IMPROPER MEDICAID BENEFITS & QUALITY CONTROL
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.

- 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.