STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, June 15, 2017

CF OPERATING PROCEDURE
NO. 165-17

Economic Self-Sufficiency Services

BENEFIT RECOVERY CLAIMS

This operating procedure describes the policies governing the Benefit Recovery (BR) unit in the establishment of claims in the Food Assistance, Temporary Cash Assistance, and Medicaid Programs.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

JERI CULLEY
Assistant Secretary for
Economic Self-Sufficiency

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

This operating procedure has been updated to reflect current claims policies, incorporating changes occurring since 2002. The procedures for Benefit Recovery Accounting can be found in CFOP 165-18, and the procedures for Benefit Recovery Collections can be found in CFOP 165-19.

This operating procedure supersedes the claims chapters of CFOP 165-17, dated December 1, 2002.
OPR: Public Benefits Integrity
DISTRIBUTION: OSGC; OSIH; ASGO; Region/Circuit Economic Self-Sufficiency staff.

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Chapter 1

INTRODUCTION

1-1. Purpose.

a. This operating procedure describes the policies governing the Office of Public Benefits Integrity Benefit Recovery (BR) program in the establishment of claims in the Food Assistance, Temporary Cash Assistance, and Medicaid Programs.

b. This operating procedure will not describe the procedures necessary for establishing and processing claims. The procedures for establishing and processing claims may be found in CFOP 165-18.

1-2. Definitions of Benefit Recovery (BR) Terms.

a. ACCESS. Automated Community Connection Economic Self- Sufficiency.

b. ACCESS Document Imaging (ADI). An easily accessible method of storing documents used to determine eligibility as well as a variety of administrative functions. The system allows staff to view images of customer information from any computer inside the DCF firewall with access to the intranet without regard to location. ADI replaced the paper file records; once scanned, the electronic version is designated as the copy of record.

c. Administrative Disqualification Hearing (ADH). An administrative disqualification hearing held by the Office of Appeal Hearings when requested by the Department of Children and Families through the Division of Public Assistance Fraud or Public Benefits Investigations (PBI). There must be documentary evidence available to substantiate that the household member intentionally violated a food assistance or Temporary Cash Assistance Program rule.

d. Administrative Error (Agency Error) (AE). A term used when the Department's action or inaction results in an overpayment of food assistance, Temporary Cash Assistance, or Medicaid.

e. Aid to Families with Dependent Children (AFDC). Now known as Temporary Cash Assistance (TCA) and Temporary Assistance for Needy Families (TANF).

f. Assistance Group (AG). Members in the assistance group at the time of the overpayment; some or all of whom are responsible for paying back the overpayment claim.

g. Authorized Representative. An Adult non-household member who is authorized in writing by the head of household, spouse, or another responsible member to act on behalf of the household if the household has difficulty completing the eligibility processes. An authorized representative may be authorized to act on behalf of a household in the application process, obtaining benefits, and using benefits. The authorized representative authorized for using benefits receives an Electronic Benefits Transfer (EBT) card for this purpose. The authorized representative designated for application processing purposes may also carry out household responsibilities during the certification period such as reporting changes in the household's income or other household circumstances. Residents of drug or alcohol treatment centers must apply and be certified through the use of an authorized representative. Residents of group living arrangements have the option to apply and be certified through the use of authorized representatives.

h. BR. Benefit Recovery.

i. Client Error (IHE/IPV). A term used whenever a recipient fails to report accurate information that results in an overpayment. Both Inadvertent Household Error (IHE) and Intentional Program Violation (IPV) are attributed to Client Error.

j. Division of Public Assistance Fraud (DPAF). A division of the Department of Financial Services that investigates public assistance fraud previously known as PAF.

k. Economic Self-Sufficiency Specialist (ESS). The individual that processes the food assistance, Temporary Cash Assistance, and/or Medicaid application.

l. Electronic Benefit Transfer (EBT). A system used to enable recipients to access their public assistance benefits with an EBT card.

m. FA. Food Assistance.

n. Florida On-Line Recipient Integrated Data Access (FLORIDA). The Florida public assistance computer system used to determine and track a recipient's eligibility and receipt of public assistance benefits.

o. FNS. Food and Nutrition Service.

p. IBRS. Integrated Benefit Recovery System.

q. IEVS. Income and Eligibility Verification System.

r. Inadvertent Household Error (IHE). A term used when a misunderstanding or unintentional error is made by the household which results in an overpayment of food assistance, Temporary Cash Assistance, or Medicaid. Also known as Client Error.

s. Intentional Program Violation (IPV (Fraud). A term used when a court of appropriate jurisdiction finds an individual guilty, an administrative disqualification hearing, a disqualification consent agreement or signed waiver, determines the individual or household fraudulently received public assistance they were not entitled to receive which caused an overpayment.

t. Liable Individual. An assistance group member who is either individually or jointly responsible for repayment of overpaid benefits.

u. MEDS. Medicaid Expansion Designated by SOBRA.

v. MN. Medically Needy.

w. MNIL. Medically Needy Income Level.

x. Notice of Case Action. A notice sent to the overpaid payee informing the household of the overpayment claim amount, hearing rights and repayment options. Also referred to as Overpayment Notice.

y. Office of Appeal Hearings (OSIH). A unit within the Office of Inspector General within the Department of Children and Families. The office employs full time hearing officers to conduct hearings for cases in which an action, intended action or failure to act would adversely affect the recipient's or family's eligibility for an amount or type of food assistance benefits, Financial Assistance, Medical Assistance, Social Services, or where action on a claim for such assistance or services is unreasonably delayed. These hearings are generally referred to as "Fair Hearings" in federal regulations.

z. OPBI. Office of Public Benefit Integrity.

aa. PA. Public Assistance.

bb. PIU. Program Improvement unit.

cc. Public Benefits Investigations (PBI). Formerly referred to as ACCESS Integrity or Front-end Fraud Prevention.

dd. QC. Quality Control.

ee. RAP. Refugee Assistance Program, Cash Assistance and Medicaid.

ff. SAO. State Attorney Office.

gg. SOBRA. Sixth Omnibus Budget Reconciliation Act.

hh. SOC. Share of Cost.

ii. SSI. Supplemental Security Income.

jj. TANF. Temporary Assistance for Needy Families.

kk. TCA. Temporary Cash Assistance, formerly known as AFDC.

ll. Treasury Offset Program (TOP). A federally mandated collection program that allows interception of federal payments (called offset) in order to repay established food assistance claims. Formally known as FTROP (Federal tax refund offset program).

mm. USDA. United States Department of Agriculture.

nn. WAGES. Work and Gain Economic Self-Sufficiency (replaced by Temporary Cash Assistance).

1-3. Legal Basis.

a. Food Assistance Overpayment.

(1) Food assistance overpayment policies contained in this operating procedure are based on Title 7 Code of Federal Regulations 273.18 and Chapter 414 of the Florida Statutes.

(2) Title 7 Code of Federal Regulations Chapter 273.18 requires the state agency to "establish a claim against any household that has received more food assistance benefits than it is entitled to receive," and to initiate collection against households as determined by specific criteria presented in the regulations.

b. Temporary Cash Assistance (TCA) Overpayment.

(1) Temporary Cash Assistance overpayment policies contained in this operating procedure are based on 45 Code of Federal Regulations 233.20, Chapter 65A-1.900 of the Florida Administrative Code, and Chapter 414 of the Florida Statutes. Temporary Cash Assistance policies became effective October 1996, in Florida. Overpayment claims for periods prior to October 1996 are based on AFDC, both state and federal, policy in effect when the overpayment occurred.

(2) Chapter 414, Florida Statutes, "specify" uniform statewide policies for recovery of overpayments of assistance, including overpayments resulting from assistance paid pending hearings decisions.

c. Medicaid Overpayment. Medicaid overpayment policies contained in this operating procedure are based on Medicaid eligibility criteria as presented in 42 Code of Federal Regulations Part 435, or Chapter 414, Florida Statutes.

d. General Program Regulations.

(1) Chapter 414.39, Florida Statutes, provides that:

(a) Any person who knowingly:

1. Fails by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose a material fact used in making a determination as to such person's qualification to receive public assistance under any state or federally funded assistance program;

2. Fails to disclose a change in circumstances in order to obtain or continue to receive any such public assistance to which he or she is not entitled, or in an amount larger than that to which he is entitled; or,

3. Aids and abets another person in the commission of any such act commits a crime and shall be punished as provided in subsection (5) of the statute.

(b) Any person who knowingly:

1. Uses, transfers, acquires, traffics, alters, forges, or possesses;

2. Attempts to use, transfer, acquire, traffic, alter forge or possess; or,

3. Aids and abets another person in the use, transfer, acquisition, traffic, alteration, forgery, or possession of, a food assistance identification card, an authorization including, but not limited to, an electronic authorization, for the expenditure of food assistance benefits, a certificate of eligibility for medical services, or a Medicaid identification card in any manner not authorized by law commits a crime and shall be punished as provided in subsection (5) of the statue.

(c) Any person having duties in the administration of a state or federally funded public assistance program or in the distribution of public assistance or authorizations or identifications to obtain public assistance, under a state or federally funded public assistance program and who:

1. Fraudulently misappropriates, attempts to misappropriate, or aids or abets in the misappropriation of food assistance, an authorization for food assistance, a food assistance identification card, a certificate of eligibility for prescribed medicine, a Medicaid identification card, or public assistance from any other state or federally funded program with which he or she has been entrusted or of which he or she has gained possession by virtue of his or her position, or who knowingly fails to disclose any such fraudulent activity; or,

2. Knowingly misappropriates, attempts to misappropriate or aids or abets in the misappropriation of, funds given in exchange for food assistance program benefits or for any form of food assistance benefits authorization, commits a crime and shall be punished as provided in subsection (5) of the statute.

