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4600.00.00BENEFIT RECOVERY

This chapter presents policy and procedures on the following:

- Identifying Over Issuances (Section 4605);
- Types of Over Issuances (Section 4610);
- Over Issuance Calculation (Section 4620);
- Initiating Collection Action (Section 4630);
- Recovery Methods (Section 4635);
- Transmittal of Repayment (Section 4640);
- Claim Against Estate (Section 4650).

4605.00.00 IDENTIFYING OVER ISSUANCES

An over issuance exists when an AG received benefits when it was not eligible to receive benefits, or in the case of spend down or liability, when the AG received benefits in an amount greater than it was eligible to receive. Benefit recovery will not be pursued if the correct information would only have affected the amount of monthly premiums or POWER Account contributions.

Benefit recovery will be pursued for assistance groups where the member failed to report or falsified information which would have made them completely ineligible for the assistance they received. This means that income reporting would not affect categories such as MA X, MAGP, MA 4, MA 8, MA 15, and MA Q.

The claims process begins with the identification of an over issuance. This occurs when the eligibility worker receives or discovers information which appears to contradict information previously used to determine eligibility. The worker may receive information that an over issuance has occurred as a result of:

- An untimely reported change;
- Information from individuals inside/outside the AG;
- Fair hearing decision found unfavorable to client;
- Transfer Penalties;
- Quality Control (QC) referral;
- Management Evaluation (ME) review;

Office of Inspector General (OIG) investigation/audit report (referred through Central Office); or

Central Office referral.

The source reporting information may have already conducted a case file review and obtained documentation to resolve the discrepancy and determine the time period and amount of any over issuance.

The eligibility worker may also discover information contrary to what is in the case record from review of reports from one of the following sources:

Department of Workforce Development (through data exchange);

Social Security Administration (SSA) (through data exchange);

Internal Revenue Service (IRS) (through data exchange);

Bureau of Motor Vehicles (BMV); or

Financial institutions.

4605.05.00 STAFF RECOVERY RESPONSIBILITIES

Recovery responsibilities of the eligibility worker and supervisor, the benefit recovery (BV) worker and BV supervisor and the Fraud Referral Coordinator are provided in the following sections.

4605.05.05 Eligibility worker Responsibilities

When a possible over issuance is identified, the worker must gather and record the following information in running record comments:

The cause of the over issuance;

How the over issuance was discovered;

The date the agency became aware of an over issuance;

Who received the income/resource/status change;

The date the income or change started and/or stopped;

The estimated length of over issuance;

Any explanation given for failure to provide information accurately or in a timely manner; and

Corrective action taken and the date such action was taken.

Before completing a referral to the BV unit the worker must review the above information to determine what further information/verification is still needed and take the actions listed below.

Obtain verification necessary to determine the time period and the amount of over issuance;

Adjust the current benefit, if appropriate, prior to referral to Benefit Recovery;

Verify that the individual was actually receiving assistance, during the time the claim of over issuance was presumed;

Advise the AG in writing that a discrepancy exists, that the source of the discrepancy is from outside the AG and that a referral to BV will be made regarding the overpayment if the discrepancy cannot be resolved. If discrepancy is identified through the data exchange (DE) subsystem, the discrepancy notice can be generated through the DE screen.

If the over issuance is referred to the prosecutor, do not discuss the possibility of repayment with any member of the AG before the final court disposition.

The AG will be allowed 10 days to rebut the allegation prior to referral to BV. The eligibility worker must allow the AG an opportunity to provide information which clarifies the situation.

The eligibility worker must also:

Complete the Benefit Recovery Referral (BVBR) screen within 30 calendar days of the day the agency became aware of the overpayment (refer to Section 4620.00.00, completing the Benefit Recovery Referral);

Respond to the BV unit requests for any additional information within 10 calendar days;

If notified that a payment has been received and no referral exists, determine if over issuance occurred and enter information on BVBR (refer to Section 4620.00.00, completing the Benefit Recovery Referral);

If notified that a payment has been received and no over issuance exists, the payment must be returned to the individual;

When notified that attendance is required, prepare for appearance in court or at a hearing.

If over issuance was discovered as a result of Data Exchange, follow the policy in Section 4415.05.00, IEVS Compliance Tracking, prior to referral to Benefit Recovery (BV).

4605.05.10 Benefit Recovery Worker Responsibilities

The Benefit Recovery (BV) caseworker is responsible for the establishment of all over issuance claims and the maintenance of recovery activities except the receipt of any repayments.

4605.05.15 Fraud Referral Coordinator/BV CODY user Responsibilities

Certain BV workers also serve as the contact for all fraud, investigation and referral activity.

The responsibilities of the Fraud Referral Coordinator/BV CODY user are:

Review all claims purported to be fraud before they can be opened. Decide on further action.

Monitor all fraud referral and investigation activities conducted within DFR.

