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.

SSI Program (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.

However, 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.

DHS remains 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 Assistance grant program.

100.02 AGENCY DUTIES

100.02.01 DUTIES OF THE DIVISION OF MEDICAID (DOM)

The duties of the Medicaid Agency are set out by enabling State and Federal legislation and the approved State Plan to include:

- To set regulations and standards for the administration of the Medicaid programs.
- To receive and expend funds for the program.
- To submit a state plan for Medicaid in accordance with state and federal regulations.
- To make the necessary reports to the state and federal governments.
- To define and determine the scope, duration, and amount of Medicaid coverage.
- To cooperate and contract with other state agencies for the purpose of conducting the Medicaid program.
- To bring suit in its own name.
- To recover payments incorrectly made to or by recipients or providers.
- To investigate alleged and suspected violations or abuses of the Medicaid program.
- To establish and provide methods of administration for the operation of the Medicaid program.
- To contract with the federal government to provide Medicaid to certain refugees.
- To determine eligibility for Medicaid for categorically needy families, children, pregnant women, aged, blind, and disabled coverage groups.
- To re-determine eligibility at the required intervals.
- To provide Medicaid Quality Control for Medicaid recipients.
- To provide the opportunity for filing appeals and to conduct fair and impartial hearings.
- To provide safeguards for preserving the confidentiality of records.
- To ensure nondiscrimination in the determination of eligibility and provision of services in accordance with federal and state regulations for Title XIX and XXI.
- To provide information and referral services on Early and Periodic Screening, Diagnosis, and Treatment.
- To provide information on family planning services.
- To identify third party resources for recipients.
- To make referrals to MDHS Division of Child Support to obtain medical support for certain recipients.

AGENCY DUTIES (Continued)

100.02.02 DUTIES OF THE DEPARTMENT OF HUMAN SERVICES (DHS)

The duties of DHS with regard to Medicaid include:

- To provide the opportunity for persons to apply for Medicaid benefits through all foster care and refugee programs.
- To determine eligibility for foster children and adoption assistance-related Medicaid applicants and certify them as eligible, notify them of eligibility and determine retroactive eligibility, when appropriate.
- To re-determine foster care and adoption assistance Medicaid eligibility at required intervals.
- To provide the opportunity for filing appeals and to conduct hearings for eligibility certifications that DHS certifies.
- To provide Medicaid Quality Control for foster care and adoption assistance recipients.
- To identify and report 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, at no charge, in the following types of situations:

- In connection with a request for a hearing as otherwise provided in the regulations relating to administrative hearings. Refer to the Section 100.03.05, Right to Appeal and Fair Hearing, for more information.
- Information regarding amounts of Medicaid received by a recipient when requested by a person filing a federal or state income tax return and when authorized in writing by the recipient. A signed authorization is also require to release information to the Internal Revenue Service (IRS).
- Information supplied by the applicant or recipient or obtained by the specialist that the applicant or recipient needs in order to be able to qualify for other benefits which he has requested. This includes medical reports, as the examining physician must release this information to his patient. It includes proof of age, documents relating to real and personal property, and other factual material that will assist an applicant or recipient in obtaining a service or a benefit.

ACCESS TO INFORMATION (Continued)

- The applicant's or recipient's statement of income and resources and other forms the applicant or recipient has signed which are contained in the case record.
- Budgets worked to determine eligibility for programs for which DOM is responsible.
- Any case information when the applicant or recipient presents a written request which specifies the material desired and the purpose for which the material will be used.

NOTE: Designated DOM staff has computer access to other agencies' records. If the client requests another agency's information which is not part of the DOM case file, it cannot be provided. The client must obtain the information directly from the source agency.

When the request is made by a person other than the applicant/recipient or their representative, the information will not be made available without the applicant's or recipient's written permission prior to releasing the information. The written release will become a permanent part of the record.

Release of Information to Legal Representative/Attorney

When legal representative/attorney requests information from the agency to assist a client, the client or his authorized/designated representative must first provide a signed statement or letter to the agency permitting information to be released to that specific individual. This statement will be made a permanent part of the case record.