(d) Any person who:

1. Knowingly files, attempts to file, or aids and abets in the filing of a claim for services to a recipient of public assistance under any state or federally funded public assistance program for services which were not rendered, or knowingly files a false claim or a claim for

nonauthorized items or services under such a program or knowingly bills the recipient of public assistance under such a program or his or her family for an amount in excess of that provided by law or regulation;

2. Knowingly fails to credit the state or its agent for payments received from social security, insurance, or other sources; or,

3. In any way knowingly receives, attempts to receive or aids or abets in the receipt of, unauthorized payment or other unauthorized public assistance or authorization or identification to obtain public assistance as provided herein commits a crime and shall be punished as provided in subsection (5) of the statute.

(e) If the value of the public assistance or identification wrongfully received, retained, misappropriated, sought, or used is less than an aggregate value of $200 in any 12 consecutive months, such person commits a misdemeanor of the first degree, punishable as provided in s.775.082 or s.775.083.

(f) If the value of the public assistance or identification wrongfully received, retained, misappropriated, sought or used is of an aggregate value of $200 or more, but less than $20,000 in any 12 consecutive months, such person commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083 or s. 775.084, Florida Statutes.

(g) If the value of the public assistance or identification wrongfully received, retained, misappropriated, sought, or used is of an aggregate value of $20,000 or more, but less than $100,000 in any 12 consecutive months, such person commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, Florida Statutes.

(h) If the value of the public assistance or identification wrongfully received, retained, misappropriated, sought, or used is of an aggregate value of $100,000 or more in any 12 consecutive months, such person commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, Florida Statutes.

(i) Repayment of assistance benefits or services, return of authorization or identification wrongfully obtained is not a defense to, or ground for dismissal of, criminal charges brought under this section.

(j) The introduction into evidence of a paid state warrant made to the order of the defendant is prima facie evidence that the defendant did receive public assistance from the state.

(k) The introduction into evidence of a transaction history generated by a Personal Identification Number (PIN) establishing a purchase or withdrawal by electronic benefit transfer is prima facie evidence that the identified recipient received public assistance from the state.

(l) All records relating to investigations of public assistance fraud in the custody of the Department and the Agency for Health Care Administration are available for the examination by the Department of Financial Services DPAF pursuant to s.414.411 and are admissible into evidence in proceedings brought under this section as business records within the meaning of s. 90.803(6).

(2) Section 414.41, Florida Statutes, states that “whenever it becomes apparent that any person or provider has received any public assistance under this chapter to which he or she is not entitled, through either simple mistake or fraud on the part of the Department or on the part of the recipient or participant, the Department shall take all necessary steps to recover the overpayment.”

(3) Chapter 65 A-1.900, Florida Administrative Code, is a compilation of those administrative rules that relate directly to overpayment and BR. An administrative rule, in part, is a legal statement that implements, interprets, or prescribes law or policy or describes the organization, procedure, or practice requirements of an agency. Florida statutes provide the authority for the state to develop administrative rules that may not reflect information as presented in the Code of Federal Regulations.

1-4. Confidentiality.

a. Confidential information is any information supplied to the Department by a program applicant/recipient or by other sources in connection with that applicant/recipient's application for, or receipt of, food assistance, Temporary Cash Assistance, Refugee Assistance, or Medicaid. Benefit Recovery staff must comply with specific policies of food assistance, Temporary Cash Assistance, and Medicaid programs regarding confidentiality of information concerning and contained within the recipient's case file material.

b. Food assistance requirements regarding confidentiality of food assistance case records and their contents are found in Section 410.0100 of the Public Assistance Policy Manual (CFOP 165-22).

c. Specific policy regarding confidentiality measures to be taken concerning the Temporary Cash Assistance case file information may be found in Chapter 420.0000 beginning in Section 0420.0100 of the Public Assistance Policy Manual.

d. Medicaid program confidentiality requirements are NOT the same as those for Temporary Cash Assistance. Medicaid information may not be released to anyone, including the recipient, unless the disclosure is directly connected to the administration of the Medicaid State Plan. These requirements may also be found in Section 430.0100 of the Public Assistance Policy Manual.

e. The BR case file is a confidential record of the recipient's BR activities.

f. Each state agency staff member or any contractors employed by the state, whether in an administrative, professional or clerical support position, is expected to use all confidential information responsibly and in accordance with current program specific policy. The BR Supervisor or their designee must ensure the disclosure of case file information is in compliance with governing policies and ensure within reason the information will be safeguarded by the person to whom it is released. NO BR FILE INFORMATION MAY BE RELEASED OUTSIDE OF THE DEPARTMENT WITHOUT PRIOR APPROVAL FROM THE BR SUPERVISOR OR HIS/HER DESIGNEE.

(1) The nature of the information being requested, the reasons for the request and use to which it will be put must be considered prior to release of any information.

(2) WRITTEN PERMISSION FROM THE RECIPIENT IS REQUIRED PRIOR TO THE RELEASE OF ANY INFORMATION THAT IS CONTAINED IN THEIR BR CASE FILE OR THAT IS AVAILABLE TO BR STAFF THROUGH COMPUTER SYSTEM(S), MICROFICHE, OR OTHER PROGRAM CASE FILES (i.e., FOOD ASSISTANCE or AFDC/TEMPORARY CASH ASSISTANCE).

(3) Any request for release of case file information received by BR, whether written or verbal, must be included as a permanent part of the BR file.

(4) Verbal requests for case file information must be documented by the BR Supervisor or his/her designee, and that documentation (whether the request was approved or not) must be included in the BR file.

g. Confidential information may be shared with any Departmental staff without the recipient's written consent when that staff member has a need to know in conjunction with the process of establishing eligibility, amount of assistance, or otherwise providing service to the recipient.

h. DPAF representatives or a state attorney may also review BR file information without the recipient's written consent, provided they are conducting an investigation of welfare fraud that may involve that recipient's case.

i. Requests for information from a governmental authority, the courts, or law enforcement official, except for a state attorney investigating a welfare fraud case, are governed by the same policies as requests from any other outside requester. (See EXCEPTION in paragraph j below.)

j. Exception. The name and current address of a Temporary Cash Assistance recipient, who is a fugitive felon, may be released to a properly identified law enforcement official, if the official provides the Department the recipient's Social Security number and the requester satisfactorily demonstrates the recipient is a fugitive felon. A fugitive felon is an individual who has been charged with, or convicted of, a felony offense in a court of law that has subsequently concealed their whereabouts from court officials for the purpose of avoiding further prosecution and/or imposition of his or her sentence.

(1) If the official making the request for information comes into the office, that official must identify himself or herself as a law enforcement official by producing proper documentation that supports his or her claim. In addition, a felony warrant or other document verifying that the recipient is a fugitive felon must be presented before the recipient's name and current address can be released.

(2) If a request is made by telephone, the BR representative must request that the official making the request, leave his or her telephone number so a return call may be made to verify the requester is a law enforcement official. Inform the official that a felony warrant or other document establishing the recipient as a fugitive felon must be provided to the Department before the name and current address of the recipient can be released.

(3) If a request for information is made by letter, it must be made on the law enforcement agency's official letterhead stationary and must be accompanied by a felony warrant or other document establishing the individual is a fugitive felon. If the written request does not meet these conditions, the request will not be honored (a return response to the requester must explain why the request could not be met).

k. If a subpoena is issued for the food assistance or Temporary Cash Assistance case record, or for any agency representative to testify concerning an applicant or recipient (other than in child support or welfare fraud cases), the court's attention must be called to those programs' policies relating to confidentiality. CONSULT WITH REGION LEGAL STAFF UNDER THESE CIRCUMSTANCES.

l. The BR case file must not be made available in full to the applicant or recipient, their authorized representative or designated counsel, if it contains any reference to informants such as neighbors, family members, friends, acquaintances; employers, co-workers, landlords, business associates, counselors or other agency representatives.

(1) Prior to providing the case file for review, the BR representative must ensure that all references to information sources (informants) have been redacted from the case file as provided for in s. 119.07, Florida Statute. This information MUST NOT be released to the applicant/recipient, his or her authorized representative, or their designated legal counsel.

(2) Photo copying of case file material will be done in accordance with Department rules pertaining to DCF recipient records.

(3) The BR Supervisor or his/her designee must be present while the BR case file is being inspected.

(4) A ‘’verified” written statement from the recipient must be provided prior to providing case file information when the request to review a BR case file is made by a person claiming to represent the interests of the recipient.

(a) A “verified” written statement could include a notarized statement or a statement signed by the recipient (properly identified) at the BR office.

(b) The statement must be dated, identify the recipient as the author of the statement, provide the recipient's case number and/or social security number, specify the name of the person to whom permission to review the case file is being granted, and indicate the time limit the recipient wants to impose on that permission to review the case file (if any).

(c) The written statement permitting review of his or her BR case file must be retained as a permanent part of the recipient’s BR file.

(d) In the event that the case file information must be sent through the postal service, it must be sent certified mail (return receipt requested) or through a certified courier service. This restriction does not apply to routine business correspondence such as requests for information, billing statements; and other related notices.

(e) Medicaid related information must never be released to either the recipient or any other source unless it is related to the determination of eligibility for assistance. Consultation with region legal staff is recommended before releasing Medicaid information under any other circumstances.

(f) IRS and BEERS data exchange confidential tax and benefit information may be shared with other state agencies only under the condition that strict security guidelines will be followed by the state in the storage, use, and disclosure of that information. This sensitive data is available to authorized Department employees through the data exchange process of FLORIDA. Each employee is personally liable for any willful disclosure or misuse of the data and therefore must be aware of the security procedures and penalties for improper use or disclosure. 26 USC 6103(p)(4)(D) protects the confidentiality of federal tax information. Anyone who knowingly, or by reason of negligence, discloses IRS or BEERS data is in violation of the law. An individual who discloses this information may be subject to civil action by the taxpayer in an U.S. District Court. Refer to Chapter 3000 of the Public Assistance Policy Manual (CFOP 165-22) for additional information regarding security of information disclosed through the Data Exchange System.

