

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**COLORADO DID NOT REPORT AND
REFUND THE CORRECT FEDERAL
SHARE OF MEDICAID-RELATED
OVERPAYMENTS FOR 70 PERCENT OF
THE STATE'S MEDICAID FRAUD
CONTROL UNIT CASES**

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October 2022
A-07-21-02834

Office of Inspector General

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Report in Brief

Date: October 2022

Report No. A-07-21-02834

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

This audit is one of a series of audits to determine whether States had recovered, and returned the correct Federal share of, improper Medicaid claims amounts and damages. For this audit, we focused on Colorado's Medicaid Fraud Control Unit (MFCU) actions related to the recoveries of Medicaid overpayments through legal judgments and settlements that the State had pursued under relevant Medicaid fraud statutes. Colorado is required to report recoveries for these MFCU-determined Medicaid overpayments to the Centers for Medicare & Medicaid Services (CMS) and to refund the Federal share to the Federal Government.

Our objective was to determine whether Colorado reported and returned the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2014, through December 31, 2020.

How OIG Did This Audit

We worked with Colorado to identify what portion of 179 MFCU cases, which resulted in MFCU-determined Medicaid overpayments totaling \$23.1 million, it reported to CMS for the period October 1, 2014, through December 31, 2020. We obtained legal documents related to MFCU-determined Medicaid overpayments as well as Colorado's documentation that supported its reporting of those overpayments to determine whether Colorado reported the correct Federal share.

Colorado Did Not Report and Refund the Correct Federal Share of Medicaid-Related Overpayments for 70 Percent of the State's Medicaid Fraud Control Unit Cases

What OIG Found

Colorado did not report and return the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2014, through December 31, 2020. Colorado reported \$5.8 million (\$3.1 million Federal share) for this period but should have reported MFCU-determined Medicaid overpayments totaling \$13.0 million (\$6.8 million Federal share) for the 179 MFCU cases that we reviewed. Colorado did not report some or all of the correct Federal share for 126 cases (70 percent of the 179 MFCU cases we reviewed). The unreported funds consisted of \$7.2 million (\$3.7 million Federal share) in amounts related to MFCU-determined Medicaid overpayments and court-ordered awards that Colorado should have already reported. Furthermore, Colorado did not correctly report to CMS MFCU-determined Medicaid overpayments related to fraud, waste, and abuse. Although Colorado had policies and procedures for the reporting of Medicaid overpayments, these policies and procedures were not always adequate to ensure that it always reported MFCU-determined Medicaid overpayments in accordance with Federal requirements.

What OIG Recommends and Colorado Comments

We recommend that Colorado refund \$3.7 million (Federal share) in unreported MFCU-determined Medicaid overpayments that related to paid claims and court-ordered awards that have been recovered and collected. We also recommend that Colorado determine the value of overpayments identified after our audit period that have been recovered and collected but not reported, report them to CMS, and refund the Federal share. We make procedural recommendations for the strengthening of policies and procedures to ensure that overpayments are reported correctly and in a timely manner.

Colorado agreed with the amount of unreported MFCU-determined Medicaid overpayments but disagreed with refunding the overpayments. Colorado said that it would review the cases to ensure that the amounts are not uncollectable and return the applicable Federal share by September 30, 2023. Colorado agreed with our other recommendations and described corrective actions. We disagree that Colorado should wait to report the overpayments; instead, we believe that Federal regulations require Colorado to immediately report the overpayments. For our other recommendations, Colorado should implement corrective actions as soon as possible to ensure that the Federal share of overpayments is reported in a timely and accurate manner.

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INTRODUCTION

WHY WE DID THIS AUDIT

This audit is one of a series of audits to determine whether States had recovered, and returned the correct Federal share of, improper provider claims amounts as well as any damages (when assessed).¹ For this audit, we focused on the State of Colorado’s Medicaid Fraud Control Unit (MFCU) actions related to the recoveries of Medicaid overpayments through legal judgments and settlements that the State had pursued under relevant Medicaid fraud statutes.² We refer to these recoveries as “MFCU-determined Medicaid overpayments.” The Colorado Department of Health Care Policy and Financing (State agency) is required to report these recoveries to the Centers for Medicare & Medicaid Services (CMS) on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) and to refund the Federal share of those recoveries to the Federal Government.