Serve as contact for Central Office staff on matters related to claims, collections, adjudications and investigations.

Maintain all fraud activity records including Fraud Hotline Referrals, other program abuse complaints, referrals for investigations, prosecutions, and criminal court results. Assign CODY investigation numbers to all referrals to be investigated by BV or Compliance Division.

Review all referrals for investigation. When appropriate, make a referral to the Compliance Division.

Review all completed investigations to determine the appropriate action to be taken on the case. Whenever possible, seek adjudication. Review resulting claims and enter in CODY along with adjudication results.

4610.00.00 TYPES OF OVER ISSUANCES

Once an over issuance is identified, the reason for the over issuance must be identified.

An over issuance may be the result of:

Client Error;
Intentional Program Violation (fraud); or
Combination of the above.

A Medicaid claim cannot be adjudicated as IPV in an Administrative Disqualification Hearing, and even if a Medicaid claim is part of a Prosecution case found guilty, it must be entered in ICES as 'CE'. (See Section 4610.10.00.) Benefit recovery will not be pursued for agency errors which resulted from worker error. These types of errors are accounted for through Medicaid Quality Control and PERM review processes.

4610.05.00 AGENCY ERROR DEFINITION

An Agency Error (AE) is an action or failure to take action by the Division of Family and Children.

Examples of agency error may include:

 A misapplication of policy;

 A calculation error;

 A computer processing error;

 Failure to take prompt action on available information;

 Some other error over which DFR has control.

4610.10.00 CLIENT ERROR DEFINITION

Client error is an over issuance caused by a misunderstanding or an unintended error on the part of the AG. Eligibility workers can help to eliminate this type of error by making sure the client understands what is needed and by what date. Eligibility workers can also help by being well organized, so that reported changes are always acted upon and never lost. ICES coding remains unchanged. A Medicaid error of this type is coded CE. A client error can occur as a result of:

 AG failure to provide correct or complete information;

 AG failure to report required changes in the AG's circumstances; and

 AG receipt of benefits (or more benefits than it was entitled to receive) pending a fair hearing decision.

4610.15.00 SUSPECTED FRAUD DEFINITION

Fraud is the act whereby a person willfully and deliberately makes false statements or suppresses facts or gives information which misrepresents the true circumstances regarding himself or others for the purpose of receiving assistance to which there is not entitlement.

Suspected fraud over issuances can occur as a result of the AG:

Misrepresenting information;

Concealing information;

Withholding information pertinent to determining eligibility, including untimely reporting;

Failing to report a change in order to continue to receive benefits for which the AG was not entitled; or

Intentionally altering or changing documents to obtain benefits to which the AG was not entitled.

Fraud, in all of its aspects, is a matter of legal determination. Therefore, fraud does not exist until this legal determination has been made through the criminal court.

Once the suspected fraud claim has been calculated **but not yet opened**, the entire claim case will be submitted to the Bureau of Investigations for review and approval.

4610.15.10 Deterrents Against Fraudulent Activity

The DFR is to establish deterrents against fraudulent activity through:

Skilled investigation;

Careful explanation of all eligibility requirements to applicants/recipients;

Diligent use of collaterals and other sources of information;

Verification of facts;

Alertness to possible misunderstandings;

Follow-up investigations where indicated;

Establishment of procedures for handling cases of suspected fraud to ensure thorough investigation and proper referrals to the County Prosecutor.

Cooperation with the news media in publicizing cases prosecuted for welfare fraud.

4610.15.15 Establishment and Investigation of Possible Fraud

Documentation of the applicant's/recipient's apparent ability or inability to understand questions regarding eligibility, especially with regard to income and resources, must be entered in the running record comments. It is unlikely that fraud can be established and substantiated if the documentation shows that the individual's mental or physical condition resulted in his inability to understand eligibility requirements and his responsibility to provide information to the DFR.

The eligibility worker may suspect fraud exists within an AG. Some clues which may indicate unwarranted receipt of assistance are:

Purchase of items which indicate that more income exists than is known;

Living at a higher standard than known income would permit;

Unexplained absences or difficulty in seeing the recipient to complete necessary redeterminations;

Reluctance to provide needed information about income and/or resources;

Unexplained and continued refusal to have certain pertinent references or relatives contacted; or

Complaints or remarks of other persons.

The worker should be alert to any information that can lead to the identification of a case discrepancy. If such information becomes available, the worker should take the action listed in Section 4605.05.05, Caseworker Responsibilities, then enter a referral to the BV unit on BVBR if appropriate.

The worker is responsible for completing all investigations that can be done from the office: By phone, mail or interview. This includes data matches. Use Subpoena (Form FI0018/State Form 48133) to obtain needed verification when a signed client "Release of Information" is not available or appropriate. If it appears that the investigation cannot be completed by the eligibility worker, a suspected fraud task can be created to the Benefit Recovery Unit who can make a referral to the Bureau of Investigation.