(g) Screen prints, listings, and other information containing recipient information must be shredded or placed in containers designated for secure destruction, when no longer needed.

1-5. Statute of Limitations.

a. Food Assistance.

(1) No claim will be computed for overpayment that occurred more than six years before the agency became aware of the overpayment.

(a) Inadvertent Household Error claims will be established when 30 months or less has elapsed between the month an overpayment occurred and the month the Department discovered the overpayment. If an overpayment also existed in the month of discovery, that month

would be included in the overpayment claim in addition to an overpayment that occurred in prior months even if it would result in 31 months of overpayment.

(b) The BR Claims Supervisor or Claims Examiner must cancel referrals with a discovery date more than 30 months from the date that the overpayment occurred. This may be determined by comparing the discovery date with the end date of the overpayment period. The BR staff will update the FLORIDA CLRC screen with the reason for the cancellation of the referral.

(2) Administrative Error (Agency Error) claims will be established when 12 months or less have elapsed between the month the overpayment occurred and the month the Department actually discovered the overpayment. If an overpayment existed during the month of discovery it may be included as a month of overpayment in addition to the 12-month time limitation.

(3) Intentional Program Violation claims will be calculated from the month the fraudulent activity initially occurred UNLESS that month is more than six years prior to the date of discovery. Benefit Recovery will not include in its overpayment claim any amount of overpayment that occurred in a month that falls more than six years from the date the overpayment was discovered.

b. TCA and Family Related Medicaid.

(1) A non-fraud overpayment claim establishment for both Agency and Client Error cases is limited to four years prior to the month the overpayment was initially discovered by or reported to the Department. The Claims Supervisor or Claims Examiner may cancel any referral with a discovery date more than 48 months from the end date of the overpayment period.

(2) Suspected fraud overpayment claim establishment is restricted by the statute of limitations for criminal prosecutions for fraud. A case involving fraud must be prosecuted before a period of two years for a misdemeanor or three years for a felony has elapsed from the date the fraud occurred until the case is filed with the state attorney.

c. SSI-related Medicaid.

(1) A non-fraud overpayment claim establishment for both Agency and Client Error cases is limited to the 24-months prior to the month the overpayment was initially discovered by or reported to the Department.

(2) Suspected fraud overpayment is limited to the 36-months prior to the month the overpayment was initially discovered by the Department

Chapter 2

GENERAL – ADMINISTRATIVE

2-1. Responsibilities. Responsibilities and duties required of BR Program staff vary according to their level of administration within the program. Some of the positions in the claims section of BR include Claims Examiners, Claims Lead Worker, Claims Supervisor, Hearing Specialist, Trainer, and specialized positions for Lottery, TOP, Program Improvement, and Compromise. The Division of Public Assistance Fraud in the Department of Financial Services conducts criminal investigations and supports the prosecution of public assistance fraud cases.

a. Benefit Recovery Chief. The BR Program Manager is responsible to ensure the program meets state and federal requirements.

b. Benefit Recovery Supervisors. Supervisors ensure that all work assignments are complete within designated time standards and in accordance with current rules, regulations, policies and procedures, and those individual members meet or exceed goals in accordance with program requirements.

c. Claims Unit Staff.

(1) Lead Claims Examiner. A Lead Claims Examiner reviews a representative sample of each Claims Examiner's workload each month; supports the unit Supervisor; and mentors Claims Examiners.

(2) Claims Examiner. Claims Examiners must evaluate referrals to determine whether an overpayment has occurred. If no overpayment is found the referral is cancelled. If an overpayment exists, an overpayment claim is established for the amount of erroneous benefits based on federal regulations and state statutes.

d. Program Improvement Unit (PIU). The Program Improvement Unit was established in 2014 to perform two specific functions: (1) data analytics; and (2) monitoring of program specialists.

e. Benefit Recovery Special Projects Unit. The statewide unit will coordinate specialized BR activities relating to administrative disqualification hearings, fair hearings related to BR, Treasury Offset Program (TOP) and training, and agency compromise.

f. Division of Public Assistance Fraud (DPAF). The Department has a Memorandum of Agreement with DPAF to perform investigations of recipients suspected of fraudulent receipt of public assistance benefits and to initiate prosecution and administrative disqualification hearing action against those recipients on behalf of the Department. All cases of potential overpayment due to suspected fraud are sent to DPAF.

g. Public Benefits Investigations (PBI). The Public Benefits Investigations (PBI) program formerly referred to as ACCESS Integrity is designed to combat fraud and reduce misspent dollars in the public assistance programs. Public Benefits Investigations will provide all information needed to BR for overpayment computations needed for administrative disqualification hearings and waivers.

h. Fraud Reward Assessment Team (FRAT). Individuals may report suspected fraud using the online website or the fraud hotline. The reporter may receive a reward of up to 10% of the amount recovered or $500,000 whichever is less in a single case. Individuals are not eligible to receive additional rewards through the program. The reporter must be at least 18 years old and make the report to DCF, DFS, or FDLE. The crime must be related to criminal fraud in the Public Assistance

program, and must contain original information that leads to the recovery of a fine, penalty, or forfeiture of property.

i. Public Assistance Case Manager and Unit Supervisor (ESS). Economic Self Sufficiency case managers and supervisors are responsible for creating, maintaining, and updating case records and related materials to determine correct benefit amounts for public assistance cases. (Specific responsibilities of the Economic Self Sufficiency staff, as they relate to the BR Program, can be found in Chapter 3600, Section 3610.05 of the Public Assistance Policy Manual.)

j. Medicaid Providers. Medicaid provider fraud cases are NOT processed by BR. Any provider fraud referrals received by the BR unit must be forwarded to the Medicaid Provider Fraud Unit (Agency for Health Care Administration) directly or through DPAF.

2-2. The Benefit Recovery Case Record. The BR electronic case records are saved on the Integrated Benefit Recovery System (IBRS), and are the permanent record of all BR case activities. All forms, verification, documentation and correspondence pertaining to a recipient's history with BR are stored on the central ACCESS Document Imaging (ADI) system. As a public record, the BR case record must be available to be entered as evidence in a fraud proceeding, i.e., criminal fraud trial or an administrative disqualification hearing.

a. Maintenance. Maintenance of a BR case record is a state/federal requirement. Case records are subject to review by auditors at all established monitoring levels, including federal overview. The case records must document the circumstances that resulted in a claim, procedures used to calculate the amount of the claim, methods used to collect the claim and circumstances that resulted in the suspension or termination of collection activity.

b. Responsibilities. The ongoing maintenance of BR case material is a shared responsibility of all BR staff. None of the case record, including claims, case documentation, budgets, correspondence, and returned mail, may be destroyed or discarded.

c. Retention Requirements for Benefit Recovery Case Records. Benefit Recovery case records must be maintained for a specified period to meet reporting, monitoring, and record keeping requirements (CFOP 15-7, Schedule 12, Item #1 and Schedule 42).

d. Classification of Benefit Recovery Case Files.

(1) Benefit Recovery case files must be retained for 3 fiscal years provided applicable audits have been released and the claim has been satisfied.

(2) Benefit Recovery debt records, all accounting and collection activities for the claim must be retained for 30 fiscal years, or 5 fiscal years after final payment, whichever is sooner, provided applicable audits have been released.

e. Active BR Files.

(1) Active BR files are defined as files with pending claims or IHE/AE collectible claims in current repayment status. These files will be maintained in IBRS as active until the pending referrals are terminated (no claim), the recipient has paid out all claims, or the case status changes so that it meets the criteria for suspension, or write off. Intentional Program Violation claims must be maintained electronically indefinitely.

(2) Benefit Recovery cases pending action by the state attorney and cases in which an outstanding capias exists will be retained indefinitely pending disposition by the state attorney or the court. When a decision is reached, retention will follow IPV or non-IPV guidelines.

2-3. Policy Clearance Procedures. Request for policy clearances from the BR program must follow a standard format. Clearances must be requested by the Supervisor only after reviewing all BR resources. If an answer cannot be found, the clearance must be requested from the PIU.

2-4. Personnel Security Procedures.

a. All candidates being considered for appointment to sensitive positions in the BR Program must pass a preliminary background screening. A prospective employee will be screened against the FLORIDA System and the national Electronic Disqualified Recipient Subsystem (eDRS) to establish that they are not guilty of a public assistance intentional program violation (IPV). If a judicial or administrative determination of guilt has been finalized, that individual CANNOT be hired. See the Appointment Guide for Managers, Supervisors, and Human Resources Liaisons under the Human Resources Department for complete guidelines.

b. Although DPAF may request assistance from BR in these cases, as a rule DPAF and the state attorney's office, without the involvement of BR, will process employee fraud cases.

(1) Employee fraud cases must be maintained in a secure area by the BR Unit or PBI.

(2) The BR claims unit may be asked to prepare claim reports for DPAF investigators when an ACCESS employee created false households and caused benefits to be issued for food assistance, AFDC/Temporary Cash Assistance or Medicaid. When employee fraud does occur and the employee is arrested, BR staff determines the amount that was stolen and DPAF prosecutes the case.

(3) Employee fraud claims established in IBRS using reason code 882 (Employee Fraud) for an investigation for employee misconduct by the DPAF, or the Office of Inspector General, will be placed in referred for prosecution status. The Collections staff will monitor the cases for the court disposition.

(4) Once the court makes a decision on the employee fraud case, the Collections staff will reclassify the claim according to the final disposition order. Revenue Management will inform BR if an adjustment to the restitution ordered is needed to cover the Bond company expense.