OBJECTIVE

Our objective was to determine whether the State agency reported and returned the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2014, through December 31, 2020 (Federal fiscal years (FYs) 2015 through the first quarter of FY 2021).

BACKGROUND

The Medicaid Program and Medicaid Fraud Control Units

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

The Federal Government pays its share of a State’s medical assistance costs (referred to as Federal financial participation (FFP) or Federal share) under the Medicaid program on the basis of the Federal medical assistance percentage (FMAP), which changes each FY and varies depending on the State’s relative per capita income. The State agency is responsible for computing and reporting the Federal share, which is based on the total computable amount

¹ See Appendix B for a list of related Office of Inspector General reports.

² MFCUs, which are required by Federal statute, investigate and prosecute Medicaid provider fraud and patient abuse and neglect in health care facilities and board and care facilities.

multiplied by the FMAP.³ The total computable amount and the Federal share are both reported on the Form CMS-64. During our audit period, Colorado's Standard FMAP ranged from 50.00 percent to 51.01 percent, the Enhanced FMAP rate ranged from 65.00 percent to 88.50 percent and the Newly Eligible FMAP ranged from 90 percent to 100 percent.

Section 1902(a)(61) of the Act requires each State to operate a MFCU or receive a waiver. The Act, section 1903(q), specifies that the function of State MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect in facility settings. The Colorado MFCU was established by State statute that was signed into law in March 1978.

Federal Requirements Concerning Reporting of Medicaid Overpayments

Federal regulations implement sections 1903(d)(2) and (3) of the Act and specify that State agencies have 1 year from the date of discovery to recover Medicaid overpayments before the Federal share must be reported to CMS. These regulations generally direct State agencies to make adjustments for the overpayments after 1 year if recovery is not made, unless the overpayments are fraud-related and are being determined in the courts (42 CFR §§ 433.316(a) and (d)(2)).

Federal regulations also state that for cases involving fraud in which a State is unable to recover a Medicaid overpayment because the relevant court has not determined the overpayment amount, the State is not required to report the Federal share of the overpayment until 30 days after the date of the final judgment. Once the court has determined the overpayment amount (that is, reached a final judgment, including, if applicable, a final judgment that has been appealed), the State then has 30 days to collect the overpayment from the provider before reporting that amount on the Form CMS-64 for adjustment (42 CFR § 433.316(d)(2); *Medicaid Program Integrity Manual*, chapter 11, § 11005).⁴

Further, Federal regulations state that a State agency is not required to return the Federal share if the State agency is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business (42 CFR § 433.312(b)). The Form CMS-64 provides a mechanism (discussed below) for State agencies to reclaim the Federal share of previously reported overpayments for cases in which the providers in question are subsequently determined to be bankrupt or out of business.

The Federal Share of Recoveries Is Computed on the Entire Recovery

On October 28, 2008, CMS issued to State health officials (SHOs) a letter (SHO # 08-004) (the SHO Letter) that interprets section 1903(d) of the Act regarding overpayments. This letter

³ CMS's *2018 Payment Error Rate Measurement Manual* defines the Form CMS-64 "total computable amount" as the Federal share plus the State share of Medicaid costs.

⁴ The *Medicaid Program Integrity Manual* was revised into only two chapters, effective April 3, 2018. Chapter 11 no longer exists in the current version of this manual; however, it was in effect for most of our audit period.

states: “Any State action taken as a result of harm to a State’s Medicaid program must seek to recover damages sustained by the Medicaid program as a whole, including both Federal and State shares The Federal Government is entitled to the applicable FMAP share of a State’s entire recovery.” This applies irrespective of whether the State action is pursuant to a State False Claims Act or other State statutory or common law cause of action.

