COLORADO
Department of Health Care Policy & Financing

OPERATIONAL MEMO

TITLE:	FRAUD INVESTIGATIONS AND OVERPAYMENTS
SUPERSEDES NUMBER:	HCPF OM 19-002
EFFECTIVE DATE:	JULY 1, 2020
DIVISION AND OFFICE:	COMPLIANCE, MEDICAID OPERATIONS OFFICE
PROGRAM AREA:	MEMBER/CLIENT FRAUD
KEY WORDS:	CLIENT FRAUD, MEMBER FRAUD, OVERPAYMENT, RECOVERY, INTEREST, FRAUD INTEREST
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HCPF Memo Series can be accessed online: https://www.colorado.gov/hcpf/memo-series

Purpose and Audience:

The purpose of this Memo is to inform county departments of human/social services of the processes for entering overpayments and overpayment interest into the Colorado Benefits Management System (CBMS) for Health First Colorado/Medicaid fraud investigations. This Memo will be available to all county staff working on investigations to advise on the reporting requirements for member/client fraud, county incentives for member/client fraud and how to code overpayments and interest. This Memo supersedes guidance issued in HCPF OM 19-002 and is the most current guidance available.

The term "member" and "client" will both be used in this document as "client" is the terminology used in CBMS and "member" is the term preferred by the Department of Health Care Policy and Financing ("Department").

Background:

State laws covering Health First Colorado/Medicaid member/client overpayments are found in the Colorado Medical Assistance Act, Article 4, Part 3: Recoveries, which begins at C.R.S. 25.5-4-300.4. Rules are also found in the Medical Assistance Staff Manual Volume 8, Section 8.065.

Pursuant to rule 8.065.1, an "overpayment" includes any medical assistance payments, including capitation payments, paid on behalf of a recipient who was not lawfully entitled to receive the benefits for which the payments were made. The rule further states that the County Department of Social Services shall recover all overpayments except that no recovery shall be made where the overpayment occurred through no fault of the recipient.

Information/Procedure:

County Fraud Investigations

Counties have the responsibility, on behalf of the Department, of determining Health First Colorado and Child Health Plan Plus (CHP+) eligibility and for Health First Colorado/Medicaid redeterminations. Persons who are found to be ineligible for these programs due to intentional program violations or error on the part of the applicant must pay back the State for claim payments made on their behalf.

During county investigations, members cannot be coerced into providing information or cooperating with the investigations. A member's willingness or refusal to speak with a county investigator or otherwise cooperate with a county investigation is an entirely voluntary decision to be made by the member. **A member's eligibility cannot be terminated for not complying with an investigation, nor can a member be threatened with eligibility termination for failure to comply.**

County Fraud Incentive

As an incentive to investigate potentially fraudulent cases, the counties receive a portion of the funds recovered. If the individual intentionally lied or misrepresented their circumstances to gain Health First Colorado/Medicaid eligibility, the federal portion of the recovery on the claim payment is returned, but the counties receive an incentive payment on that recovery of 100% of the State funds paid on the claims. The enhanced incentive payments do not apply to CHP+ cases.

However, if the member/client received medical assistance benefits due to unintentional member/client error, the county continues to receive an incentive payment of 25% of the State share of the amount recovered [CRS 25.5-1- 115 (3)].

County Reporting

The county is also required to report medical assistance member/client fraud investigations to the State, which reports it to the General Assembly. This reporting requirement necessitates information gathering from counties as specified below.

The Department is granted the authority to request this information from the counties by C.R.S. 25.5-1-118 (2), which states: "The county departments or other state designated agencies, where applicable, shall report to the state department at such times and in such manner and form as the state department may from time to time direct."

In order to provide the report to the legislature as required by the law, the attached form entitled Annual Activities Report (Attachment A) should be used to report county fraud investigations and recovery activity to the Department electronically.

This form is to be submitted by all counties annually; a report is due even if no activity occurred in the year. **The report is due to the Department on July 31st of each year.** Definitions to assist counties in completing the report are below:

Criminal Complaints– Total number of criminal complaints concerning member/client fraud that were requested

Criminal Complaints Dismissed - Total number of member/client fraud criminal cases that were dismissed without conviction

Criminal Complaints Acquitted - Total number of member/client fraud criminal cases in which the member/client was acquitted

Criminal Complaint Convictions - Total number of member/client fraud criminal cases that resulted in criminal conviction

Confessions of Judgement - Total number of member/client fraud cases that were resolved by agreement signed by the member/client admitting that fraud occurred

Fraud: The intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person

Fraud Investigations: Any investigation of a case that is suspected of involving inappropriate medical assistance for a person whether or not the investigation concludes that member/client fraud existed; includes investigations that reveal member/client error

Fraud Recoveries – Recovery amount that has been established as an overpayment due to member/client fraud, whether or not a prosecution occurred

Member/Client: An individual who has been determined eligible for medical assistance; a recipient

Non-fraud Recoveries - Recovery amount that has been established as an overpayment due to reasons other than fraud, such as member/client error or mistake

Fines and Penalties – Monetary amount a Court orders to pay as a penalty

Restitution Ordered – Monetary amount ordered by the Court to repay for services

Restitution Collected – Monetary amount actually received to recoup expenses stemming from services

Terminations– Total number of member/client fraud investigations that led to terminations this year

Entering and Coding Overpayments

If the county determines the member/client has received assistance due to intentional deception or misrepresentation, the county's technicians/investigators may code any overpayments that stem from the intentional deception or misrepresentation as an intentional program violation in CBMS. Pursuant to Section 8.057 and 8.058, the county must send out a notice to the member/client alerting them of the opportunity to contest this determination through the established appeal process.

If the county can substantiate their claim of intentional deception or misrepresentation and provide the member/client with an opportunity to contest the determination, that is sufficient for our technicians/investigators to terminate and create an intentional program violation overpayment. Although there is no Intentional Program Violation hearing process for medical assistance only cases, if an investigation determines that there was an intentional member/client deception or misrepresentation which caused a member/client to be ineligible, the intentional program violation code is appropriate. It is not necessary to obtain a conviction to use this code.

Additionally, if a case has been adjudicated through an Intentional Program Violation hearing for a different benefit program, and the medical assistance case stems from the same set of facts, that is sufficient to code any related medical assistance recoveries or terminations as intentional program violation if the circumstances are the same.

In no circumstances should a recovery be made where the overpayment occurred through no fault of the recipient or applicant, such as Agency error. Additionally, though

a member/client may have received assistance due to intentional deception or misrepresentation, the member/client may not be refused Health First Colorado/Medicaid coverage should they be truly eligible.

Health First Colorado Interest

Much like the overpayments above, the federal government is required to be paid a portion of the interest collected on Health First Colorado/Medicaid or CHP+ overpayments. It is not permissible for state or counties to keep the federal share portion of interest on medical assistance fraud recoveries.

Counties that receive interest payments will enter those amounts into the County Financial Management System (CFMS) under code M100.4349 (Interest-Medicaid Overpayments). On reports, it will appear as 4349 Interest M100 Medicaid under the Medicaid Collections heading. This code will allocate 50% of funds to the federal government and 50% to the county. The county funds are unrestricted.

The code is only to be used for interest payments regarding medical assistance recoveries. Counties are required to follow the standard claims process for recovery of the original claim.

Attachment(s):
Legislative Report Form – Attachment A

Department Contact:
hcpf_report.clientfraud@state.co.us