

Title 23: Division of Medicaid

Part 100: General Provisions

Part 100 Chapter 6: Improper Payments [Refer to Part 305]

Part 100 Chapter 7: Quality Control [Refer to Part 305]

Title 23: Division of Medicaid

Part 100: General Provisions

Part 100 Chapter 6: Improper Payments [Refer to Part 305]

Rule 6.1: Types of Improper Payments.

~~A. 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.~~

~~1. 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 changes can be made.~~

~~2. 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:~~

~~a) 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. [Reworded and moved to Part 305, Rule 1.1C.]~~

~~1) 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."~~

~~2) 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.~~

- ~~3) 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:
 - ~~(a) Making a false statement or misrepresentation; or~~
 - ~~(b) Failing to disclose a material fact; or~~
 - ~~(c) Not reporting changes in income or other eligibility factors that affect the benefit; and~~
 - ~~(d) 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.~~~~
- ~~b) 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. [Moved to Part 305 Definitions]~~
- ~~e) Agency Error. Agency errors occur in instances such as the following:
 - ~~1) The specialist misapplies rules or fails to follow procedures which would have resulted in denial or closure if the correct action had been taken.~~
 - ~~2) 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.~~
 - ~~3) 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.~~~~

- ~~4) 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:~~
- ~~(a) 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.~~
 - ~~(b) 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.~~
 - ~~(c) 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.~~
 - ~~(d) Failure to check SVES for unreported income.~~
- ~~5) 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.~~

Source: MS Code Ann. § 43-13-121.1 (Rev. 2001).

~~*Rule 6.2: Reporting an Improper Payment.*~~

~~A. 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, for recovery.~~

Source: MS Code Ann. § 43-13-121.1 (Rev. 2005).

~~*Rule 6.3: Claims Against Estates.*~~

~~A. 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 rules and procedures. An Improper Payment Report will be completed if applicable.~~

Source: MS Code Ann. § 43-13-317.1 (Rev. 2005).

Part 100 Chapter 7: Quality Control **Refer to Part 305**

~~*Rule 7.1: Quality Control Reviews. [moved to Part 305 Rule 1.5]*~~

- ~~A. 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.~~
- ~~B. 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.~~
- ~~C. A corrective action committee 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. 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.~~

~~Source: CFR § 431.810 et. seq. (Rev. 1990).~~