The SHO Letter also states that “[t]he Act’s broad mandate demands that a State return not only the Federal amount originally paid attributable to fraud or abuse, but also an FMAP-rate proportionate share of any other recovery.” This includes the Federal share of any legal expenses, such as attorneys’ fees and court costs. These expenses may be claimed for reimbursement as administrative costs that benefit the Medicaid program at the regular administrative percentage rate.

Reporting of Fraud-Related Medicaid Overpayments

States use the Form CMS-64 to report actual Medicaid expenditures for each quarter. In turn, CMS uses the Form CMS-64 to reimburse States for the Federal share of Medicaid expenditures. The amounts that States report on the Form CMS-64 and its attachments must be actual expenditures with supporting documentation (42 CFR § 430.30).

CMS’s *Medicaid Program Integrity Manual*, Pub. No. 100-15, instructs State agencies to report MFCU-determined Medicaid overpayments on line 2 of the Form CMS-64.9C1 feeder form⁵ (Form CMS-64.9C1), if collected, or, for overpayments identified but not yet collected within regulatory timeframes, on the Form CMS-64.9O feeder form⁶ (Form CMS-64.9O) (chapter 11, §§ 11005 and 11035).⁷

CMS’s *State Medicaid Manual*, Pub. No. 45, instructs State agencies to apply the FMAP rate at which the original expenditure was matched when reporting recoveries (chapter 2, §§ 2500(D)(2) and 2500.6(B)). If the expenditure cannot be immediately tied to a specific period, State agencies are to compute the Federal share at the FMAP rate in effect at the time the refund was received.

⁵ The Form CMS-64.9C1 feeder form is used to provide detailed information about fraud, waste, and abuse collection efforts. The total from this feeder form carries over to the Form CMS-64 Summary sheet, line 9c.

⁶ Before it was revised (as discussed below), the Form CMS-64.9O feeder form was used to provide detailed information about overpayments identified but not yet collected, including overpayments concerning fraud, waste, and abuse. The total from this feeder form carried over to the Form CMS-64 Summary sheet, line 10c.

⁷ CMS’s *State Medicaid Manual*, chapter 2, § 2500.1(B), sets forth detailed instructions for the Form CMS-64 and states that collections identified through fraud, waste, and abuse efforts should be reported on line 9c.

According to CMS officials:

- In FY 2011, CMS revised the Form CMS-64.90 so that State agencies should report only Medicaid overpayments *not* resulting from fraud, waste, and abuse on that form.
- At the same time, CMS introduced the Form CMS-64.90FWA feeder form (Form CMS-64.90FWA) to separately track uncollected Medicaid overpayments resulting from fraud, waste, and abuse (including MFCU-determined Medicaid overpayments).
- The Form CMS-64.90FWA is formatted similarly to the Form CMS-64.9C1 but includes a separate line for State agencies to report amounts reclaimed for cases in which the State agencies subsequently determine that the providers in question are bankrupt or out of business. The Form CMS-64.90FWA was available in the Medicaid Budget and Expenditures System beginning with FY 2011.^{8,9}

State Agency Policies and Procedures for Reporting Medicaid Fraud Control Unit-Determined Overpayments

The State agency has written policies and procedures concerning preparation and submission of the Form CMS-64, which include procedures for reporting Medicaid overpayments. In response to our questions regarding reporting timeframes for Medicaid overpayments, State agency officials told us that the State agency reports Medicaid overpayments immediately instead of waiting for the providers to make payments.

HOW WE CONDUCTED THIS AUDIT

According to information provided by the State agency, during our audit period (October 1, 2014, through December 31, 2020), MFCU-determined Medicaid overpayments totaled \$24,321,883 for 229 cases. We removed 50 of the 229 cases, for reasons provided in Appendix A, and reviewed the remaining 179 MFCU cases with Medicaid overpayments totaling \$23,129,078.