2-5. Roberts vs. Austin Consent Judgement.

a. On January 13, 1981, a civil case was brought against the State of Florida, the Department of Health and Rehabilitative Services (now the Department of Children and Families) for giving food stamp recipient files to the state attorney for fraud investigation without any lawful process, subpoena or warrant. The case files requested for investigation were chosen solely because the affected households received food stamp allotments of $125 a month or more. No official of the Department, and no representative of the state attorney, had any reason to suspect that particular members of the affected households had engaged in public assistance fraud.

b. On May 14, 1983, the Department entered into a Consent Judgment in this case. The case was brought before the District Court on behalf of plaintiffs Alice Roberts, Mary Jo Roberts, Clara Lee London, Jane Doe, and all other persons similarly situated. The Consent Judgment is now known as "Roberts-vs-Austin." The Consent Judgment outlined certain criteria that had to be met by the Department prior to referring certain food stamp cases to what was then Overpayment, Fraud and Recoupment (OFR). It is now referred to as Benefit Recovery or referring a food assistance case or any information from a food assistance case to the Division of Public Assistance Fraud or the State Attorney's Office. The following is a summary of those elements of the Roberts-vs-Austin Consent Judgment that directly affect the Economic Self-Sufficiency overpayment referral procedures:

(1) The conditions established in the Consent Judgment will be applicable to all past, present, and future food assistance recipients of the State of Florida.

(2) The Department of Children and Families shall not provide a food assistance case file or any information concerning a food assistance case to a state attorney's office unless the conditions of the Consent Judgment have been met (see paragraphs (3) through (8) following).

(3) The Department of Children and Families must have a reasonable basis to suspect fraud in the case of a specific recipient prior to providing a food assistance case file or information concerning a food assistance case to the DPAF.

(4) The Department of Children and Families must provide written notice to a food assistance recipient or household advising them of any information received by the Department of Children and Families that causes their eligibility status or benefit level to become questionable. The notice must advise them that they are entitled to a reasonable amount of time to resolve the matter. If they fail to respond or fail to resolve the matter within 10 days, the case will be referred to DPAF for possible investigation. If DPAF declines to investigate and the referral is dropped, BR will process the referral without regard for Roberts-vs-Austin as it no longer applies.

(5) The Department shall, at minimum, ensure that advance notice is provided to the recipient or household, when a DPAF representative will be conducting a home visit. This ensures that the recipient or household is advised of their rights prior to any discussion with a DPAF representative.

(6) Division of Public Assistance Fraud may refer a recipient's case to a state attorney's office when an investigation has established reasons to suspect fraud in that case. The state attorney's office will decide if criminal prosecution is appropriate.

(7) Once a case is referred to the state attorney, the Department shall make that case available to their office.

(8) The Department shall refuse to release any case file to the State Attorney's office that has not been properly referred. This restriction would not prohibit the state attorney's office from providing the Department with information that could result in the Department referring the case to the Division of Public Assistance Fraud for investigation.

Chapter 3

BENEFIT RECOVERY OVERVIEW

3-1. Overpayment.

a. An overpayment exists when a recipient or assistance group receives benefits in an amount greater than that to which they were entitled. These benefits may be in the form of direct assistance (food assistance benefits, Temporary Cash Assistance or Refugee Assistance Program cash payment) or Medicaid payments. The term overpayment will be used throughout this operating procedure to include overpayment, which refers to food assistance overpayment.

b. Eligibility Specialists determine when a potential overpayment exists. When these staff make this determination, they process a referral of the assistance group to BR using the FLORIDA eligibility system.

c. Prioritizing and Assigning Overpayment Referrals. BR referrals are assigned to BR Claims Examiners each day via a "round robin" method. Assignment of current referrals to Claims Examiners is prioritized in the following order:

(1) Intentional program violation (suspected fraud) (all programs, both active and inactive);

(2) All quality control referrals (both active and inactive, all programs and error types);

(3) All active/inactive food assistance cases (all error types);

(4) All active/inactive cash assistance cases;

(5) Medicaid referrals not associated with suspected fraud;

(6) Companion referrals of a lower level may be completed with a higher level referral;

(7) Referrals may be canceled if there is not enough information provided in the file (on-line for electronic reviews) to establish verification that the referral is valid; and

(8) Overpayments from Inadvertent Household Errors or Agency Errors of less than $400 do not require a referral (Transmittal BR 2013-09).

d. Referral Disposition Time Frames. Referrals must be reviewed according to the following time frames:

(1) 45 day time standard:

(a) Suspected fraud referrals from the date the computation request is received from DPAF and the referral is available for processing on IBRS, whichever date is later;

(b) Suspected fraud referrals that are dropped by DPAF with a source code of FR or AH and PBI would like to pursue an ADH; or,

(c) Quality Control Referrals.

(2) Review of all non-fraud referrals must be completed within 180 days from the date the referral is received by BR on IBRS.

e. Food Assistance (FA) and Temporary Cash Assistance (TCA). The overpayment is the amount of food assistance and/or Temporary Cash Assistance benefits for a specific month a recipient or assistance group received over and above the amount of benefits they were actually entitled to receive.

f. Medicaid Overpayment. A Medicaid overpayment is the amount of Medicaid benefits paid on behalf of an individual or assistance group who was ineligible for medical assistance or services provided by a Medicaid approved provider.

(1) Medicaid ineligibility exists for any month in which a member of a Medicaid coverage group was totally ineligible for benefits received, unless that person was eligible for any other Medicaid coverage group. (See Chapters 6 and 7 of this operating procedure for Medicaid overpayment Ex Parte policies.)

(2) An overpayment in the Medically Needy program may exist in any month in which the recipient's share of cost (SOC) was understated. The amount of benefits paid on behalf of the recipient for any portion of the month that the recipient did not meet the SOC is considered an overpayment.

(3) If no benefits were paid on behalf of the ineligible individual or assistance group, a Medicaid overpayment does not exist.

(4) When any member of the assistance group is ineligible for medical benefits paid on their behalf, an accounting of those benefits including capitation fees must be obtained by accessing the Florida Medicaid Management Information System (FMMIS).

3-2. Overpayment Error Types. An overpayment may occur as a result of error on the part of the agency, the recipient, or both. A determination must be made for each occurrence of an overpayment regardless of the cause whether agency, recipient or both. There are four categories of error type: Agency Error, Inadvertent Household Error, Suspected Fraud, and Intentional Program Violation.

a. Administrative Error/Agency Error (AE).

(1) Agency Error occurs when an incorrect payment or benefit was received by or paid on behalf of a recipient or assistance group resulting from an error caused by the Department. Agency Error may occur because of a misapplication of policy, arithmetical error, computer processing error, failure to take prompt action on available information, duplicate payment of benefits or some other situation over which the agency has control.

(2) Under Temporary Cash Assistance policy only, an unavoidable overpayment occurs when both the agency and the recipient have done all they can to ensure that accurate benefits are received and an overpayment still occurs in the receipt of Temporary Cash Assistance.

b. Inadvertent Household Error (IHE). Inadvertent Household Error or Client Error exists when a recipient or assistance group unintentionally receives benefits they were not eligible to receive due to:

(1) Failure to provide, report or give complete, accurate or timely information about their circumstances resulting from negligence or misunderstanding of their responsibilities as a public assistance recipient; or

(2) Requesting a fair hearing and choosing to receive continued benefits pending receipt of the fair hearing decision. Any excess benefits received during the appeal process when the fair hearing is found in favor of the Department, are considered as Inadvertent Household (Client) Error (IHE) overpayment.

c. Suspected Fraud. This is a temporary classification pending a decision by a hearing officer or a court, regarding the issue of guilt. The referral has been investigated by PBI or DPAF, and a computation has been requested. The referral is considered non-fraud Client Error until the disposition is received.

d. Intentional Program Violation (IPV). Intentional program violation (fraud) exists when a court or Hearings Officer finds that a recipient knowingly failed to report or failed to correctly report information pertinent to their eligibility for assistance. Intentional program violation may include:

(1) Making a false or misleading statement to the ESS;

(2) Misrepresented, concealed, or withheld information including identity theft;

(3) Using food assistance/EBT benefits to buy non-food or unauthorized items such as alcohol or cigarettes (these cases would be processed by USDA);

(4) Presenting altered or changed documents to obtain benefits to which the household was not entitled;

(5) Using or possessing improperly obtained EBT benefits;

(6) Trading or selling food assistance/EBT benefits; or,

(7) Committing any act that constitutes a violation of the Food Stamp Act, the Food Stamp program regulations, or any Florida statute relating to the use, presentation, transfer, acquisition, receipt, or possession of Food Assistance benefits.

e. No Overpayment. When a referral reviewed for food assistance or Temporary Cash Assistance overpayment results in no overpayment, but intent to defraud is indicated, the case may be pursued as an administrative fraud case and referred to DPAF for the filing of an administrative disqualification hearing (ADH). No further action is required on referrals from other programs that result in no overpayment regardless of fraud intent. These referrals must be terminated and their unit of origin notified of their disposition. (See CFOP 165-13 for PBI procedures and for any exceptions to this policy.)

3-3. Simultaneous Overpayment. Simultaneous Overpayment is caused by more than one error type, e.g., Agency Error and Client Error, which occurs during a single month. When a simultaneous overpayment occurs in any month, the Claims Examiner must compute a budget for each error type beginning with suspected fraud, then Client Error non fraud, and finally Agency Error in that order (see Transmittal BR2016-06).