Legal representatives/attorneys generally do not have the degree of knowledge required about a client's circumstances to enable them to act on the client's behalf in the application process. As a result, a legal representative/attorney may not be named as an authorized or designated representative. Agency notices, including the DOM-307, DOM-309 and eligibility notices may not be mailed directly to a client's legal representative/attorney. However, if the client has provided their legal representative/attorney with copies of the 307, 309 and/or other notices, the information can be discussed with the legal representative/attorney, provided there is a signed consent in the case authorizing release of information to that specific individual. **NOTE**: Information may be released to any person when a valid release of information has been executed by the client for that individual.

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 without a recipient's consent. Any other exceptions are subject to prior approval of the Executive Director or Deputy Administrator of the Division of Medicaid.

Protected Information

Protected information is of two general types: eligibility/financial and medical. It includes 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.

100.03.04A RELEASE OF INFORMATION WITHOUT CLIENT CONSENT

As previously indicated, the Division of Medicaid has established the following criteria for release and use of eligibility and financial information about applicants and recipients. Except as provided below, no information regarding applicants or recipients may be released without consent unless prior approval of the Executive Director or the Deputy Administrator of the Division of Medicaid is obtained.

1. Disclosure to Other Agencies

Information concerning Medicaid applicants or recipients is subject to disclosure to agencies authorized under Titles IV-A (TANF), IV-B (Child and Family Services), IV-D (Child Support), XX (Social Services) XVI (SSI) of the Social Security Act and other agencies which are Federal or Federally assisted programs and provide assistance, in cash or in-kind, or services, directly to individuals on the basis of need, pursuant to appropriately executed data exchange agreements and other cooperative agreements between the Division of Medicaid and the applicable agency. Access is restricted to those persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the Division of Medicaid.

Some agencies which have standards of confidentiality comparable to those of Medicaid and which provide assistance or services to applicants and recipients, and with whom information is exchanged for the purpose of administration of the Medicaid Program are listed below.

- Department of Human Services;
- Social Security Administration and District Offices;
- Mississippi State Department of Health and County Health Departments, only if they are a provider of Medicaid services for which the information is requested;
- State Department of Mental Health and Regional Mental Health Centers, only if they are a provider of medical services for which the information is requested;
- State Mental Hospitals and general hospitals, the Social Service Department and the reimbursement offices for providers, only as to services each provider rendered to a specific Medicaid recipient;
- Veteran's Administration, only if they are a provider of services and then only for those recipients for whom they provided the service or to confirm benefits.

Release of Eligibility Information Without Consent (Continued)

- Medicaid program staff in other states, when a client moves or when there is a question of dual participation or to verify the status of Medicaid in MS for an applicant in the other state.

The release of information is based on a request from the other agency and must relate to the function of the Division of Medicaid's programs and the function of the agency requesting the information. When an agency makes a request for information which that agency normally would be ascertaining for itself and which is not in behalf of the applicant or recipient, the request will be denied. Lists of information on applicants or recipients are not released to other agencies unless the release is specified in an interagency agreement.

2. Disclosure to Division of Medicaid's Fiscal Agent

Information concerning applicants and recipients may also be disclosed to the Division of Medicaid's fiscal agent for purposes of eligibility verification, claims processing and claims payment pursuant to the contract between the Division of Medicaid and the fiscal agent which provides that the fiscal agent shall be bound by the same standards of confidentiality as the Division of Medicaid.

3. Disclosure Related to Third Party Liability

Information necessary to identify third party liability (TPL) and to pursue reimbursement of Medicaid lien amounts from legally liable third parties may be made available to the recipient upon written request, to the recipient's insurance carrier upon a release of information signed by the recipient or to providers of medical services for the recipient. Any other release for TPL purposes should be cleared through the Legal Unit of the Division of Medicaid. (See NOTE below for the procedure regional offices will follow in obtaining clearance from Legal)

4. Disclosure to Prosecuting Attorneys

Information shall be provided to county and district attorneys, the US prosecuting attorney, the Office of Inspector General (OIG), Medicaid Fraud Control Unit of the Attorney General's Office or other investigative boards and agencies duly authorized by state and federal law related to abuse, suspected fraud or fraudulent receipt of Medicaid and to obtaining or enforcing medical support. **NOTE:** Before releasing any case record information to a county, district or US prosecuting attorney, the regional office will notify the Bureau of Enrollment and a manager will obtain clearance from the Legal Unit of the Division of Medicaid on the release.