4610.15.20 Investigation of Possible Fraud

If the AG is currently eligible, assistance is not to be discontinued solely because an investigation of suspected fraud is being conducted, nor is the worker to discuss an investigation by the Bureau of Investigation with the client.

The DFR is required to pursue suspected fraud. It is the responsibility of the eligibility worker to do the initial investigation and then, if appropriate, create a suspected fraud task for Benefit Recovery. Based on the BV worker and the B of I investigator's findings, and if the case meets the Local Prosecutor's criteria, the individual may be referred for prosecution to the County Prosecutor.

The methods used in investigating possible fraud should be adapted to the situation of the AG and the eligibility factors concerned. The investigation must be conducted in such manner that:

The legal rights of the AG are preserved;

The privacy of the home is not invaded without consent;

Search and seizure are not committed;

The AG's right to due process of law is protected;

The right to legal counsel is not obstructed; and

Confidential information is used only for the administration of assistance.

4610.15.25 Report of Fraud Investigations and Adjudications

When the investigation is completed, a report of all facts in the case is to be made. If the report reveals no basis for the suspicion of fraudulent activity, such decision is to be entered in the case record. Exoneration of the innocent is as important as prosecution of the guilty. If the report indicates a basis for suspected fraud, the period of time during which it is believed that the AG fraudulently obtained assistance is to be made a part of the record.

It is important that all investigations for all programs be entered in CODY System. The Benefit Recovery worker's initial investigations should be entered as well as referrals to the Bureau of Investigation. Update and add information as changes occur.

All individuals referred for prosecution or an ADH must be reported in CODY. CODY must be updated as each case progresses through the legal system.

4610.15.30 Referral to County Prosecutor

The Bureau of Investigation (B of I) will decide whether to refer a case for prosecution. The County Prosecutor has the final word concerning the type and number of cases against which criminal charges will be filed or whether criminal charges will be filed at all. The DFR should have an agreement with the Prosecutor and knowledge of the documents

and procedures which the Prosecutor will request. All available evidence must be provided with the referral. Repayment of a claim must never be discussed with the AG pending the outcome of the Criminal Court action therefore; claims intended for prosecution should not be opened until adjudication is completed.

Once the decision has been made to refer the claim(s) for prosecution, 'prosecutor information' must be entered on BVRC. Then change the claim status from 'PD' (pending) to 'RP' (referred for prosecution). When the adjudication process is completed, the results must be entered on BVRC and the claim is opened (established) by changing the status to 'OA" (open awaiting client response).

A specific criminal statute exists for acts of welfare fraud committed September 1, 1984 or after, and is applicable for all programs. There are five separate areas of welfare fraud and abuse listed.

The accused person must knowingly or intentionally:

Obtain public relief (or assistance) by impersonation, false statement or other means;

Acquire, possess, use, transfer, sell, trade, issue or dispose of public relief or an authorization document used to obtain public relief;

Use, transfer, acquire, issue or possess a blank or incomplete authorization document to secure public relief;

Counterfeit or alter an authorization document to receive public relief or use, transfer, acquire or possess a counterfeit or altered authorization document; or

Conceal information for the purpose of receiving public relief or assistance.

4610.20.00 EVIDENCE USED TO SUBSTANTIATE FRAUD

When preparing a case for a court, evidence is necessary in order to prove the DFR's allegation of fraud. Evidence can include written records or statements or verbal testimony. Information received through Data Exchange is not verified unless the agency providing the information is the source of the payment. It is necessary to secure verification directly from the employer, bank or other source of the income.

It is also necessary to prove the intent to fraud. Verification that the AG member understood his responsibility for reporting the information in question may

be used to substantiate intent. This verification could include:

The completed Rights and Responsibilities form;

The signed application;

Previously submitted Change Report forms; or

Recorded and/or verified instances of other changes reported by the AG which could or did affect the benefits received.

An application or Change Report form submitted during the period fraud is suspected which omits the information that resulted in the over issuance may be used to substantiate intent.

Recorded instances which indicate that the AG visited/called the office during the period fraud is suspected and did not report the change which resulted in over issuance may be used to substantiate intent. These instances might include a record of the dates benefits were issued to the AG, redetermination interviews with applications, signed Notice of Rights and Responsibilities or Personal Responsibility Agreement, or reports of beneficial changes but not the adverse change.

These examples are not all inclusive; other types of evidence of intent may also be used.

4610.25.00 COURT DETERMINATION OF FRAUD

Fraud must be determined by a court of appropriate jurisdiction. This may be through criminal court. The court may designate a repayment schedule. This schedule may be in conjunction with probation. If this occurs the judge may order repayment be made through the County Court or probation system. If the ordered restitution is less than the claim, unless the court order strictly forbids any further collection after the restitution is paid, the balance should be collected. Court Probation (CP) must be entered on BVCP under "repayment method".