We worked with the State agency to identify what portion of the \$23,129,078 it reported on the Form CMS-64 for the period October 1, 2014, through December 31, 2020. We obtained

⁸ The Medicaid Budget and Expenditures System (MBES) is a Web-based application that Medicaid and Children's Health Insurance Program (CHIP) State agencies use to report budgeted and actual expenditures for Medicaid and CHIP for each fiscal period in addition to the actual quarterly expenditures that occur. Summarized statistical data are available for download.

⁹ The *Medicaid Program Integrity Manual* in effect for most of our audit period did not include guidance for the preparation of the Form CMS-64.90FWA. CMS updated this manual in FY 2018; this update eliminated guidance for the preparation of the Form CMS-64.9C1. Information for the Form CMS-64 and its feeder forms and subsidiary schedules is available at <https://www.medicaid.gov/medicaid/finance/state-expenditure-reporting/index.html> (accessed on Jun. 9, 2022).

legal documents related to MFCU-determined Medicaid overpayments as well as the State agency's documentation that supported its reporting of those overpayments on the Form CMS-64 to determine whether the State agency reported the correct Federal share.

For our review of the overpayments that the State agency reported, we recalculated the amounts using the FMAP rates in effect as of the paid claims dates and compared that to the amounts the State agency calculated for the Federal share that should have been reported for both the claims amounts and the penalties. We determined that the State agency's calculations were materially accurate. For each MFCU case, we determined the quarter in which the 30-day collection period ended and generally identified that quarter as the quarter for which the State agency should have reported the associated overpayments on the Form CMS-64. For further details on this analysis, see Appendix A.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology and Appendix C contains details on the Federal share of the MFCU-determined Medicaid overpayments to be refunded.

FINDINGS

The State agency did not report and return the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2014, through December 31, 2020. The State agency reported \$5,831,617 (\$3,145,335 Federal share) for this period. However, we determined that the State agency should have reported MFCU-determined Medicaid overpayments totaling \$13,046,142 (\$6,815,073 Federal share) for the 179 MFCU cases that we reviewed. Specifically, the State agency correctly reported the entire amount of Medicaid overpayments as well as the entire Federal share for 53 of the 179 MFCU cases. However, the State agency did not report some or all of the correct Federal share for the remaining 126 cases (70 percent of the MFCU cases we reviewed).

The unreported funds consisted of \$7,214,525 (\$3,669,738 Federal share) in amounts related to MFCU-determined Medicaid overpayments and court-ordered awards that the State agency should have already reported, including:

- \$6,519,822 (\$3,296,325 Federal share) in unreported MFCU-determined Medicaid overpayments related to paid claim amounts; these comprised:
 - \$2,376,009 (\$1,199,877 Federal share) that were related to overpayments that the State agency believed were "State-only funds" but were in fact paid claim amounts that should have been reported and

- \$4,143,813 (\$2,096,448 Federal share) that were for other paid claims that the State agency did not report; and
- \$694,703 (\$373,413 Federal share) in MFCU-determined Medicaid overpayments related to court-ordered awards that the State agency collected but did not report.

In addition, of the \$5,831,617 (\$3,145,335 Federal share) that the State agency reported, it did not report \$4,770,144 (\$2,598,604 Federal share) in a timely manner.

Furthermore, the State agency did not report MFCU-determined Medicaid overpayments related to fraud, waste, and abuse on the correct feeder form of the Form CMS-64.9C1, if recovered, or the Form CMS-64.90FWA, if not recovered within regulatory timeframes.

These errors occurred because although the State agency had policies and procedures for the reporting of Medicaid overpayments, these policies and procedures were not always adequate to ensure that it always reported MFCU-determined Medicaid overpayments in accordance with Federal requirements.

OVERALL FEDERAL REQUIREMENTS AND GUIDANCE REGARDING THE REPORTING OF MEDICAID FRAUD CONTROL UNIT-DETERMINED MEDICAID OVERPAYMENTS

Section 1903(d)(3)(A) of the Act states: “[t]he pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.”