Release of Eligibility Information Without Consent (Continued)

5. **Disclosure of Subpoenaed Information**

Subpoenas for recipient or applicant information may be answered as directed by the Legal Unit of the Division of Medicaid only if the recipient or applicant gives written permission for the information to be released or upon court order. The regional office will notify the Bureau of Enrollment immediately upon receipt of a subpoena and a manager will contact the Legal Unit for clearance on answering the subpoena.

6. **Disclosure to Providers**

Eligibility and availability of benefits may be verified for Medicaid or CHIP providers.

7. **Release of Information in an Emergency Situation**

If release of information is deemed necessary by the agency due to an emergency situation and time does not permit obtaining written consent before the release, the agency must notify the family or individual immediately after supplying the information.

Requests for Information from Non-Custodial Parents or Relatives

Information must not be released to a child's non-custodial parent or other relative without a court order that has been cleared by state office. When a non-custodial parent/relative is seeking information and presents a court order, the regional office will notify the Bureau of Enrollment. A manager will contact Legal for clearance.

100.03.04B 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 Bureau of Enrollment for further action. Requests will be considered pursuant to the Access to Public Records Act, as applicable.

100.03.04C 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.

100.03.04D SAFEGUARD AWARENESS TRAINING

Training on the security standards for data provided by the Internal Revenue Service (IRS) and 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 and SSA information.

A confidentiality statement for each type of data is signed by employees. The person providing the training signs and dates the confidentiality statements to certify 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 IRS and SSA safeguard training requirements.

100.03.05 RIGHT TO APPEAL AND FAIR HEARING

At the time of any action affecting an applicant or recipient's claim for assistance, the applicant or recipient must be:

- Informed of his right to a fair hearing;
- Notified of the method 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.

The agency must grant the opportunity for a fair hearing to any applicant or recipient 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. 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 applicant/recipient. In addition, individuals are notified of appeal rights by statements included on the ABD and FCC application forms and on all notices. A hearings pamphlet is included with adverse action notices informing clients of the right to appeal and providing other information about the hearings process. These pamphlets are also available for distribution in regional offices.

100.03.05A THE HEARING PROCESS

Hearings Defined

A fair hearing is an orderly, but informal meeting in which a client or his representative 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 applicant or recipient 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 the client's 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 client or his representative may request to present an appeal through a local-level hearing, a state-level hearing, or both. In an attempt to resolve issues at the lowest level possible, offices should encourage clients 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 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 client has moved to another regional office's jurisdiction at the time the appeal is made, it is possible for the regional office serving the client's 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 hearing must be made in writing by the client or his legal representative.

"*Legal representative*" includes the client's authorized representative, an attorney retained to represent the client, a paralegal representative with a legal aid service, the parent of a minor child (if the client is a child), a legal guardian or conservator or an individual with power of attorney for the client.

The client may be represented by anyone he designates. If the client elects to be represented by someone other than a legal representative, he must designate the person in writing. If a person, other than a legal representative, states that the client has designated him as the client's representative and the client has not provided written verification to this effect, the regional office will ask the person to obtain written designation from the client.

Oral Hearing Requests

An oral request for a hearing must be put in written form. When an oral request is made, the specialist will inform the client that the request must be put in a letter or signed statement and mailed to the regional office *or* the specialist will mail the appropriate hearing request form, i.e., DOM 350, Request for Local Hearing, or DOM 352, Request for State Hearing, to the client for signature and return. The specialist must explain that the hearing will not be scheduled until a written request is received by either the regional or state office. If the written request is not received within the adverse action period, continuation of benefits is not applicable. If the request is not received in writing within 30 days, a hearing will not be scheduled unless good cause exists.

Written Hearing Requests

A simple statement requesting a hearing that is signed by the client or his legal representative is sufficient; however, if possible, the client should state the reason for the request. The written request may be mailed to the regional office or state office. If the letter 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 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 Executive for assignment to a hearing officer.