Since June 1999, Small Claims Court can no longer be used to determine fraud but it can be utilized to assist in collection efforts (See Section 4635.25.00). If there is a judgment from Small Claims Court, "SC" must be added on BVCP under "repayment method" (see Section 4635.40 for more information).

4620.00.00 COMPLETING THE BENEFIT RECOVERY REFERRAL

Once it has been determined that an over issuance referral is necessary and that the over issuance occurred within the appropriate time period as listed in the previous section, the eligibility worker is to complete the Benefit Recovery

Screen BVBR including the comments screen which is accessed by using the PF2 key. Refer to Section 4605.05.05, Eligibility worker Responsibility, as to the necessary information which must be entered on the comment screen. If incorrect dates are entered, the BV worker can correct these dates later on BVRC.

**4620.05.00 ASSIGNING THE REFERRAL TO THE BENEFIT
 RECOVERY WORKER**

After a BV referral has been made a task is generated for a BV worker. All claim referrals are to be assigned to a worker within ten working days of the referral being made.

4620.05.10 Total Ineligibility

Failure to meet certain eligibility requirements will render an AG totally ineligible, thus negating the necessity for individual monthly calculations. These eligibility factors are:

State residency;

Excess resources;

Excess gross income;

Entire AG made up of individuals who fail to comply with SSN requirements;

AG's refusal to provide requested information/verification (use Form 2244) concerning AG composition, income, or resources.

4620.35.00 DETERMINING THE AMOUNT OF OVERPAYMENT (MED)

The total amount of Medicaid benefits paid during a period in which the AG was ineligible for MA is recoverable from the recipient or his estate.¹ For a member who was covered in a managed care program, this would be the monthly capitation paid by the state for each ineligible month, not the paid claims. (For information regarding the filing of a claim against an estate, refer to Section 4650.00.00) Recovery can be pursued even when there is no suspicion of fraud. Medicaid benefits paid in error pending receipt of a hearing decision are to be recovered.

A recipient who acquires excess resources is totally ineligible. The amount which is recoverable is the total

¹ IC 12-15-2-19

Medicaid expenditures for the month in which the recipient was ineligible.

An overpayment of Medicaid benefits may occur as a result of budgeting an incorrect amount of income; however, consideration of the income may result in the imposition of or increase in spend-down or liability rather than total ineligibility.

The calculation of the Medicaid overpayment is done off-line. However, BVMC is available for the manual calculation of claim amounts when entering more than one month. The issued benefit amounts and the correct benefit amounts should be entered on BVMC. Press PF16 to have the system calculate and display the claim amount. This information is then entered into the system to proceed with the benefit recovery process.

For the individual whose liability should have been higher, the amount to be recovered is the difference between the correct and incorrect liability or the amount of Medicaid expenditures for the month, whichever is less. When entering liability/spend-down situations on BVMC, the order must be reversed. Enter corrected liability/spend-down amount in the "Issued" field and the previous amount in "Correct" benefit field.

For the individual whose spend-down should have been higher, the amount to be recovered is determined as follows:

- (a) Subtract the incorrect spend-down from the correct spend-down.
- (b) From that difference, subtract the individual's "out of pocket" expenses and his spouse's/parent(s)' out of pocket expenses incurred that have not already been entered into the system as non-claims.
- (c) The resulting amount or the amount of the Medicaid expenditures for the month, whichever is less, is the amount to be recovered.

When requesting the claim history of all Medicaid expenditures the DFR should use State Form 6533 OMPP 1042 (revised 7-03) and follow the procedures below:

For medical expenditures involving recipient Third Party Liability (TPL), requests should be addressed to EDS, third party liability, PO Box 68762, Indianapolis, IN 46268-8762.

Requests for Medicaid expenditures involving recipient fraud, estate recovery and all other Medicaid expenditure requests involving reimbursement should be addressed to the Office of Medicaid Policy and Planning (OMPP) Attn: Estate Recovery, 402 W. Washington, Room W-382 MS 07, Indianapolis, IN 46204 (FAX 317-232-7382).

EXAMPLE 1:

The DFR verified that as of April the AG had \$500 in excess resources, which had not been reported. As of May 1st, the AG's resources were within the resource limitation. Medicaid expenditures for April were verified to be \$750. The amount to be recovered is \$750.

EXAMPLE 2:

Based on the AG's reported income, he had a spend-down of \$34. In March he began receiving rental income. This was discovered in July and a \$100 increase in his spend-down was budgeted effective August 1st. Recovery is for the months of May through July.