Federal regulations state that “[a]n overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State’s overpayment determination” (42 CFR § 433.316(d)(1)).

Federal regulations also state that for cases involving fraud in which a State is unable to recover a Medicaid overpayment because the relevant court has not determined the overpayment amount, the State is not required to return the Federal share of the overpayment until 30 days after the date of the final judgment. Once the court has determined the overpayment amount (that is, has reached a final judgment, including, if applicable, a final judgment that has been appealed), the State then has 30 days to collect the overpayment from the provider before reporting that amount on the Form CMS-64 for adjustment (42 CFR § 433.316(d)(2); *Medicaid Program Integrity Manual*, chapter 11, § 11005).

Federal regulations state that a State agency is not required to return the Federal share if the State agency is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business (42 CFR § 433.312(b)). The Form CMS-64 provides a mechanism (discussed below) for State agencies to reclaim the Federal share of previously

reported overpayments for cases in which the providers in question are subsequently determined to be bankrupt or out of business.

The *Medicaid Program Integrity Manual*, Pub. No. 100-15, instructs State agencies to report MFCU-determined Medicaid overpayments on line 2 of the Form CMS-64.9C1, if collected, or, for overpayments identified but not yet collected, on the Form CMS-64.90 (chapter 11, § 11035).¹⁰

Appendix D contains details on the Federal requirements and guidance related to the reporting of MFCU-determined Medicaid overpayments.

THE STATE AGENCY DID NOT REPORT THE CORRECT FEDERAL SHARE OF MEDICAID FRAUD CONTROL UNIT-DETERMINED MEDICAID OVERPAYMENTS AND COURT-ORDERED AWARDS

Federal Requirements and CMS Guidance for Reporting the Federal Share of Medicaid Fraud Control Unit-Determined Medicaid Overpayments

In accordance with section 1903(d) of the Act and Federal regulations at 42 CFR part 433, subpart F, the State agency must refund the Federal share of Medicaid overpayments to CMS. The SHO Letter interprets section 1903(d) of the Act regarding overpayments. The letter states: “Any State action taken as a result of harm to a State’s Medicaid program must seek to recover damages sustained by the Medicaid program as a whole, including both Federal and State shares The Federal Government is entitled to the applicable FMAP share of a State’s entire recovery.”

For additional details on this CMS guidance, see Appendix D.

Departmental Appeals Board Decision

The Department of Health and Human Services, Departmental Appeals Board (DAB), issued DAB No. 2546 in 2013.¹¹ In this decision, the DAB distinguished provider overpayments from court-ordered penalties, fines, and costs for purposes of refunding the Federal share. The DAB noted that provider overpayments should be refunded to the Federal Government, regardless of whether the State is able to collect, while court-ordered penalties, fines, and costs (i.e., court-ordered awards) should be refunded when the State has actually collected them.

¹⁰ Beginning in FY 2011, CMS implemented the Form CMS-64.90FWA feeder form (Form CMS-64.90FWA) to separately track uncollected Medicaid overpayments resulting from fraud, waste, and abuse (including MFCU-determined Medicaid overpayments).

¹¹ *Missouri Department of Social Services*, DAB No. 2546 (2013). Although the DAB decision refers to a 60-day timeframe for the State to attempt to recover overpayments before reporting, the Patient Protection and Affordable Care Act amended section 1903(d)(2) of the Act to extend the timeframe to 1 year.

Medicaid Fraud Control Unit-Determined Medicaid Overpayments Related to Paid Claims and Court-Ordered Awards That Were Not Reported

During our audit period, the State agency did not report MFCU-determined Medicaid overpayments totaling \$7,214,525 (\$3,669,738 Federal share) that involved overpayments related to paid claims and collected court-ordered awards that the State agency should have already reported on the Form CMS-64.

Of this amount, a total of \$6,519,822 (\$3,296,325 Federal share) in unreported MFCU-determined Medicaid overpayments related to paid claim amounts. These funds involved two different kinds of errors, as discussed in the subsections below.

