## 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.