Incorrect spend-down amount	\$ 34
Correct spend-down amount	134
Difference	\$100

<u>Month</u>	<u>Out of Pocket Expenses</u>	<u>Medical Expenditures</u>
May	5/11 - \$10 - wife 5/20 - <u>25</u> - recip.pd. \$35	\$150
June	6/10 - \$40 - wife	\$ 50
July	None	\$200

For May:
\$100 (difference between correct and incorrect spend-down)
- 35 (recipient's "out of pocket" expenses and his wife's expenses)
\$ 65 (recovery amount because it is less than expenditures)
\$150 Medicaid expenditures

For June:
\$100 (difference between correct and incorrect spend-down)
- 40 (wife's expenses)
\$ 60 (recovery amount)
\$ 50 Medicaid expenditures; Recovery amount

For July:
\$100 (difference between correct and incorrect spend-down)
The recovery amount is \$100

The total recovery amount is \$215.

4630.00.00 INITIATING COLLECTION ACTION

Collection activity will begin when the BV worker changes the status code on screen BVRC to OA, Open Awaiting Client Response. This will generate the demand notice (BV01) to the payee of the AG for repayment of the claim.

Claims against an AG with multiple claims will be collected in sequence. When a collection is received, the payment will be posted on the '01' claim until it is paid in full, then the '02' claim, etc. It is possible to rearrange the sequence for repayment on ICES screen BVCA.

4630.25.00 NOTIFICATION OF MEDICAID OVER ISSUANCE

After the benefit recovery referral has been investigated and established as a claim, code OA should be entered in the status field of BVRC to open the claim. When the code is entered the system automatically generates a notice of Medicaid over issuance (BV01). The notice lists the amount of the overpayment, available repayment methods and appeal

4635.00.00 RECOVERY METHODS

Recovery of amounts of over issuance will be made by one or more of the following methods:

Lump sum and/or installment payments;

Interception of lottery winnings;

Federal pay and/or State tax refund interceptions; or

A combination of the above.

The BV worker must notify the overpaid AG of the amount and cause of over issuance as well as the various repayment methods available. This is done when opening the claim by putting it in 'OA' status on BVRC. ICES then generates the BV01, Notice of Overpayment. Sections 4635.05.00 through 4635.10.30 describe methods of repayment.

4635.05.00 LUMP SUM AND INSTALLMENT PAYMENTS

AGs will be given the option of repaying an over issuance either in a lump sum or in regular installments. This includes former AGs who are under court order to repay, as long as the order does not require repayment in a specific manner.

The BV unit will negotiate a payment schedule with the AG and accept regular installments for repayment of any amounts of the over issuance not repaid through a lump sum payment. Any payment will be accepted and credited to the claim, but unless the repayment plan is acceptable, it will not prevent the claim from being delinquent. Payments are due by the 28th of each month. If the minimum acceptable payment is not made by that date, the claim is delinquent. If the client has both a TANF and/or a Medicaid and a SNAP overpayment and does not specify to which claim a repayment should be applied, the payment is to be divided equally between each program.

Minimum acceptable payments will repay any claim within three years. Screen BVPC records lump sum and installment payments made by the individual against an over issuance claim. When the claim is paid in full, the system will automatically close the claim and send an alert to the worker. All payments can be seen on screen BVTH. Through screen BVTR, Financial Management can reverse any payment that has already been posted. For example, if an incorrect payment amount was entered by the Accounting Section, payment reversals entered on BVTR will automatically debit claim payments and adjust the claim balance.

4635.10.00 Social Security Benefits

Medicaid benefit recovery cannot be made from active members of RSDI or SSI benefits provided by the Social Security Administration. The federal government is only allowed to pursue garnishment of benefits in the following situations:

- 1) Payments for child support or alimony;
- 2) Payments for court-ordered victim restitution;
- 3) Levy for unpaid federal taxes.

4635.25.00 CIVIL ACTION

All steps necessary to institute civil action are taken when the BV unit determines that such action is required to recover over issuances from former AGs.

If a case is returned indicating that civil action cannot be taken against an AG, the BV unit will notify the referring caseworker that there is an unpaid over issuance which cannot be collected at this time. If the former AGs receive Food Stamp or TANF benefits at a later date, appropriate recoupment action must be taken.

4635.30.00 VOLUNTARY REPAYMENT/CIVIL RECOVERY

After determining that a Medicaid overpayment has occurred and repayment is appropriate, the DFR is to discuss with the AG the reason recovery is necessary and whether or not he will voluntarily make repayment. If the AG is willing to repay, he must sign a repayment agreement.

Cases are to be referred to Small Claims Court when AGs refuse to sign the repayment agreement or fail to make repayment within the specified period of time. The DFR must present to the judge all necessary evidence, including the legal basis, substantiating that benefits were paid incorrectly in behalf of the individual. Additionally, the DFR must present documentation showing potential sources from which recovery can be made.

Recovery cannot be made from SSI benefits provided by the

Social Security Administration.² However, Small Claims Court can still issue a judgment if the AG has no available income or assets or his MA case has been discontinued.

