100.04 IMPROPER PAYMENTS

When Medicaid benefits are available to recipients improperly, the state and regional office must identify these situations and take corrective action. An improper payment may be in the form of an underpayment or an overpayment.

Underpayments

An underpayment occurs when Medicaid has not paid its full share of a recipient's medical expenses usually because of incorrect income or deductions. 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 Section 101.14, Reinstatements.

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 for cost of care than it should have. An overpayment may result from the following:

- **Suspected Fraud**

The ABD and FCC 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. "

Overpayments (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 client acted willfully and intentionally to obtain more benefits than those he was entitled to receive. Instead, the client 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 client's part to supply the pertinent or complete facts affecting Medicaid or CHIP eligibility.

  The specialist must be alert to whether or not the client 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 client 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.
    - 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.
    - Failure to check SVES for unreported income.

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

100.04.01 IMPROPER PAYMENT REPORT

Completion of the Report by Regional Office

Form DOM-354, Improper Payment Report, or FCC DOM-354, Improper Payment Report for Families, Children and CHIP, will be prepared to report improper payments for ABD and FCC, respectively. The 354's should be completed 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 client said about the factor in question and the date on which the information was given, whether the client gave statements on the application or gave them verbally to the specialist and the reason the client gave for withholding or falsifying the information;
- The date on which and the circumstances under which the specialist learned of the correct information.
- Steps the specialist has taken to verify the correct information. For example, securing bank statements, 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 client was able to understand reporting responsibilities for giving accurate information and the meaning of his failure to do so.
- Whether the client or client 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.
- Preparation of the Improper Payment Report should be delayed until all appeals have been exhausted and a final decision has been issued on the ineligible factor.

Calculating Overpayments

Overpayments may result when an applicant or 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 client (10 days) and acted on by the agency (10 days). Then consider the 10-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 and the improper payment period runs through September.

    - When dealing with information withheld or improperly reported at application, the first benefit month will be the first month of the overpayment.

      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.

    - 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.

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 occured, re-budget each change in the order in which it occurred.
- Always evaluate eligibility for Extended Medicaid before establishing an overpayment in 85 due to earnings or child support.
- Evaluate each person's eligibility for other coverage groups, e.g., the HOH and child are determined ineligible in 85 due to unreported income; however, an overpayment exists only for the adult since the child would have had eligibility in the 91 program based on the verified income.

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 Enrollment.

Processing the Improper Payment Report

When the Improper Payment Report and supporting documentation are received in the Bureau of Enrollment, 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.

100.04.02 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 Bureau of Enrollment 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.