3-4. Continuous Overpayment. An overpayment is considered continuous even when the reason, the source, the amount, or the error type changes, provided the original basis of the overpayment and any other subsequent basis of the overpayment exists without a break of at least one month, with or without an actual overpayment of benefits (see Transmittal BR2016-03).

a. The basis is the factor (earned income, unearned income, and household composition) that caused the overpayment. A temporary decrease in income may cause some months of the claim to have no OI/OP, but the claim continues as long as the basis of the overpayment has not ended. A new start date does not need to be determined and OI/OP is considered continuous through those month(s) in which no OI/OP actually occurred.

b. The overpayment remains continuous without a new start date determination if the factor changes, but there is not a one month break in the overpayment basis. A change of employer does not constitute a change in factor as the factor remains earned income.

c. If the factor changes (example, earned income to unearned income) and a one-month calendar break occur between the factors, a new start date must be determined using the appropriate method.

3-5. Expunged Benefits. Expunged Benefits are applied as credits to the amount the recipient must repay. An expunged benefit may only be used one time and must be in the same program and sequence. The benefit must total at least $1.00 to be considered.

3-6. Overpayment Process.

a. The Economic Self-Sufficiency Specialist (ESS) must take the following actions once a determination is made that an overpayment of public assistance benefits appears to have occurred:

(1) Correct future month's benefits to prevent a continuing overpayment;

(2) Complete and submit a referral via FLORIDA BVBR screen to the BR unit if Agency or Client Error occurred and to DPAF if fraud is suspected;

(3) Complete the FLORIDA CLRC with information to explain the referral as required in the Public Assistance Policy Manual;

(4) No action will be taken on the referral either by BR or DPAF until the action stated in paragraph (1) above is taken;

(5) A referral to BR or DPAF is accomplished by accessing and completing the BVBR screen on FLORIDA. The referral will be automatically transmitted to BR or DPAF. “Roberts vs, Austin” requirements are applicable to IPV food assistance referrals only;

(6) Referrals will be assigned as per Chapter 3 of this operating procedure; and,

(7) When applicable, the public assistance case record(s) related to the overpayment issue will be accessed according to established statewide procedures.

b. The BR Claims Examiner will:

(1) Review the overpayment referral electronically using the FLORIDA on-line file or scanned case file through ACCESS document imaging (ADI).

(2) Record the detailed overpayment circumstances in the BR case on IBRS, and a brief summary in FLORIDA on CLRC. Any related verification or information necessary to substantiate the overpayment claim(s) must be in the scanned BR casefile.

(a) Although it is the ESS’s responsibility to obtain documentation or verification of any circumstances that affect an assistance group’s ongoing eligibility, it is the Claims Examiner’s responsibility to assure accurate computation of overpayment whether the ESS verifies the circumstance or not.

(b) The Claims Examiner is responsible for obtaining all documentation or verification needed to determine the amount of the overpayment except in the case of a DPAF/AI/QC

requested computation. DPAF/PBI/QC will provide documentation needed to substantiate all overpayment computations requested by those entities.

(c) If the overpayment circumstance continues to exist at the time of the BR review, the ESS designated contact must be notified to resolve the issue(s). The referral may be completed upon receipt of verification from the designee that the issues are resolved and the assistance group's ongoing benefits have been adjusted appropriately.

(d) When circumstances causing the overpayment affect another AG or program not addressed in the referral, BR must make a determination either to make an additional referral for the AG/program or request that the ESS unit make the appropriate referral. If the referral that needs to be completed is for an active food assistance IHE/IPV, the ESS unit will initiate the referral so the "Roberts vs Austin" requirements will be met.

(3) Refer the appropriate cases to DPAF when fraud is suspected as a result of the review.

(4) Determine the overpayment amount based on the best information available.

(5) Compute the overpayment budget in IBRS. Proofread all budgets for accuracy prior to generating a claim.

(6) Produce a claim determination from the monthly IBRS overpayment budgets.

(7) Associated BR screens in FLORIDA will be updated with information from IBRS.

(8) Generate the initial overpayment notice to the overpaid recipient through the IBRS system.

(a) The initial overpayment notice will advise the recipient of the following:

1. Amount of overpayment;

2. The program or error type; and,

3. Repayment option plan.

(b) If the notice is for a food assistance claim, it must also include the following:

1. The intent to collect from all adults in the household when the overpayment occurred;

2. The reason for the overpayment;

3. The time period associated with the claim;

4. The phone number to call for more information about the claim;

5. That if not paid, the claim will be sent to other collection agencies which will use various collection methods to collect on the claim;

6. The opportunity for a fair hearing regarding the overpayment claim. The household will have 90 days to request a hearing, unless the amount of the claim was established at a prior hearing;

7. The opportunity to inspect and copy records related to the claim; and,

8. The method used to compute the overpayment.

(c) The date that the initial overpayment notice is sent to the recipient after the claim is established is considered as the completion date for the review of the referral.

(d) Sending the initial overpayment notice to the recipient in cases of suspected fraud will be delayed until the disposition of the case either a hearing officer or a court official.

(9) Update the CLRC and IBRS with the disposition status of each referral.

c. BR may use the Information Eligibility and Verification System (IEVS) as verification of income for determining the overpayment as the best available information after attempts to verify through available electronic sources are futile.

(1) If IEVS information is used as verification of income, the Claims Examiner will send a notice of averaged wages to the recipient after computation of the claim, informing the recipient of the method used to determine the claim amount. A minimum of 10 days will be allowed to refute the IEVS report and provide actual earnings statements (see Transmittal BR2016-01).

(2) If the recipient provides actual documentation of the monthly income, the Claims Examiner will use the information provided by the recipient to re-compute the overpayment budgets.

(3) Indirect sources may be used such as collateral contacts and in some instances the recipient's statement. Source information must be documented.

(4) If there is no information available on which a correct basis of payment may be established, the Claims Examiner does not have sufficient documentation to establish a claim. The Claims Examiner should cancel the referral. The comment field on IBRS and CLRC on FLORIDA must be updated to include the reason for the cancellation.

(5) The overpayment Notice (Demand Letter) is sent to the overpaid recipient. The Claim Determination must be sent for all food assistance claims in accordance with procedures contained in CFOP 165-19, Benefit Recovery Collections.

(6) A Notice of Averaged wages will be sent to the overpaid recipient if actual wages were not used in the overpayment computation in all programs based on the approval of federal waiver 216009.

(7) The household will have the opportunity to contest the amount of overpayment claim through the fair hearing process. If the household disagrees with the amount of overpayment claim the BR unit shall discuss with the recipient the information on which the overpayment was based. The recipient must be offered an opportunity to provide additional verification to refute the amount of the overpayment claim. If the recipient requests a hearing within the 90-day initial period, collection will be suspended pending a decision. If the claim is upheld, a post fair hearing notice will be sent, and collection activities will resume.

(8) The BR Fiscal Accountant will update the accounts-related screens in IBRS. Fiscal Accountants are responsible for the prompt and accurate maintenance of all accounts-related activity as presented in the Accounts Receivable Procedural Manual.

(9) The Revenue Specialist will pursue recovery of overpaid benefits from active liable or responsible recipients through recoupment activities as assigned and where appropriate.

(a) Cash repayments from former recipients or for inactive claims will be pursued by the vendor contracted to process collections.

(b) The Revenue Specialist will be assigned all new claims on active recipients and will:

1. Respond to inquiries received from overpaid active recipients regarding repayment options;

2. Review the collection status of new claims of active recipients after waiting the required amount of days after the initial repayment request letter is sent; and,

3. Follow procedures for Revenue Specialists outlined in CFOP 165-19, Benefit Recovery Collections.

3-7. Benefit Recovery Case Recording and Documentation.

a. The BR Claims Examiner will review and analyze all information related to an overpayment issue as referred by the public assistance field units via the BVBR screen. The findings of that review and subsequent activity taken on any overpayment claim(s) established as a result of the review must be documented in the BR electronic file.

b. The BR Case Summary Record (Clearance Sheet). The BR case summary record will be part of the electronic BR case file. It may be a unit developed summary form, however the form must contain the following elements of a case review:

(1) Demographic Data. Verify the accuracy of these elements and record on the case summary form as appropriate:

(a) Recipient or assistance group case name;

(b) FLORIDA case number/category/sequence/claim sequence; and,

(c) PIN number.

(2) Overpayment Time Period. Identify the period of time during which the overpayment issue(s) existed. This time period may, or may not, correspond exactly to the time period originally referred by the ESS.

(3) Identify the Affected Program(s). Food assistance, cash assistance, family related Medicaid, SSI related Medicaid, etc., or combination of programs involved.

(4) Error Type(s). Identify the type of error that resulted in an overpayment, e.g., AE, IHE, or IPV.

(5) Summary of Referral Issue(s). The issue must be stated for the period under review. This summary must also address issues that occur during the time period under review, whether or not it was included on the original referral.

(6) Related Issues. Other related issues present at the time of the review that are not addressed on the referral must be considered when computing the claim amount. Any overpayment claim established without consideration of other related issues would render the claim incorrect.

(7) Verifications. Verifications used to calculate the claim must be copied and the copies retained in the BR case record, or the information provided by the verification document(s) must be thoroughly recorded in the case summary form.

(8) Additional Information. Reference to any additional information required for completion of an overpayment review must be included in the case summary. This information may include, but is not limited to, the following:

(a) Income verification from an employer, accountant, data exchange cross match (IEVS), self-employment records, Social Security Administration, etc. (NOTE: All data exchange information must be processed in compliance with procedures contained in Chapter 3000 of the Public Assistance Policy Manual.);

(b) Resource verification, such as a bank statement, lump-sum settlement documentation, deed to a second home, etc.;

(c) Household size documentation (e.g., lease, landlord's statement, HUD document, collateral contact, etc.); and,

(d) Individual household member status (e.g., verify student status through school records, marital status through legal documents, or relationship status through birth certificate or adoption documents, etc.).