Hearing Requests Made In Person

The client 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 client. Otherwise, if the client is unsure of the type hearing desired, the specialist will explain the difference between the two levels of appeal and explain a state hearing may still be available if the local hearing decision is not favorable. The specialist will assist the client 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 mailing the request to state office or the client may choose to mail 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 client has 30 days from the date the appropriate notice is mailed to request either a local or state hearing. This 30-day filing period may be extended if the client 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. However, if a client'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 client wishes to have his eligibility reconsidered, he may reapply.

Timeframe for Holding Local or State Hearings

The Division of Medicaid must take final administrative action on a hearing, 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.

Scheduling the Hearing

Upon receipt of a written 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 client or representative 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.

Scheduling the Hearing (Continued)

The notice scheduling the time and date of a state or local hearing must be mailed to the client 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.

Attendance at the Hearing

A state or local hearing is not open to the public. All persons attending the hearing will attend for the purpose of giving information on behalf of the claimant 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 written request and can be terminated only by a written statement in which the client or representative withdraws the request for a hearing. A state or local 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. As indicated, the withdrawal must be in writing and signed by the client or representative.

A hearing request will be considered abandoned if the client or representative 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 client 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 Client

The client or his representative 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 applicant or recipient'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 clients under the following circumstances:

- The Division of Medicaid may consolidate the cases and conduct a single group hearing when the only issue involved is one of a single law or agency policy.
- The clients may request a 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 clients, the policies governing fair hearings must be followed. Each individual client in a group hearing must be permitted to present his own case and be represented by his own lawyer 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 client is expected to keep his testimony within a reasonable time as a matter of consideration to the other clients involved.

SSI

In Mississippi, persons who are eligible for SSI are automatically eligible for Medicaid. If an SSI applicant or recipient disagrees with the decision to deny or terminate SSI benefits, the individual must contact the Social Security Office which issued the adverse action. SSA handles appeals when the issue is SSI benefits and automatic Medicaid eligibility.

100.03.05B CONTINUATION OF BENEFITS

If a client or 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. Benefits will continue at the original or former level until a final hearing decision is rendered.

NOTE: The override function in MEDS may be used to reinstate QMB benefits for prior months pending the outcome of a hearing. If CHIP is involved, the reinstatement of benefits must be effective for the next possible month. If the hearing decision is favorable to the client, any lost CHIP benefits will be handled through the agency error process.

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 12-days from the notice date. This 12-day period includes the 10-day adverse action period plus 2 days mailing time. If a hearing is requested by telephone, the client must be advised to put the request in writing prior to the end of the specified period. Any hearing requested or dated after this period will not be accepted as a timely request for continuation of benefits.

Continuation of Benefits When Local Decision is Adverse

The client 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 client, 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 client to recoup the cost of any medical services furnished the client 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.

100.03.05C REGIONAL OFFICE RESPONSIBILITIES IN THE HEARING PROCESS

The regional office is responsible for completing a supervisory review of the action under appeal and for preparing the state hearing record. The 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.

100.03.05C1 SUPERVISORY REVIEW

- A supervisor will review the record and re-examine the action taken on the case to determine if policy has been properly applied;
- If any adjustments are needed, a supervisor will ensure that corrections are made;
- If continuation of benefits is applicable, a supervisor will ensure that benefits continue at the same level prior to the proposed adverse action that is under appeal.
- The supervisor will also ensure all needed verification is in the case record and will secure any additional evidence needed for the hearing when necessary.

100.03.05C2 PREPARATION OF THE HEARING RECORD

A local hearing record is not needed since the claimant 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 Executive Division 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 written hearing request submitted by the claimant or representative;
- 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 notice(s) 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 on disability but the client's income was not established, a hearing on the disability factor will have limited value if the client was also ineligible on income or some other factor.

100.03.05C3 HOLDING THE LOCAL HEARING

The regional office is responsible for scheduling and rendering decisions on local hearings, except those which involve CHIP agency errors. The procedures for handling local and state hearing requests involving denial of CHIP because of agency error are discussed later in this section.

Purpose of a Local Hearing

The purpose of the local hearing is to provide an informal proceeding to allow the client or representative to:

- Present new or additional information;
- Question the action taken on the client's case, and
- Hear an explanation of eligibility requirements as they pertain to the client'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 client 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 client unless the client waives advance notice time. The case record will be documented if the client waives the advance notice.