Medicaid Overpayments Related to Paid Claims That the State Agency Did Not Report Because It Regarded These as “State-Only Funds”

The State agency did not report and return MFCU-determined Medicaid overpayments that it believed (for reasons discussed later in this section) were “State-only funds.”¹² However, Medicaid Management Information System (MMIS) documentation provided by the Colorado MFCU showed that these overpayments were related to Medicaid paid claim amounts and, therefore, should have been reported.¹³

As shown in Table 1 on the following page, the amounts that the State agency had regarded as “State-only funds” matched the paid claim amounts of the MFCU-determined Medicaid overpayments.

¹² The State agency defined “State-only funds” as funds representing criminal restitutions (i.e., fines, penalties, and interest) that courts had ordered to be paid to the victim in cases in which the State agency believed it was the victim.

¹³ The State agency uses the MMIS, a computerized payment and information reporting system, to process and pay Medicaid claims.

Table 1: Judgment/Settlement Amount Compared to Paid Claims Amount			
Provider	Judgment/Settlement amount¹⁴	Paid Claims Data From Medicaid Management Information System¹⁵	Difference
A	\$1,281,885.41	\$1,281,885.41	\$0.00
B	17,082.68	17,082.68	0.00
C	1,007,620.45	1,007,620.45	0.00
D	4,362.50	4,362.50	0.00
E	1,687.40	1,687.40	0.00
F	2,762.50	2,762.50	0.00
G	4,744.74	4,744.74	0.00
H	55,863.25	55,863.25	0.00
Total	\$2,376,008.93	\$2,376,008.93	\$0.00

State agency officials said that the State agency did not report the \$2,376,009 (\$1,199,877 Federal share) in MFCU-determined Medicaid overpayments because they believed that these were “State-only funds” for which there was no FFP. These officials added that they defined these amounts as court-determined restitutions (footnote 12) because the court documents did not specifically identify the purpose to which the amounts were related. Therefore, in the State agency’s view, these funds were not necessarily tied to any specific overpayments and accordingly, the State agency did not define these recoveries as “overpayments.” The State agency was thus executing informal procedures that did not align with Federal requirements and that did not reflect any formal policies. As a result of the manner in which the State agency used these informal procedures to identify “State-only funds” and to treat court-determined restitutions, the State agency did not report and refund the Federal share of these overpayments. However, we determined that the \$2,376,009 (\$1,199,877 Federal share) in MFCU-determined Medicaid overpayments were in fact related to paid Medicaid claims for which the State agency had received FFP and that should therefore have been reported on the Form CMS-64 as required.

Medicaid Overpayments Related to Other Paid Claims That the State Agency Did Not Report

The State agency also did not report MFCU-determined Medicaid overpayments related to other paid claims that it did *not* regard as “State-only” funds. The State agency had written policies and procedures for the reporting of Medicaid overpayments that it *had* recovered. However, it did not have policies or procedures that conveyed actions to be taken for Medicaid overpayments that it had *not* recovered. Instead, the State agency followed informal

¹⁴ These amounts were taken from court documentation and settlement documents provided by the Colorado MFCU.

¹⁵ Claims data were provided by the Colorado MFCU.

procedures that classified these amounts as “State-only” funds based on State agency officials’ belief that it did not have to report overpayments it had not recovered.

However, Federal regulations specify that the State agency must report overpayments related to paid claims 1 year from the date of discovery regardless of whether recovery has been made, unless the provider is bankrupt or out of business (42 CFR § 433.300(b)). Also, the DAB ruled in 2013 (footnote 11) that Medicaid overpayments related to paid claims must be reported immediately after the end of the 1-year period specified in 42 CFR § 433.300(b). For overpayments resulting from fraud, if a final determination of the amount of the overpayment has not been made within 1 year of discovery of the overpayment, the State agency is not required to return the Federal share of such overpayment until 30 days after the date on which a final judgment is made (42 CFR §§ 433.316(a) and (d)(2)). For these amounts, over a year had passed since discovery of the overpayments, and final judgments had been made.

