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SECTION K - IMPROPER MEDICAID BENEFITS & QUALITY CONTROL

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QUALITY CONTROL

A. INTRODUCTION

A Medicaid Eligibility Quality Control (MEQC) review on a random sample basis is required by federal regulations on all Non-SSI aged, blind, and disabled actions handled by the Medicaid Eligibility Division, Regional Office. To carry out this function, it will be necessary that staff follow the procedures set out below.

B. MEQC PROCEDURES

MEQC reviews are accomplished by MEQC Management Staff, Medicaid Investigators with Quality Control and Medicaid Regional Office staff.

1. MEQC Management Responsibilities

The MEQC Management Staff will:

- Submit MEQC Sampling Plan information to the HCFA Regional and Central Offices for approval as required by federal regulations.

- On a monthly basis, identify the cases to be reviewed by using a HCFA approved scientific random sampling method of the aged, blind, disabled Medicaid only cases in the MMIS Recipient file.

- Assign the sampled cases to the appropriate Medicaid Investigator who will conduct the field audit on the cases.

- Review the Medicaid Investigator's MEQC findings and clear with the Medicaid Investigator as necessary.

- Notify the Medicaid Regional Office of the MEQC findings with a copy of this notification to the Medicaid Eligibility Division.

- Submit the appropriate MEQC findings to the HCFA Regional and Central Offices in the time and manner as required by federal guidelines.

2. Medicaid Investigator Responsibilities

The Medicaid Investigator of the MEQC Unit will:

- Instruct the Medicaid Regional Office to mail the case record to his/her attention in the State Medicaid office.
- Analyze the case record, make copies of pertinent material, record information on the MEQC work forms.
- Return the case record to the appropriate Regional Office no later than two weeks after it is received.
- Conduct a field investigation in accordance with the MEQC policy.
- Complete the review with decisions based on MEQC findings and federal and state policy.

3. Medicaid Regional Office Responsibilities

The Medicaid Regional Office will:

- Immediately upon receipt of a request for a case record from MEQC, mail the case record to the appropriate Medicaid Investigator.
- Upon receipt of the notice of MEQC findings, review the report and determine if agreement exists.
- If the Regional Office disagrees with the MEQC findings, a memorandum should be sent immediately to the Medicaid Eligibility Division stating the reason for the disagreement and providing any relevant documentation. The disagreement will be resolved as described below.

4. Disagreement Resolution With MEQC Findings

When the Medicaid Eligibility Division receives a reconsideration request from a Regional Office within the two week period from mailing of the MEQC findings to the Regional Office, staff in the Medicaid Eligibility Division will review the information provided by the Regional Office and forward to the MEQC Unit for reconsideration.

The MEQC Unit will:

- Review the Regional Office reconsideration request and accompanying documentation 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 Medicaid Regional Office.

- Report final MEQC findings to the HCFA Regional and Central Offices in a time and manner as required by federal regulations.

NOTE: A reconsideration cannot be made on a MEQC finding if the request for the reconsideration is received more than two weeks after the mailing of the MEQC notice to the Medicaid Regional Office.

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C. CORRECTIVE ACTION

A corrective action committee at the Division of Medicaid will be responsible for reviewing the overall MEQC findings after the data has been compiled at timely intervals.

The four areas of corrective action and analysis are:

1. Program Analysis

Program analysis uses the analyzed MEQC findings as well as other relevant information to identify causes of errors in eligibility and claims processing. Often, this involves selecting a particular concentration of error types for further analysis. The data and program analysis findings are combined with other relevant information for corrective action planning.

2. Corrective Action Planning

This activity identifies, evaluates, and selects ways to eliminate or reduce errors in each program process. Corrective actions are designed to make changes in agency policies. Some resulting changes may take substantial deployment of resources and lead time for implementation while others may be short range in nature. However, both types of corrective action measures require the same process of planning, development, and implementation.

3. Corrective Action Implementation

Corrective action implementation represents the point at which the State agency translates all the preceding information, analysis, and decisions into action. The implementation process includes assignment of responsibility for specific tasks, tracking of task completion, and measurement of progress.

4. Corrective Action Evaluation

This activity analyzes whether the implemented corrective action has eliminated or reduced the error rates and misspent dollars in the areas of eligibility and liability determinations or claims processing.

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IMPROPER MEDICAID BENEFITS

A. INTRODUCTION

When Medicaid benefits are made available to the recipients improperly, the State and Regional Offices must identify and take action to recover the amounts thus paid.

Improper payments arise from the following sources:

- Cases of suspected fraud. That is, the individual at the time of application or during the period of eligibility willfully falsifies, misrepresents, or withholds information which, if known, would have resulted in denial or reduction of Medicaid benefits to that recipient or a difference amount of Medicaid Income.

- Cases involving misunderstanding by the recipient (client error) or agency error.

- Cases involving the improper use of a Medicaid card by a person other than the eligible recipient.

B. TYPES OF IMPROPERLY PAID MEDICAID BENEFITS

When the Regional Medicaid Office becomes aware of a possible improper eligibility situation through contact with the client, quality control report, State Office referral or other source, the Regional Office will establish the facts and initiate appropriate steps to correct the case. The Regional Office will also determine the type of improper Medicaid eligibility situation.

The types are explained below. After determining the type of improper payment involved, the Regional Office will initiate an Improper Payment Report (DOM-354) to the State Medicaid Eligibility Division.

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1. Suspected Fraud

A decision of suspected fraud will be determined using the following principals:

- Whether the applicant or recipient obtained Medicaid by making a willfully false statement or by knowingly withholding information bearing on his eligibility. The worker must be alert to indications as to whether or not the client understood that the information he gave or withheld had a bearing on his receipt of Medicaid or the amount of his Medicaid Income.