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 eligibility, 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 the client requests a state hearing 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.

100.03.05C4 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 client must be notified of the decision via DOM-351, Notice of Decision on Local Hearing. This form must be used to notify the client since it advises the client 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 state office will notify the client of the new effective date of closure, reduced benefits or other revised eligibility dates in the state hearing decision letter.

100.03.05C5 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 the client's favor 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.

100.03.05C6 STATE HEARING REQUESTED AFTER ADVERSE LOCAL DECISION

As indicated, the client has the right to appeal a local hearing decision by requesting a state hearing; however, the state hearing request must be made in writing within 15 days of the mailing date of the DOM-351. This means the state hearing request must be received by the regional office or state office on or before the 15th day after the local hearing notice is mailed. If the state hearing request is made orally, then the claimant must be informed that the request must be put into writing and received with the allotted 15-day time period.

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.

100.03.06 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 state 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 mailed directly to state office, a copy 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.

100.03.06A 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 Bureau Director, Deputy, 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 client. If the client is agreeable to the adjustment of the claim, the state hearing request will be withdrawn in writing with the reason for the withdrawal stated.

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.

100.03.06B HOLDING THE STATE HEARING

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

- The hearing will be recorded and a transcript of the proceeding will be typed for the record.
- The reason for the hearing, i.e., the action taken by the regional office which prompted the appeal.

Holding The State Hearing (Continued)

- The client's rights and the purpose of 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 client or representative 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 discussed at the hearing and the claimant will be notified in writing of this decision.

During the hearing the client or his representative 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 claimant 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.

100.03.06C 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 client 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.

100.03.06D CHANGES WHICH OCCUR DURING THE HEARING PROCESS

If the regional office becomes aware of a change in the client's circumstances which will result in an adverse action other than the issue currently under appeal, the client must be notified in writing. Adverse action notice requirements, i.e., 10-day notice plus 2 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 client may choose to have the new adverse action issue incorporated into the current appeal; however, the client 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 client 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 the appropriate 10-day notice. The hearing will be reconvened after the adverse action notice is mailed and the advance notice period has expired. The client 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.

100.03.06E 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.

100.03.06F 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 claimant.

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.

100.03.06G 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 the client or representative, with a copy to the regional office, Bureau Director, Deputy, and the Deputy Administrator for Enrollment.

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 claimant will be notified of the new effective date of reduction or termination of benefits or services, which will be fifteen (15) days from the date of the notice of decision.

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

100.03.06H CHIP AGENCY ERRORS

The Division of Medicaid is responsible for ensuring payment for eligible beneficiaries. Providing timely CHIP benefits is a special concern because, unlike Medicaid, the CHIP effective dates are determined relative to monthly processing deadlines which do not allow the regional office to take retroactive or corrective action when an error is discovered for a prior month.

Each regional office must have a plan for timely and accurate case processing to prevent CHIP errors. This may include upfront identification of potential CHIP applications, flagging CHIP cases submitted for supervisory review, routing and handling of information within the office and monitoring reports. These types of procedures must be in place and functioning in the regional office to limit the number of CHIP agency errors.

When CHIP agency errors occur, resolution must come through a local or state hearing request. When a state or local hearing is requested due to loss of CHIP benefits and the review by the regional office determines an agency error did occur, the final hearing decision for local and state hearings will be made in the Bureau of Enrollment. The regional office must not issue a verbal or written hearing decision on these cases.

The regional office will be responsible for preparing a hearing folder to include an explanation of how the error occurred, the months of agency error, the children involved, along with copies of pertinent documents from the case record and MEDSX. The hearing folder will be sent to the Enrollment Bureau.

NOTE: If a fair hearing is requested on a CHIP termination or denial and agency error was not involved, the procedures described previously in this section will be followed based on the type of hearing requested, i.e., local or state.

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.

100.05 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 Enrollment.

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 Bureau of Enrollment. Appropriate policy staff will complete a final review before the disagreement is provided to the MEQC supervisor for re-consideration.

100.05.01 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 Bureau of Enrollment 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.

100.05.02 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.

100.05.03 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 Bureau of Enrollment 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.