In addition, we determined that the State agency had recovered a small portion of these amounts (\$35,824 (\$42,446 Federal share)) but had still not reported the collected overpayment.¹⁶

As a result of its reliance on these informal procedures, the State agency did not report MFCU-determined Medicaid overpayments related to paid claims totaling \$4,143,813 (\$2,096,448 Federal share) on the Form CMS-64 as required.

Medicaid Overpayments Related to Court-Ordered Awards That the State Agency Collected but Did Not Report

The State agency did not report and return MFCU-determined Medicaid overpayments related to court-ordered awards that it had collected. State agency officials said that the interest, penalties, fines, and similar amounts awarded by the courts could permissibly be claimed as “State-only funds” in the State agency’s accounting system. However, the DAB ruled in 2013 (footnote 11) that court-ordered awards that have been collected must be reported immediately after the end of the 1-year period specified in 42 CFR § 433.300(b). Contrary to Federal requirements and this legal decision, the State agency did not report court-ordered awards that it had collected and that totaled \$694,703 (\$373,413 Federal share) on the Form CMS-64 as required.

In addition, Federal requirements bear upon any other court-ordered awards that the State agency might collect in the future. During our audit period, we identified \$10,082,936 (\$5,041,668 Federal share) that the State agency must report and refund if and when it collects these awards.

¹⁶ The Federal share shown here is greater than the total amount because there were some cases in which the State agency reported the entire total amount but not the entire Federal share portion that it should have reported.

THE STATE AGENCY REPORTED THE FEDERAL SHARE OF MEDICAID FRAUD CONTROL UNIT-DETERMINED MEDICAID OVERPAYMENTS LATE AND ON INCORRECT FEEDER FORMS OF THE FORM CMS-64

Federal Requirements and Guidance Regarding Reporting Timeframes and Feeder Forms of the Form CMS-64

Federal regulations define final written notice as “that written communication, immediately preceding the first level of formal administrative or judicial proceedings, from a Medicaid agency official or other State official that notifies the provider of the State’s overpayment determination and allows the provider to contest that determination, or that notifies the State Medicaid agency of the filing of a civil or criminal action” (42 CFR § 433.304).

Federal regulations specify that a State agency has 1 year from the date of discovery to collect Medicaid overpayments before the Federal share must be refunded. For overpayments resulting from fraud, if a final determination of the amount of the overpayment has not been made within 1 year of discovery of the overpayment, the State agency is not required to return the Federal share of such overpayment until 30 days after the date on which a final judgment is made (42 CFR §§ 433.316(a) and (d)(2)).

Federal regulations state that “[a]n overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State’s overpayment determination” (42 CFR § 433.316(d)(1)).

The *Medicaid Program Integrity Manual*, Pub. No. 100-15, instructs State agencies to report MFCU-determined Medicaid overpayments on line 2 of the Form CMS-64.9C1, if collected, or, for overpayments identified but not yet collected, on the Form CMS-64.90 (chapter 11, §§ 11005 and 11035) (footnote 10).

Medicaid Fraud Control Unit-Determined Medicaid Overpayments Reported Late

Of the \$5,831,617 (\$3,145,335 Federal share) in MFCU-determined Medicaid overpayments that the State agency reported on the Form CMS-64, it did not report \$4,770,144 (\$2,598,604 Federal share) in a timely manner as required by Federal regulations. The State agency did not follow applicable Federal regulations and as a result, it reported each of these overpayments, on average, 404 days late.

In response to our questions about these funds, the State agency referred to 42 CFR § 433.316(d)(1) and stated that in its view, the discovery date is not necessarily the date that a provider is made aware of a potential overpayment but is instead the date of the final written notice (as defined in 42 CFR § 433.304) of the State agency’s overpayment determination. However, the State agency said that it did not report an overpayment until the funds were recovered, to ensure that a provider had gone neither bankrupt nor out of business before the State agency refunds the Federal share.