3-8. Suspected Fraud Criteria and Procedures.

a. If the referral screen initiated by the ESS Processor indicates suspected fraud, the referral will be submitted to DPAF for further investigation automatically through the FLORIDA system. DPAF will review the case and either accepts the case for further investigation or returns the referral as a non-fraud IHE referral.

b. There may be instances when the BR Claims Examiner or Supervisor believes that a referral returned to the BR unit by DPAF must be re-examined. Procedures for re-referral to DPAF can be found in the procedure manual.

3-9. No Liable Individual. If no liable individual exists, or for FA referrals, all liable individuals are deceased and less than $400 in EBT benefits remain in the account, an overpayment will not be established. Exception: Identity theft with at least $15.00 remaining in the EBT account.

3-10. Benefit Recovery Resource Materials. Benefit Recovery has multiple sources of information available to assist in processing referrals, establishing an overpayment and initiating recovery of overpayment claims. These resources include, but are not limited to, the following:

a. Benefit Recovery electronic file;

b. Food assistance, Temporary Cash Assistance, Medically Needy, and other related public assistance physical case or electronic files;

c. The Public Assistance Policy Manual;

d. The BR Accounts Receivable Accounting Guide;

e. CFOP 165-19, Benefit Recovery Collections;

f. All information on the FLORIDA system;

g. Income and Eligibility Verification System (IEVS);

h. Child support payments via the Clerk of Courts Information System;

i. Florida Medicaid Management Information System (FMMIS);

j. Outside sources; and,

k. IBRS.

3-11. Monitoring of Benefit Recovery.

a. The objectives of monitoring of BR activities are as follows:

(1) To identify areas of non-compliance with federal regulations, state statutes, court rulings and established program policies and procedures;

(2) To identify training needs and ensure the provision of necessary technical assistance;

(3) To identify policies and/or procedures which require manual revisions or additional clarification; and,

(4) To determine the effectiveness of the BR unit in applying procedures involved in the implementation of collection, recoupment and administrative disqualification requirements.

b. Monitoring of the BR unit occurs at two tiers: Level II (state program office, BR Program Improvement Unit), and level III (BR Supervisor/lead workers).

Chapter 4

FOOD ASSISTANCE OVERPAYMENT

4-1. Overview. This chapter provides policies to be used in determining food assistance overpayment claims. The Public Assistance Policy Manual, previous manual material and clearances in effect at the time the overpayment occurred, will be used as the main source of reference for food assistance policy.

4-2. Food Assistance Overpayment. All overpayments discovered by or reported to the Department must be reviewed by the Department and a claim established, when appropriate, regardless of the type of error involved except in the following situations:

a. A claim will not be established for the sole reason that the Department failed to ensure that the assistance group or individual:

(1) Signed the application;

(2) Completed a current work registration;

(3) Completed a timely review; or,

(4) Failed to provide a required form for completion.

b. When reviewing the circumstances of an overpayment, the Claims Examiner may determine that the last month of the overpayment for the program and error type was past the statute of limitations. The Claims examiner will document the comment field of the IBRS screen with the reason for not computing the claim. No claim will be established on cases if more than six years pass between the month that an overpayment occurs and the month the Department discovers a possible overpayment.

c. No claim will be established solely due to a failure to report a change in household circumstances that the household is not required to report.

d. If the food assistance referral is an Agency or Inadvertent Household Error that will result in less than a $400 claim, the claim will not be established unless it is:

(1) Requested by Quality Control;

(2) An Identity theft claim;

(3) A claim split for the reason of a change in the liability of an individual as long as the total of the combined claims meet the $400 threshold limit; or,

(4) A continuous overpayment when the total value of the claim(s) meet the $400 threshold.

e. If ESS fails to act timely on a reported change, the overpayment will be attributed to Agency Error.

f. Unless otherwise specified, food assistance policy in effect at the time the overpayment occurs governs the calculation of the amount of food assistance overpayment.

g. Income is considered available to the household when received rather than when earned or promised.

h. Beginning November 22, 1996, the Riverside Amendment prohibited an increase in food assistance benefits when cash assistance decreased due to the recipient's failure to meet a program requirement. In food assistance overpayment budgets, the Claims examiner will calculate the claim using the TCA benefit amount that would have been issued if the failure to meet the program requirements had not occurred.

i. Categorically eligible households are households in which all members are receiving or are authorized to receive PA and/or SSI benefits. The USDA states that no special status will be given to these households. In July 2010, the Department implemented Broad-based Categorical Eligibility. See Policy Transmittal P10-07-0010.

j. Each person who was an adult member of the household when the overpayment or trafficking occurred is responsible for repayment of the food assistance overpayment claim. For that reason, the Claims Manger must verify the participation status of each household member and ensure the participation status is correct in IBRS. Members of the household who were not included in the food assistance group, but were mandatory members, are also responsible for repayment of the food assistance overpayment claim. The emancipated minor who applies for and receives food assistance on behalf of themselves and/or their household is also considered liable for the repayment of any overpayment claims against their household. This also includes minors (who may not be legally emancipated minors) serving as representatives for the household or their own assistance group.

k. When an authorized representative (AR) withholds information or reports incorrect information concerning the circumstances of the household they represent, the overpayment claim will be charged to the household. Every adult who was in the assistance group at the time the overpayment occurred will be held liable for repayment of the overpayment claim. For intentional program violations as defined at 7 CFR 273.16, if the authorized representative who is not an assistance group member, causes an overpayment and retains the food assistance for their personal use without the knowledge of the assistance group, a referral will be completed and submitted to DPAF.

l. Simplified reporting policy affects how the BR unit determines food assistance overpayment. This policy became effective beginning August 1, 2003, and has undergone numerous changes. When determining a food assistance overpayment, the Simplified Reporting policy rules in effect at the time of the overpayment will be used.

m. BR will not compute OP in the SUNCAP program. **Exception(s):** In the instance where the recipient requests a fair hearing and their benefits reinstated at the prior level, if the fair hearing is found in the Department's favor, all benefits received during the time of the pending fair hearing would be considered an overpayment. A claim would be established and repayment activities initiated. DPAF may request trafficking computations on SUNCAP cases.

n. Trafficking in the food assistance benefits has always been an Intentional Program Violation (IPV) that could subject a program participant to disqualification from Food Assistance Program participation. DPAF will be required to provide the DISCOVERY DATE, the REFERRAL DATE, and the REFERRAL PERIOD for the BVBR/IBRS screen. DPAF will also provide the transaction amounts and dates to be used in the budgets with their request for a computation. Trafficking is an IPV claim and cannot be established without court action, a hearing, or a waiver. The computation of trafficking claims may result in households owing more benefits than were actually issued. This would occur when a household receives an overpayment and then traffics those benefits. FNS issued a clearance stating that trafficking is independent of the payment or certification process and, therefore, any corresponding claims assessed by the Department are unrelated. FNS regulations make it clear that it is appropriate to hold all adult household members jointly and separately liable for trafficking claim regardless of who actually trafficked or misused the food assistance. Collection on these claims will follow the same procedures for overpaid food assistance cases.

4-3. Determining Food Assistance Overpayment.

a. Application vs Recertification. Food assistance policy makes a distinction between the reporting requirements of an initial applicant and a recertification applicant. This distinction affects how BR looks at changes that occur during the application process and for determining when the overpayment begins. For purposes of determining the overpayment use the following distinction:

(1) An initial applicant is one who has not received the food assistance for at least one full month prior to submitting a new application or prior to reapplication. An unreported change that the household is aware of, that occurs prior to, during, or up to the time of the application certification interview, would result in a false application. The Overpayment begins the first month of incorrect payment as a result of the unreported or unbudgeted change.

(2) A recertification applicant is someone who was certified to receive food assistance benefits during the month prior to the month of application or recertification. When a change occurs before or during the recertification process but is not timely reported or budgeted, the overpayment begins the first month affected by the unreported change, which is usually the first month of the new certification period.

b. The "10 – 10 – 10" Rule.

(1) The "10 – 10 – 10" Rule will be used to determine the first month of an overpayment in food assistance cases if TCA or Medicaid is also authorized. See EXCEPTIONS in paragraph (4) below for determining the overpayment period for those cases having food assistance only benefits.

(2) The full "10 – 10 – 10" Rule is applied to the date of change for Client Error cases. The Rule allows 10 days for the recipient to report the change, 10 days for the Department to act on the change and 10 days for advance notice of adverse action to be given to the recipient.

(a) The date of change for determination of an IHE overpayment is the date that the recipient first receives the assets or income, regardless of whether the income is earned or unearned. In other situations, the "date of change" is the date the circumstance actually changed. The full count of the "10 – 10 – 10" Rule is applied when determining an IHE overpayment.

(b) The date of change for determination of an Agency Error overpayment is the date the error was reported to or discovered by the Department. A partial count of "10 – 10" is applied to Agency Error. The Rule allows 10 days for the Department to act on the reported change and 10 days for adverse action notice to be given to the recipient.

(3) "10 – 10" would NOT be applied in cases that involve the agency acting incorrectly on a reported change (i.e., inaccurately budgeting income, incorrect notation of household size, misapplication of policy, etc.). The overpayment in these cases would always begin with the first month the incorrect action became effective.

(4) Exceptions to Application of the "10 – 10 – 10" Rule.

(a) Assistance groups receiving food assistance only with no TCA or Medicaid benefits will follow the reporting requirements for food assistance only in effect at the time of the overpayment.

(b) An overpayment exists in any month where any duplicate benefits were issued by Florida. This is attributed to Agency Error.

(c) When a child with earned income turns 18 years old, the earnings will be included as income in the month following the month of the 18th birthday unless the birthday falls on the first day of the month. If the child turns 18 on the first of the month, the income is countable in that month.

c. Administrative Error (AE). Information is considered available the day it becomes known to the Department, whether reported by the recipient or made known to the Department by other means.