- Whether the applicant or recipient had given information on other factors of eligibility or at other times which appeared to contradict the later statements he made, and whether it appeared that he made the later statements knowing that they are different.

- Whether the Regional Office relied on the client's statement of his action, and granted or continued Medicaid to him on the basis of his statement.

Section 43-13-129 Mississippi Code of 1972 states: "Any person making application for benefits under this article for himself or for another person, and any provider of services, who knowingly makes a false statement or false representation or fails to disclose a material fact to obtain or increase any benefit of payment under this article shall be guilty of a misdemeanor, and upon conviction thereof, shall be punished by a fine not to exceed Five Hundred Dollars ($500.00) or imprisoned not to exceed one year, or both such fine and imprisonment. Each false statement or false representation of failure to disclose a material fact shall constitute a separate offense. This section shall not prohibit prosecution under any other criminal statutes of this State or the United States."

Since fraud is a serious charge to make against a person, and the results can be serious, 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 a mere preponderance; it must be clear and convincing."

The application form which the person signs carries with it a warning about the penalty for giving false information, so that when the individual gives the information completing the application and signs it, he/she has been put on warning about giving incorrect or incomplete information.

2. Client Error

These are situations in which there is no evidence that the client willfully misrepresented or withheld information, but all indications are that he misunderstood, was unable to comprehend the relationship of the facts about his situation to eligibility requirements, or there was other inadvertent failure on his part to supply the pertinent or complete facts affecting his receipt of Medicaid.

3. Agency Error

Agency errors occurs when:

The worker overlooks a clue which, if pursued to conclusion, would have led to a finding of ineligibility. Examples are:

- Failure to follow-up when the client reports that he expects a definite stated change in his income, living arrangement, other area affecting his eligibility.

- Failure to follow-up when the client is asked to apply for a possible benefit, such as Social Security, veteran's benefit, unemployment compensation, or other retirement or disability benefit.

- Failure to follow-up when the client or someone on his behalf reports a plan to sell, transfer, or otherwise dispose of his property, real or personal, or to buy or acquire property otherwise.

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- Redeterminations are not timely completed. When the review is made and the worker finds information leading to ineligibility, then all the benefits received following the required review date are improper because of agency error. Had the review been completed on time, the worker would have been aware of the information and improper benefits would not have been received.

- The worker misrepresents a policy which if correctly applied to the client's situation would have resulted in denial or closure.

- The worker makes a mathematical error in the test for financial need; used the wrong figure in this test, selects the incorrect test for financial need for the client's situation or computes net income incorrectly, etc.

- The State or Regional Office makes a mathematical error. That is, through machine or human oversight or failure, eligibility is authorized or continued to an ineligible person or the amount of Medicaid Income is improperly computed.

C. IMPROPER PAYMENT REPORT

Form DOM-354, Improper Payment Report will be prepared by the Medicaid Regional Office to report instances of improperly paid Medicaid benefits. Prepare the form in accordance with the instructions for the form, including the following vital information:

- Which factor of eligibility is involved and how the information given or withheld affects eligibility or Medicaid Income.

- What the client said about the factor in question and the date on which the information was given, whether the client gave statements on the DOM-300 or made them verbally to the worker; and the reason the client gave for withholding or falsifying the information.

- The date on which and the circumstances under which the worker learned of the correct information; that is, who gave difference statements, when, and why, or in what way the worker discovered the suspected fraud and the facts.

- What additional steps the worker has taken to secure more or more correct information. For example, bank clearances, checking of property records, interviews with persons in a position to know the facts or involved with the client in the matter, etc.

- Why the worker considered the withholding of giving of incorrect information willfully; that is, whether the client was able to understand his responsibility for giving full and accurate statements and the meaning of his failure to do so.

- Whether the client or client and spouse have resources from which they might repay the amounts improperly received.

- If a transfer of resources is involved, DOM-322 must be issued and an opportunity for rebuttal offered prior to issuing an improper payment. Delay the preparation of DOM-354 until after the rebuttal period is over.

- Delay the preparation of DOM-354 until all appeals have been exhausted and a final decision on the factor of ineligibility, etc. has been determined.

1. Handling of DOM-354 By Eligibility Division

Upon receipt of the improper payment report, the staff of the Medicaid Eligibility Division will:

- Review the report from the Regional Office to ensure that it is complete and that the Regional Office has properly applied policy. This may involve further clearance with the Regional Office.

- Enter the initial information on the periods of ineligibility or improper amount of Medicaid Income on Form-355, This form is referred to the Program Integrity Division for entry of amount of benefits erroneously received.

- Prepare a memorandum to the Program Integrity Division setting out the facts in the case. The memorandum is transmitted to the Program Integrity Division along with a copy of the Regional Office DOM-354 report as appropriate.

2. Handling of DOM-354 By Program Integrity

The Program Integrity Division upon receipt of the material from the Medicaid Eligibility Division will assign the case to a Medicaid Auditor/Investigator for Investigation in order to obtain documentation of the information bearing on the factor of ineligibility and the circumstances surrounding the fraudulent receipt of Medicaid services, or the collection of additional information when indicated.

The investigation into the improper payment may be handled by way of a letter requesting repayment, an in-person interview with the client or a referral to the county or district attorney, or a combination of all three, in order to obtain repayment of the benefits improperly paid by Medicaid.

3. Claims Against Estates

When the Regional Office determines that a recipient has received benefits for which he was not eligible and the recipient is deceased, the case should be reported immediately to the Medicaid Eligibility Division. If the case has already been reported and the Regional Office learns of the death of the person, this fact should be reported immediately.