The specialist makes a mathematical error in the test for financial need; enters incorrect income or resource figures in the system, transposes figures or otherwise determines eligibility using incorrect income or resources when the correct information was available in the case record.
  - The redetermination is not completed timely and the specialist subsequently finds information leading to ineligibility. In this instance all benefits received following the review due date are improper due to agency error. Had the review been completed timely, the case could have been closed to prevent improper benefits from being received.
  - The specialist fails to take action on a reported or anticipated change, fails to check information available to the agency or overlooks a clue which, if pursued to conclusion, would have led to a finding of ineligibility. Examples are:
    - Failure to follow-up when the individual reports that he expects a definite stated change in his income, living arrangement or other area impacting eligibility.
    - Failure to follow-up when an applicant or recipient is asked to apply for a possible benefit, such as Social Security, veteran’s benefits, unemployment compensation or other retirement or disability benefits.

Overpayments (Continued)

- Failure to follow-up when the individual reports a plan to sell, transfer, or otherwise dispose of his property, real or personal, or to buy or acquire property otherwise.
- Failure to check data sources for unreported income.

- The central or regional office, through system or human oversight or failure, authorizes or continues eligibility to an ineligible person or improperly computes Medicaid Income.

There are no exceptions for taking corrective action to resolve an agency or client caused error and there are no exceptions for preparing and submitting an Improper Payment Report for improperly paid Medicaid or CHIP benefits when one is applicable.

100.05.01 IMPROPER PAYMENT REPORTING

Completion of the Improper Payment Report by Regional Office

Form DOM-354, Improper Payment Report, will be prepared to report improper payments for ABD and MAGI. The 354 should be completed no later than the month following the month of discovery according to form instructions with the following information included:

- The factor of eligibility involved, and how the information given or withheld affects eligibility or Medicaid Income;
- What the individual said about the factor in question and the date on which the information was given, whether the individual gave statements on the application or gave them verbally to the specialist and the reason the individual gave for withholding or falsifying the information;
- The date on which and the circumstances under which the specialist learned of the correct information.

IMPROPER PAYMENT REPORTING (Continued)

- Steps the specialist has taken to verify the correct information. For example, securing bank statement, checking property records, contact with insurance company or employer, etc.
- Whether the specialist considers the withholding or giving incorrect information to be willful, whether the individual was able to understand reporting responsibilities for giving accurate information and the meaning of his failure to do so.
- Whether the applicant or recipient (and spouse) have resources from which to repay the amounts improperly received.

Instances to Delay Preparation of the Report

Preparation of the Improper Payment Report should be delayed as follows:

- If a transfer of resources is involved, DOM-322 must be issued and an opportunity for rebuttal offered; therefore, preparation of the Improper Payment Report must be delayed until after the period for rebuttal is over.
- If substantial home equity is discovered and verified, a DOM-314 must be issued and an Improper Payment Report delayed until the rebuttal period is over.
- If a hearing has been requested, preparation of the Improper Payment Report should be delayed until all appeals have been exhausted and a final decision has been issued on the eligibility factor.

Calculating Overpayments

Overpayments may result when a recipient is found ineligible or eligible for reduced benefits or a different amount of Medicaid Income. In calculating the overpayment, the specialist will:

- Determine the action which would have been taken at the time had the correct information been known to the agency or had the agency taken timely action;
- Determine the effective date action would have been taken had the correct information been known to the agency;
    - For an unreported change, determine the earliest date the agency can substantiate that the recipient was aware of the change. The effective date of the change will be used if the agency cannot document an earlier date. Then allow time for the change to have been reported by the individual (10 days) and acted on by the agency (10 days). Then consider the 15-day adverse action notice or timely notice requirement, as applicable, in determining the beginning month of the overpayment.

      Example: On August 25th, the RO received verification a CHIP recipient became covered by other full health insurance effective May 1st. Eligibility is terminated effective September 30th. The beginning month of the CHIP overpayment is July (allowing the 10/10/15 day rule) and the improper payment period runs through September.

      Example: An ongoing recipient failed to report a new marriage which occurred on May 10th. The marriage was reported on August 9th. The spouse's income causes ineligibility and the case was closed September 30th. The DOM-354 must be submitted in September for the period July through September using the 10/10/15 rule for determining the beginning date of the improper payment period.
    - When dealing with information withheld or improperly reported at application, the first benefit month will be the first month of the overpayment. Do not apply the 10/10/15 day rule for improper payments that begin with the month of application.

Calculating Overpayments **(Continued)**

Example: A Healthier MS applicant is approved effective May 1. It is subsequently determined on November 12th he had failed to report resources exceeding the limit at time of application. The case is closed effective November 30th. The beginning month of the Medicaid overpayment is May and the improper payment period runs through November. DOM-354 must be submitted in December, the month after the month of discovery of the improper payment.

Example: An applicant fails to report a spouse with income living in the household when applying on January 10th. The case was approved effective January 1st. The unreported marriage and spouse living in the home was discovered by the RO in August and the case is closed September 30th. The Improper Payment period is January through September. DOM-354 must be submitted in September.