When the DFR receives a favorable judgment in a Small Claims Court, the judgment is to then be entered on the Circuit Court docket as a permanent court record since this is not done by a Small Claims Court. Through this recording an individual can be pursued on the judgment through a lien on real property.

The FSSA Office of General Counsel is to be consulted for specific information and/or assistance regarding Small Claims Court procedures and other legal matters which may arise when pursuing recovery.

4635.35.00 HEARING REQUESTED ON OVER ISSUANCE

When an AG requests a fair hearing regarding the circumstances of an over issuance, the amount of over issuance, or the repayment plan established by the BV unit, the Request for Hearing Screen HERQ must be completed. When the individual's request is in writing, a copy must be sent to Hearings and Appeals, 402 West Washington Street, Room E034, Indianapolis, IN 46204. A copy may also be faxed to 317-232-4412.

When an AG requests an appeal of the claim, the BV worker needs to code BVCP with a repayment agreement type of "AP" to show the claim is under appeal. When the hearing decision is issued, an alert will be generated so the worker is aware of the results. If the county is sustained, the worker will request a new notice be generated to the AG giving them another 30 days to sign a repayment agreement and make their first payment. If the county is not sustained, the claim will need to be terminated and any payments that had been collected will need to be refunded. The Administrative Law Judge may remand it back to the county to make adjustments in which case a new Notice of Overpayment (BV01) would be sent.

When the final hearing decision is received, repayment will begin the following month in the amount specified by the hearing decision.

4640.00.00 TRANSMITTAL OF REPAYMENT

Payments must be mailed to:

FSSA Claim Repayment
P.O. Box 1007
Indianapolis, IN 46262-1007

All checks or money orders should be made payable to "State of Indiana". The person's name, claim number, RID number

² 42 CFR 433.36

or Social Security Number should be on the payment. The check and/or money order are receipts of payment. Financial Management will post all payments.

If no referral has been made prior to the repayment, an eligibility worker must complete the referral screen BVBR immediately so the claim can be established and repayments can be accepted.

4650.00.00 CLAIMS AGAINST THE ESTATE

Under the provisions of the Social Security Act (42 USC 1396p) the state is required to recover certain Medicaid benefits correctly paid on behalf of an individual from the individual's estate.³

The circumstances under which a recovery claim must be filed are explained in this and the following sections.

Upon the death of a Medicaid recipient, the total amount paid for medical coverage, except as explained in Section 4650.05 and Section 4650.20.10, is allowed as a preferred claim against the estate of such person in favor of the state. All assets owned by the deceased individual at the time of death, including both real and personal property, become a part of the estate, even if no probate proceedings are initiated in court. The estate does not include property held jointly with rights of survivorship, property held in trust, or life insurance proceeds paid to the deceased's survivors or other beneficiaries.

The claim provision is applicable to all categories of MA, including the categories providing limited coverage, except for SLMB (MA J) and QI (MA I and MA K). This exception applies to recipients who die on and after May 1, 1999 and is applicable to the state's payment of the Medicare premiums. Amounts paid for Medicare premiums under any MA Category will not be recovered from the recipient's estate. For recipients whose death occurred before October 1, 1993, the claim includes benefits paid for services provided after the recipient became 65 years of age. For recipients whose death occurs after October 1, 1993, the claim includes benefits paid for services provided

- 1) After the recipient became age 55 if the services were provided after October 1, 1993, and
- 2) After the recipient became age 65, if the services were provided before October 1, 1993.

In addition, a claim against the estate can be filed for the amount of Medicaid benefits "incorrectly paid" on behalf of

³ IC 12-15-9-1; Social Security Act, Section 1917(b)(1)

a recipient regardless of age.⁴

It is not required that there be a previous court judgment as to the amount of Medicaid benefits incorrectly paid. However, the existence of such a court judgment would expedite the probate proceedings when the claim against the estate is filed.

4650.05.00 NON-ENFORCEMENT OF CLAIM

If a spouse survives the recipient, recovery shall be made after the death of the surviving spouse. Only those assets that were included in the recipient's probate estate are subject to recovery after the surviving spouse's death.⁵

If the recipient (or the recipient's spouse upon his or her death) is survived by a dependent child, no recovery shall be made while the child is under age twenty-one (21) or is a dependent who is non-supporting due to blindness or disability by SSI standards.⁶

In addition a claim may not be enforced against the personal effects, ornaments, or keepsakes of the deceased.⁷

Resources that are protected under the Indiana Long Term Care Program (ILTCP) are not subject to recovery from the recipient's estate. Refer to Section 2615.25.15 concerning the ILTCP.⁸ A claim may be waived if it is not cost effective to pursue the claim. If the cost of collection is equal to or exceeds the amount that can be collected, then it is not cost-effective to pursue the claim.

4650.10.00 FILING THE CLAIM

Estate administration may be accomplished using one of the following three procedures: supervised administration (the normal procedure), unsupervised administration, or by a "no administration" procedure. The process for filing claims depends on the type of estate administration procedures used.