(1) Application. An overpayment begins with the first allotment incorrectly authorized or budgeted due to an administrative error and ends with the last incorrectly authorized benefit. An overpayment at application exists when inappropriate action was taken on a reported change that occurred prior to, during, or up to the time of the certification or recertification interview.

(2) Ongoing. Prior to August 1, 2003, an overpayment begins the first month the Department would have made the change effective had it acted timely after application of the "10-10 (-10)" Rule in all food assistance households. To establish the first month of an overpayment in cases involving Agency Error, it is necessary to determine the date the change was made known to the Department. An Agency Error overpayment occurs in an ongoing case whenever a required change is timely reported after the certification or recertification interview, but the Department failed to act timely on the reported change.

d. Inadvertent Household Error (IHE) – Non-Fraud Client Error and Intentional Program Violation (IPV).

(1) Application. An overpayment begins with the first food assistance benefits issued incorrectly when a change occurs prior to the application or prior to the recertification interview. An unreported change that occurs prior to, during, or up to the time of the certification or recertification interview would result in a false application. In false application situations, an overpayment begins with the first month of incorrect payment. In these situations, it is appropriate to make a suspected fraud referral to DPAF.

(2) Ongoing. To establish the first month of an overpayment, it is necessary to determine the date the change occurred. The "10 – 10 – 10" Rule is applied from the date of the change for any food assistance case that has other program benefits authorized.

(a) Assistance groups assigned to simplified reporting with no other benefits authorized, are not subject to the 10-10-10 rule and instead will follow current simplified reporting rules.

(b) Other changes in simplified reporting food assistance only cases that occur and are not reported during the certification period will not cause an overpayment. A Client Error overpayment only occurs when required changes are not reported timely.

4-4. Computing Food Assistance Overpayment.

a. The claims examiners will determine the correct monthly benefit by applying the same policy used by the ESS to determine eligibility for the month in question. The Claims Examiners will use actual gross income if available, but income reported on Data Exchange may be used as best available information when documentation is not available on electronic sources. Income reported on the IEVS (Data Exchange) may be averaged by dividing the number of months in the quarter into the amount of the quarterly income.

b. A food assistance overpayment claim computation will include all income received by the household during the budget month. When benefits are withheld from the Temporary Cash Assistance to repay a previous overpayment claim, the gross amount of the Temporary Cash Assistance is

included in the food assistance overpayment budget for Client Error repayment; the net is used for Agency Error repayments. For all OSDI and SSI-related payments, the net amount will be used.

(1) When food assistance is approved early in the month and Temporary Cash Assistance is approved later in the same month, there is no overpayment in the food assistance program if the Temporary Cash Assistance benefit was not included in that month's food assistance budget.

(2) If the case was already in an overpayment period at the time of the Temporary Cash Assistance approval, and the ESS approved the Temporary Cash Assistance in error, continuous overpayment policy must be followed. The Claims Examiner will begin including the Temporary Cash Assistance in the month of receipt.

c. If a food assistance overpayment occurred during a month when an amount was automatically recouped from the food assistance allotment, the overpayment claim will be based on the gross payment prior to any recoupments.

d. The earned income deduction will not be applied to any part of earned income that the household failed to report, if that income is the basis of the overpayment, UNLESS, the claim is an AE claim, then the earned income deduction will be applied. If income from a certain source is underreported, the deduction is not allowed for the total corrected amount, not just the portion of the income that was underreported.

Chapter 5

TEMPORARY CASH ASSISTANCE OVERPAYMENT

5-1. Overview. This chapter provides policy used in the determination of Temporary Cash Assistance overpayment claims. Also, this chapter defines the guidelines for determining the beginning month of an overpayment.

a. Unless otherwise specified in this operating procedure, Temporary Cash Assistance policy in effect at the time an overpayment occurred must be used when calculating the amount of the overpayment claim.

b. The BR Specialist must utilize the Public Assistance Policy Manual as the primary source of relevant Temporary Cash Assistance policy.

c. All overpayments discovered by or reported to the Department must be reviewed by the Department and a claim established, when appropriate, regardless of the type of error involved, except as outlined in paragraph d below.

d. BR will not establish a claim for the sole reason that the Department failed to ensure an assistance group or individual:

(1) Signed the application;

(2) Completed a current work registration;

(3) Completed a timely review; or,

(4) Failed to provide a required form for completion.

5-2. Standard Disregard or the 200 and ½ Earned Income Disregard. The standard earned income disregard, also known as the 200 and ½ disregard, will be applied to earned income as per ESS policy.

a. If the recipient was ineligible for the 200 and ½ disregard, the Claims Examiner will not allow it in the claims budget. If the recipient was eligible for the disregard, it will be allowed in the budget.

b. When the earned income disregard of $90 or the $200 and ½ is budgeted in error, the overpayment begins with the first month the disregard was incorrectly budgeted.

c. The penalty of non-disregard will be applied in the first month of an overpayment that occurred due to the recipient's failure to report earned income.

d. Once an individual is found eligible for the 200 and ½ disregard, there is no time limit for the receipt of the disregard; provided the individual continues to meet criteria each time eligibility is evaluated.

5-3. Establishing Temporary Cash Assistance (TCA) Overpayment Using the "10 – 10 – 10" Rule. When an error occurs in the Temporary Cash Assistance Program, the overpayment begin dates will be determined using the "10 – 10 – 10" Rule on all ongoing cases. The "10 – 10 – 10" Rule allows 10 days for the recipient to report a change, 10 days for the agency to act on a change, and 10 days for the adverse action notice to be sent.

a. The "10 – 10 – 10" Rule WILL NOT be applied in cases that involve the Department acting incorrectly on a reported change (i.e., inaccurately budgeted income, incorrect household size,

misapplication of policy, etc.). An overpayment in this kind of case would always begin with the first month the incorrect action became effective.

b. For Client Error, all three time frames ("10 – 10 – 10") are applied. For Agency Error, only the second and third time frames ("10 – 10") apply.

c. The overpayment will begin the next full month after applying the "10 – 10 – 10" Rule without regard to whether the PAS had enough time to send the adverse action notice.

d. Exceptions to the "10 – 10 – 10" Rule are as follows:

(1) The BR Claims Examiner must allow either 10 or 45 days from the date the IEVS report depending on the Data Exchange Type and the processing time for the Data Exchange Type, or the date the PAS received the Data Exchange hit, before computing an Agency Error overpayment claim.

(2) When the Department fails to take action or takes incorrect action to remove the needs of a child who reaches 18 years old from a TCA benefit, the overpayment begins the month of the child's birthday if the child was born on the first day of the month. If the child was born on any day other than the first, the overpayment claim begins the month following the month of birth. Exception: The child may remain eligible until he/she turns 19 if enrolled in a secondary school or its equivalent. The child then loses eligibility at the month following graduation or with the age change to 19 as outlined above, and the overpayment begins.

(3) When SSA notifies the Department via data exchange that an assistance group member is approved for Supplemental Security Income (SSI), the overpayment claim begins with the first month the recipient received both SSI and was included in a Temporary Cash Assistance benefit. The overpayment claim would continue until the individual's needs are removed from the benefit. A referral to BR must NOT be completed if SSA does NOT notify the Department of an application or approval for SSI for an assistance group member. In that instance, the overpayment would be attributed to SSI.

(4) When a member or members of the assistance group leave the home, their needs must be removed from the TCA benefit the month following their departure. If the entire household leaves the state, the TCA benefit must be cancelled the month following their departure and the overpayment claim begins the first full month the member(s) is out of the household, or the first full month the household is out of state, if the benefits are not closed timely.

(5) Policy requires the parent or caretaker relative to report a child leaving the home within five (5) days of departure. If the report was made timely but an overpayment occurred, the error type will be attributed to the agency. If the report was not made timely, the error type will be attributed to the recipient.

(6) Income is considered available to the household when it is actually received. The date of receipt is the date of change. This date will be used in determining the beginning date of the overpayment.

5-4. Administrative Error (AE). Information is considered available the day it becomes known to the Department, whether reported by the recipient or made available to the Department by other means.

a. Application. An overpayment begins with the first benefit incorrectly budgeted and authorized due to an administrative error and ends with the last incorrectly authorized and budgeted benefit. An overpayment at application exists when incorrect action was taken on a reported change that occurred prior to, during, or up to the time of the approval for assistance.

b. Ongoing. An overpayment begins the first month the Department would have made the change effective had it taken timely action. An overpayment also begins the first month an incorrect action by the agency causes an overpayment.

5-5. Inadvertent Household Error (IHE) Non-Fraud and Intentional Program Violation (IPV) Fraud.

a. Application.

(1) An overpayment begins with the first Temporary Cash Assistance benefit were issued incorrectly when an unreported change occurs prior to applying for assistance, or the actual receipt of assistance. Receipt of assistance is defined as the date benefits are available in EBT.

(2) An unreported change that occurs prior to, during, or up to the time of receipt of the grant, would result in a false application. An overpayment would begin with the first month that the client received an incorrect grant amount as a result of the unreported change. In this situation, a suspected fraud referral is appropriate.

b. Ongoing. An overpayment begins the first month in which the change would have been effective had it been timely reported.

5-6. Computing Temporary Cash Assistance Overpayment.

a. The BR Claims Examiner will determine the correct monthly benefit level by using the actual gross income when available. Income reported on Data Exchange may be used as best available information if the actual income from electronic sources is not available. Income reported on the IEVS (or Data Exchange) will be averaged by dividing the number of months in the quarter into the amount of the quarterly income, and using the amount as the monthly amount for the overpayment budgets.

b. An overpayment that occurs when sanctions are not applied timely will begin the first month that the sanctions must have been applied after allowing the 10 days for the ESS Processor to impose the sanctions and 10 days for the adverse action notice to be sent to the recipient. When an overpayment occurs because the sanctions were imposed timely but incorrectly, the first month the Department incorrectly imposed the sanction is the beginning month of the overpayment claim.

c. Relocation Assistance Program policy provides recipients with Temporary Cash Assistance without receiving TCA. An overpayment claim may be established when the contract provider requests or approves a recovery due to the client failing to relocate.

d. The Relative Caregiver Program provides payments for certain children placed with relatives by the Department. Eligibility factors are consistent with TCA. An overpayment in the Relative Caregiver program may occur in the following circumstances:

(1) The payment was made to a person who is not either a relative of the child, or a relative of a half sibling placed in the same home;

(2) The child was never in the home of the relative or the person who received for the child;

(3) The incorrect payment standard was used;

(4) Other income received by the child was not budgeted; or,

(5) The child fails to meet other eligibility requirements.