- If a change was reported timely, but the agency failed to take action on the reported change, the first month of the overpayment will be the effective month the regional office should have made the change. Allow 10 days for the specialist to process the change and 15 days for the advance notice period.
- A child under age 19 is entitled to 12-months continuous eligibility provided the approval of eligibility was correct at the time of application or renewal. The continuous eligibility period does not apply to a child approved in error at application or at renewal. For instance, if health insurance coverage is not reported on the MAGI application for a child approved in CHIP, any months the child was on CHIP with insurance are improper payment months.
- Children are also subject to the "early-out" termination reasons, such as when a current CHIP recipient obtains insurance after approval. If this change is not reported or acted on timely, an Improper Payment Report is needed. Apply the 10/10/15 day rule to determine the beginning date of the improper payment period which runs through and includes the month of closure of the CHIP case.

Calculating Overpayments (Continued)

- Use appropriate income and resource levels for the time period in question.
  - For cases with unreported resources or income, obtain verification and re-budget using the verified resources or income received during the period in question.
  - If multiple reportable changes occurred, re-budget each change in the order in which it occurred.
- Always evaluate eligibility for Extended Medicaid before establishing an overpayment for a family whose parent/caretaker becomes ineligible due to earnings or child support (after 01/01/2014, child support is no longer income but spousal support would apply).
- Evaluate each person's eligibility for other coverage groups. For example a parent/caretaker may no longer be eligible but the child(ren) in the case may continue to qualify.

Submitting the Improper Payment Report

Once the specialist completes the Improper Payment Report, the form must be reviewed and signed by a supervisor. The completed report with pertinent information supporting referral of the case for an improper payment is then submitted to the Bureau Director, Deputy for final review prior to sending the report to the Office of Eligibility.

Processing the Improper Payment Report

When the Improper Payment Report and supporting documentation are received in the Office of Eligibility, designated staff will:

- Review the report to ensure it is complete and that policy has been properly applied. This process may involve further contact with the regional office for additional information or clarification if supporting documentation is unclear or lacking.
- Determine the total improper amount of Medicaid Income or CHIP premiums paid in error.

- Approve the report and transmit the Improper Payment Report and attachments to the Third Party Liability Unit (TPL) for recovery efforts.

100.05.02 CLAIMS AGAINST ESTATES

When it is determined a recipient has received benefit to which he was not entitled and the recipient is deceased, the improper payment should be reported immediately. If the Improper Payment Report has already been submitted and the regional office learns of the death of the individual, this should be reported to the Office of Eligibility immediately.

When the TPL discovers a transfer(s) during the estate recovery process, the case will be referred back to the regional office. The transfer must be developed in the usual manner following transfer policy and procedures. An Improper Payment Report will be completed, if applicable, after the rebuttal process has concluded.

100.06 QUALITY CONTROL

A Medicaid Eligibility Quality Control (MEQC) review on a random sample basis is required by federal regulations on all non-SSI Medicaid actions handled by the regional offices. On a monthly basis, cases are selected for review from the MMIS Recipient file using an approved sampling method. The sampled cases are assigned to a Medicaid Investigator who will:

- Request that the regional office mail the case to his/her attention at the state office;
- Review the case record, make copies of pertinent material, record information on MEQC forms;
- Return the case to the appropriate regional office within 2 weeks after it is received;
- Conduct a field investigation as defined by MEQC policy;
- Complete the review and make an eligibility decision based on MEQC findings and federal and state policy.

The MEQC supervisor then reviews the investigator's findings and notifies the regional office of the review outcome. A copy of the MEQC memorandum is also issued to the Bureau Director, Deputy, over the regional office and the Deputy Administrator for Eligibility.

Regional Office Responsibilities

The Medicaid Regional Office will:

- Mail the case record to the appropriate Medicaid Investigator upon receipt of a MEQC request;

- Review the case record upon receipt of notice of MEQC findings to determine if there is agreement with the finding;

- When there is a disagreement with the finding, send a memorandum immediately stating the reason for the disagreement and providing any relevant information to the Bureau Director, Deputy, who will review and forward the disagreement to the Office of Eligibility. Appropriate policy staff will complete a final review before the disagreement is provided to the MEQC supervisor for re-consideration.

100.06.01 MEQC DISAGREEMENT RESOLUTION PROCESS

The request for reconsideration must be received from the regional office within a 2-week period based on the mailing date of the MEQC findings to the regional office. As indicated, staff in the Office of Eligibility will review the information and if the disagreement is appropriate, will forward it to the MEQC supervisor requesting reconsideration. MEQC will:

- Review the regional office's reconsideration request and make a final decision on the review;
- Make corrections on the MEQC worksheets, if necessary;
- Provide a written notice of the decision to the regional office;
- Make final MEQC findings to CMS within the timeframe and manner required in federal regulations.

NOTE: The finding will not be reconsidered if the request for reconsideration is received more than 2 weeks from the mailing date of the original finding to the regional office.

100.06.02 FAILURE TO COOPERATE WITH MEQC

If the recipient fails to cooperate with Medicaid Quality Control and the investigator is unable to obtain information needed to complete the review, it will be referred back to the regional office for a redetermination. As part of the redetermination process, the information needed by Quality Control will be requested. If the information is not provided, coverage will be terminated because the agency is unable to determine eligibility.

100.06.03 CORRECTIVE ACTION

A corrective action committee at the Division of Medicaid is responsible for reviewing the overall MEQC findings after the review data has been compiled. If the state error rate exceeds federal tolerance, a corrective action plan must be implemented. The Office of Eligibility is responsible for identifying major error trends and planning, developing and evaluating the short and long-term responsibilities, tasks, and goals of the corrective action plan. Implementation of the plan involves staff at the state and regional levels working together to eliminate or reduce errors and misspent dollars identified through the MEQC process.