When estates are administered under the supervised and unsupervised administration procedures, the probate court first appoints a personal representative to administer the estate. The personal representative then "opens" the estate. Once an estate is opened for probate, a notice to

⁴ IC 12-15-2-19

⁵ IC 12-15-9-5

⁶ IC 12-15-9-2

⁷ IC 12-15-9-2

⁸ 405 IAC 2-8-1(e)(2)

creditors is published in the legal notices of a local newspaper of general circulation. After published notification, there is a five-month period during which creditors of the deceased individual may submit claims against the estate. While the five-month time limit does not apply to governmental entities, it is important for the DFR to submit claims as soon as possible. The DFR should file the claim within five-months whenever possible.

A systematic and regular review of the legal notices and the probate docket of the county probate court are to be made by the DFR to ascertain whether or not an estate has been opened for any deceased MA recipients. As soon as the DFR learns that an estate has been opened, the DFR should initiate the process for filing a claim with the probate court.

Estates with a gross value under \$50,000 and meeting certain other legally established conditions, may be settled using the "no administration" procedure. In these cases, there are no probate court proceedings, and a claim by small estate affidavit may be used to claim assets.

A claim by small estate affidavit cannot be made until forty-five (45) days have elapsed since the death of the decedent. The affidavit must be made by or on behalf of the DFR and state the following: 1)the value of the gross probate estate wherever located (less liens and encumbrances) does not exceed fifty thousand dollars (\$50,000); 2) forty-five (45) days have elapsed since the death of the decedent 3)no application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction; and 4) the claimant is entitled to payment or delivery of the property.⁹

When preparing a claim, the DFR is to request from the Office of Medicaid Policy and Planning (OMPP), via State Form 6533, Medicaid Expenditures Request, and the total amount of Medicaid expenditures paid on behalf of the individual. The address is: OMPP, ATTN: Estate Recovery, 402 W. Washington, Room W-382 MS 07, Indianapolis, IN 46204. The claim against the estate should be filed with the Clerk of the Probate Court as soon as possible. (However, when a small estate claim affidavit is used, it is presented to whoever is holding assets of the deceased, and is not filed with the Clerk of Probate Court). The form on which the claim is filed may be obtained from the

4650.10.05 Recovery from Special Needs Trusts

Funds remaining in a "special needs trust", as defined in Section 2615.75.20.05, are to be recovered after the recipient's death.

⁹ IC 29-1-8-1

These claims will not require the preparation of an affidavit or filing with the probate court. Because the terms of the trust require the trustee to pay any remaining funds to the state up to the amount of Medicaid expenditures, the state's claim is to be presented to the trustee for payment. This is accomplished by letter to the trustee signed by the local DFR office manager with documentation of expenditures attached. The claim includes all Medicaid expenditures on behalf of the deceased, regardless of age.

4650.15.00 OPENING AN ESTATE

If an estate is not opened and the heirs have no intention of doing so, any interested party (such as a creditor) may petition the court to open an estate and to request the appointment of an administrator. Prior to petitioning the court, these cases should be evaluated by the DFR in conjunction with an FSSA attorney, to determine if there are sufficient assets in the estate to offset the cost of opening and administering the estate. If not, opening an estate should not be initiated.

Cases in which there are sufficient assets should be referred to the FSSA attorney to prepare and file with the court, a petition to open an estate and appoint an administrator.

4650.20.00 PRIORITY OF THE CLAIM

Payment of debts from resources in the estate of the decedent is made in accordance with legally-established priorities. Priority in the payment of claims is important whenever the estate of the deceased is insolvent (such as when the total amount of all claims against the estate exceeds the assets of the estate). If the amount of the DFR claim is not satisfied in full after distribution of the estate assets, such debt must be considered cancelled.

The FSSA attorney should be consulted regarding the order of priority of the DFR claim in relation to that of other claimants.

4650.20.05 Compromise Of Claims

IC 4-6-2-11 provides "No claim in favor of the state shall be compromised without the written approval of the governor and the attorney general, and such officers are hereby empowered to make such compromise when in their judgment, it is the interest of the state so to do."

This applies to situations where the State agrees to accept less than the amount that is available and to which it is legally entitled. If the estate is insolvent and the State will receive the entire balance of the estate after payment of claims that have higher priority, that is not a

compromise and it does not require the approval of the governor and attorney general.

The settlement must be in the State's best interest. In most cases for which a compromise is approved, there is some reason that the claim would be risky to pursue. Some examples are when 1) another claim arguably has priority such as expenses of last illness, 2) there is a dispute as to the amount of the claim, or 3) the asset is a land contract or other asset that is not easily liquidated and the State agrees to accept cash in a lesser amount.