Chapter 6

FAMILY-RELATED MEDICAID OVERPAYMENT

6-1. Overview. The purpose of this chapter is to provide policy used in the determination of Family-Related Medicaid overpayment claims. This chapter also defines guidelines for determining the beginning and ending months of an overpayment.

a. Medicaid policies in effect at the time the overpayment occurred must be used when calculating the amount of the Medicaid overpayment claim. BR must maintain copies of obsolete Medicaid policy materials to assure that correct policy is used. The BR Claims Supervisor must also make sure claims staff are kept up to date with current Medicaid policies.

b. Although Medicaid policies and procedures will often be cited or referenced, it is NOT the purpose of this chapter to provide Medicaid policy.

c. Family Coverage (1931 Medicaid) is based on Section 1931 of the Social Security Act until the Affordable Care Act was implemented on 1/1/2014.

d. BR does not compute overpayments for Kidcare (Florida Healthy Kids, Medikids, or Children's Medical Services).

6-2. Determining Medicaid Overpayment. A reportable Medicaid overpayment occurs when an individual or assistance group is totally ineligible for the Medicaid coverage group in which they received benefits or services or any other Medicaid coverage group, for which funds were expended on their behalf.

a. A Medicaid overpayment may also occur in the Medically Needy Program when it is determined that the share of cost (SOC) was understated and the recipient failed to meet the corrected SOC. If the recipient is determined to have been eligible with a SOC, the overpayment is the amount paid by Medicaid during the ineligible period (the period when the recipient did not meet the SOC). An understated SOC occurs when incorrect information was budgeted in determining the SOC, creating a SOC that was below the correct amount. There may be instances when the corrected SOC is met on a day other than the first day of the month. In that situation, the overpayment will be reported for all Medicaid expenditures prior to the day of the month that the corrected SOC was met by the assistance group. When determining the amount to use as the overpayment shown in FMMIS, the amount paid must be used and NOT the amount billed.

b. For Medicaid overpayments to occur, Medicaid funds must have been expended on behalf of the ineligible member(s) of the assistance group during the month(s) or days of ineligibility.

c. When eligibility under a different coverage group is uncertain, the BR worker shall request in writing the necessary information to make a determination. The BR worker will allow the recipient 10 days to provide information. This includes the opportunity to provide unpaid medical bills to help meet a corrected SOC. If pertinent information from the recipient is not available, the eligibility decision will be based on information from the eligibility file. If the recipient fails to cooperate with the Claims Examiner or if the Claims Examiner is unable to locate the recipient, the recipient will be considered ineligible for all Medicaid benefits received during the overpayment period. It will then be the responsibility of the recipient to refute the Medicaid overpayment claim. The recipient MUST be notified of their responsibility to refute the information used to determine the overpayment claim in the letter requesting the additional information, and of the consequences of their failure to refute the information.

d. An Ex Parte determination must be made when a recipient is totally ineligible for the Medicaid coverage group where they were previously covered. The Claims Examiner will assess the

case using the correct information to determine whether or not the individual could have been eligible for another Medicaid coverage group during the month(s) in question. The results of the Ex Parte determination must be recorded in the BR file.

e. To determine when a Medicaid overpayment begins, the Claims Examiner must determine the month that the change occurred. ("10 – 10 – 10" does not apply to Medicaid overpayments.) In cases of unreported income or assets, that would be the date the income/asset actually became available to the recipient. Use budgeting procedures in the Public Assistance Policy Manual to determine the net income for each filing unit member. In Medically Needy cases, any Medicaid benefits expended for any portion of the month that the recipient did not meet their SOC is considered an overpayment.

(1) A Medicaid overpayment occurs when an assistance group is ineligible in any month.

(2) If ineligibility is due to income, the overpayment occurs for any month in which the assistance group is ineligible for Medicaid under any coverage group, including the first month income is received.

(3) If ineligibility is due to a reason other than income, the overpayment occurs for any month the individual or assistance group is determined ineligible during the entire month.

(4) To determine the actual amount of the overpayment, the following must be considered:

(a) Complete the Ex Parte;

(b) If the recipient was eligible under another coverage group, no overpayment exists;

(c) If the recipient was ineligible for any other Medicaid group, an overpayment exists if Medicaid funds were expended in behalf of the recipient or AG;

(d) Medicaid budgets are computed using income, assets, and circumstances in the month they were actually received or occurred;

(e) TCA is not considered as income when computing the Medicaid overpayment budgets;

(f) If the overpayment would be attributed to the Agency, but no services were used and only capitation was paid, the referral will be cancelled as per memo BR06-04; and,

(g) Medicaid payments found on FMMIS may NOT be used as an allowable Medical expense to help meet the recipient's share of cost.

6-3. Medicaid Coverage Groups. Information regarding the different coverage groups and their eligibility requirements may be found in the Public Assistance Policy Manual, Chapter 2000.

6-4. Medicaid Filing Units. The standard filing unit for Family Medicaid consists of the people who live together and whose needs and income are considered in determining the assistance group's eligibility. The income of all filing unit members must be reviewed when assessing the member's Medicaid eligibility.

a. Although an individual can only receive Medicaid benefits in one coverage group at a time, they can have their needs, income and assets included in more than one filing unit. Effective

January 4, 2004, eligible members of a 1931 Medicaid assistance group must be included as a counted member in other Medicaid filing units if they are a mandatory member of that coverage group. Optional members may be included as a counted member in other Medicaid coverage groups.

b. Under the Affordable Care Act (ACA) effective January 1, 2014, the filing unit was changed to align with tax filing status, as tax filers and dependents.

Chapter 7

SSI-RELATED MEDICAID OVERPAYMENT

7-1. Overview. The purpose of this chapter is to provide policy for establishing SSI-Related overpayment claims.

a. This chapter is not designed to provide ESS policy material for SSI-Related programs; however, SSI-Related ESS policies may be cited or referenced.

b. The BR Claims Examiner must use the Public Assistance Policy Manual (overpayment are not listed under ESS publications) when feasible.

c. Benefit Recovery must maintain a copy of obsolete Medicaid Manual materials to be used for claims establishment related to overpayment periods prior to current manual materials.

d. The SSI-related policies in effect at the time the overpayment occurred must be used when calculating SSI-related overpayment claims.

7-2. SSI-Related Coverage Groups Subject to Establishment of Overpayment Claims. Programs subject to the overpayment calculation by BR include:

a. Institutional Care Program (ICP);

b. Medicaid expansion designated by SOBRA-aged or disabled (MEDS-AD);

c. Medically Needy (MN);

d. Emergency Medicaid for Aliens (EMA); and,

e. Channeling (available in Broward, Dade, and Monroe Counties only).

NOTE: BR policy does not address buy-in programs; therefore, BR will not establish claims on QMB, SLMB, or QI1.

7-3. Overpayment Referrals.

a. Referral to BR will be submitted when a member or members of a coverage group is/are overpaid or ineligible for benefits received due to income, assets, transfer of assets or other technical factors.

b. A referral to DPAF is initiated if fraud is suspected and the statute of limitations has not expired.

7-4. Program Eligibility. The eligibility factors in use by ESS at the time of the overpayment will be used. Consult the Public Assistance Policy Manual.

7-5. SSI-Related Medicaid Potential Overpayments. An eligibility error exists when payment is made for a recipient or assistance group who:

a. Was ineligible when authorized or when services were received;

b. Was eligible for Medicaid but was ineligible for certain services received;

c. Had not met recipient liability requirements when authorized for Medicaid;

d. Had not incurred medical expenses equal to the amount of his excess income over the State's financial eligibility level; or,

e. Was making an incorrect amount of payment toward the cost of services.

7-6. Establishing When Overpayments Have Occurred.

a. If Medicaid funds are expended on behalf of ineligible member(s) of an assistance group during a month in which an eligibility error occurred, an overpayment exists. If the recipient or any member of the assistance group would be eligible for the Medicaid services under another coverage group, a Medicaid overpayment does not exist.

b. If any or all members were found ineligible for other Medicaid coverage group(s) after the Ex Parte determination, an overpayment exists. If the recipient or any member of the assistance group would be eligible for the Medicaid services under another coverage group, a Medicaid overpayment does not exist.

7-7. Ex Parte Determination.

a. The BR Claims Examiner will complete an Ex Parte determination for each potential Medicaid overpayment. This may include requesting that the recipient provide additional information within 10 days of request before an Ex Parte determination can be made. If the additional information is not provided, BR must use the best available information to complete the Ex Parte process.

b. The Medicaid policy in effect at the time of the overpayment must be used in determining the existence and amount of the Medicaid overpayment.

7-8. Beginning Month of Overpayment. For an SSI related overpayment, there is no difference in establishing a begin date due to error type. AE, IHE and IPV will all follow the guidelines below:

a. A reportable overpayment due to any error begins the first day of the second month following the month in which the change affecting the recipient’s entitlement occurred.

b. An exception to this policy exists when the overpayment or ineligibility occurred in the first month of entitlement. If the recipient was ineligible at approval, a reportable overpayment begins from the date of initial entitlement regardless of the error type.