Procedure for Approval

The DFR or the FSSA attorney should submit to the Office of Medicaid Policy and Planning (OMPP), attn: Estate Recovery Specialist, in writing, the following information: 1) the amount of the claim, 2) available assets in the estate, 3) the proposed settlement, and 4) the reason for settlement, and 5) why it is in the best interest of the state to accept the settlement. OMPP will forward the information to the collection section of the attorney general's office for final action.

4650.20.10 Waiving Estate Claims For Undue Hardship

The Medicaid program's claim against the estate of a deceased recipient must be waived if enforcement of the claim would result in undue hardship for an heir.¹⁰

The decision to approve or deny an application for a waiver of the estate recovery claim will be made by the Office of Medicaid Policy and Planning based on information provided by DFR staff and the FSSA attorney in accordance with the following procedures.

1. At the time a claim is filed, a notice is to be included with the claim, explaining the undue hardship provisions and the process for applying for a waiver of the state's claim. An application (State Form 48259/OMPP 003) is to be provided upon request to an heir who wishes to apply for a waiver.
2. The hardship applicant will complete the form and return it, along with supporting documentation, to the attorney or designated local DFR office staff person. The applicant must indicate one of four situations as the basis for his claim:
 - a. Enforcement of the state's claim will cause the applicant to become eligible for public assistance;

¹⁰ IC 12-15-9-6; 405 IAC 2-8-2

- b. Enforcement of the state's claim will cause the applicant to remain dependent on public assistance;
 - c. Enforcement of the state's claim will result in the complete loss of the applicant's sole source of income and the beneficiary's income does not exceed the Federal Poverty Level (FPL);
 - d. Other compelling circumstance (the applicant must describe).
3. If the applicant indicates only the last category, other compelling circumstances, the application is to be immediately forwarded to the Office of Medicaid Policy & Planning, attn: Estate Recovery Specialist, Indiana Government Center South, 402 West Washington St., Indianapolis, IN 46204. If any of the other three situations are checked by the applicant, the local DFR office must make the appropriate determination, attach all documentation to the application and forward it to the OMPP.
4. If the applicant specifies hardship category 2a or 2b, the DFR must determine if the hardship applicant would be eligible for TANF, Medicaid, Food Stamps, or SSI if he/she loses access to the asset(s) in the deceased recipient's estate. The caseworker's determination must show the eligibility result as if the applicant owned the asset and as if he did not own it. For example:

A recipient and his non-disabled son live together on a farm. The son works on the farm and his father shares the farm income with him. The property is in the recipient's name only and when he dies the property becomes subject to estate recovery. The son, who is beneficiary of the estate, applies for a hardship waiver claiming that without the income from the property, he will become eligible for Food Stamps. The DFR must make a Food Stamp eligibility determination. (The son does not need to actually file a Food Stamp application.) The caseworker determines that if the applicant were to own the farm, he would not be eligible for Food stamps due to the income he would have from the farm. Without the farm and its income, he meets Food Stamp eligibility requirements. Therefore, if the state enforces its claim against the estate, the son would become eligible for assistance.

In the above example, assume that father and son do not live together. The son is employed and he and his family receive Food Stamps. When his father dies, he files a hardship application claiming that if he could be allowed to inherit the farm he would no longer need Food Stamps. The

caseworker's determination shows that if he owned the farm he would lose Food Stamp eligibility.

The hardship applicant is responsible for providing all necessary verifications. Caseworkers should apply the usual verification requirements in a hardship determination, and inform the applicant in writing of the documentation that he must provide to substantiate the hardship claim. The caseworker will need to inform the applicant of the various types of acceptable verification; however, the responsibility for obtaining the verification rests solely with the applicant. The determination must be made within 30 days of receipt of the application and forwarded to the OMPP. If the applicant does not provide necessary verification within 30 days, the caseworker must indicate such in a letter accompanying the application to the OMPP. The letter should specify the verifications that the applicant failed to submit and a copy of the caseworker's notification to the applicant concerning the need for verifications should be included.

5. If a hardship applicant claims that his only source of income comes from the property in the estate, the caseworker must determine whether or not that income is less than the FPL. The standards effective 2/24/98 are as follows:

Family Unit	Annual Standard
1	\$ 8,050
2	10,850
3	13,650
4	16,450
5	19,250
6	22,050
7	24,850
8	27,650
Each additional, add	2,800

For this determination, "family unit" is defined as a group of persons related by birth, marriage, or adoption who live together. In determining the amount of income to compare to the standard, the caseworker will consider: 1) gross income from employment, 2) all unearned income, and 3) net self-employment income and rental income in accordance with the methodologies used for the aged, blind, and disabled Medicaid categories. The applicant is responsible for providing the necessary verifications.

6. The Office of Medicaid Policy and Planning will make a decision to approve or deny the application and will issue a Notice of Action, State Form 48260/OMPP 0004, to the applicant within 45 days of the application date. A copy of the notice will be sent to the FSSA attorney. An applicant has the right to appeal the decision.