The relevant Federal requirements regarding documentation for providers that have gone bankrupt or out of business appear in Federal regulations at 42 CFR §§ 433.318(c) and (d)(2). The former provision states that the State agency is not required to refund the Federal share of an overpayment to CMS at the end of the 1-year period following discovery if the provider in question has filed for bankruptcy in Federal court before the end of the 1-year period following discovery and the State is on record with the court as a creditor in the amount of the Medicaid overpayment. The latter provision states:

A provider is considered to be out of business on the effective date of a determination to that effect under State law. The agency must—

- (i) Document its efforts to locate the party and its assets. These efforts must be consistent with applicable State policies and procedures; and
- (ii) Make available an affidavit or certification from the appropriate State legal authority establishing that the provider is out of business and that the overpayment cannot be collected under State law and procedures and citing the effective date of that determination under State law.

Federal regulations further specify that, unless the State agency is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business, after the 1-year recovery period has expired, a State agency must report and return the Federal share of the overpayment, regardless of whether or not the State agency has recovered all or part of that amount (42 CFR § 433.312). Therefore, if a State has not met the documentation requirements regarding bankrupt or out-of-business providers under 42 CFR §§ 433.318(c) and (d), cited above, then it must refund overpayments within regulatory timeframes and any other court-ordered awards (including double and treble damages) if and when it collects those amounts.

The State agency did not follow regulations when it delayed reporting of overpayment amounts totaling \$4,770,144 (\$2,598,604 Federal share) on the Form CMS-64. Using the court judgment date or the settlement date as the “final written notice” date, we determined that on average, the State agency reported overpayments 404 days late.

Medicaid Fraud Control Unit-Determined Medicaid Overpayments Reported on Incorrect Feeder Forms of the Form CMS-64

For the MFCU-determined Medicaid overpayments that the State agency reported, its practice was generally to report the amounts on line 2 of the Form CMS-64.90FWA. This form is used to report Medicaid overpayments related to fraud, waste, and abuse that have not been

recovered within regulatory timeframes.¹⁷ However, all MFCU-determined Medicaid overpayments that were recovered within regulatory timeframes should have been reported on line 2 of the Form CMS-64.9C1.¹⁸ By using the Form CMS-64.9OFWA to report all MFCU-determined Medicaid overpayments as well as other recoveries from other individual sources (such as CMS Program Integrity audits and Medicare Integrity Contractor audits, among others), the State agency adversely affected CMS’s ability to track recoveries by the individual sources and evaluate the effectiveness of those various sources.

CMS developed the Form CMS-64.9OFWA to work in conjunction with the Form CMS-64.9C1 as a mechanism for CMS and State Medicaid agencies to track both unrecovered and recovered Medicaid overpayments related to fraud, waste, and abuse (whether or not specifically identified as such by MFCUs). Because the State agency reported all Medicaid overpayments on the Form CMS-64.9OFWA, CMS did not receive accurate information on fraud, waste, and abuse that should have been available to both CMS and the State agency.

The State agency said that it had policies and procedures for the reporting of Medicaid overpayments. However, the State agency did not provide us with their approved written policies and procedures for the reporting of Medicaid overpayments. Also, the State agency did not correctly report funds on the correct forms because State agency officials did not understand that overpayments recovered within regulatory timeframes should be reported on the Form CMS-64.9C1 while overpayments not recovered within regulatory timeframes should be reported on the Form CMS-64.9OFWA. In addition, State agency officials told us that they did not know that the State agency should have been using the Form CMS-64.9C1 to report MFCU-determined Medicaid overpayments.

The Medicaid Budget and Expenditures System (MBES; footnote 8) provides line definitions that explain the uses of each line on the Form CMS-64.9C1 and Form CMS-64.9OFWA. Also, CMS’s *Medicaid Program Integrity Manual* (Chapter 11, § 11035; issued September 23, 2011) and *State Medicaid Manual*, section 2500.6(B), provide additional guidance (including guidance as to applicable FMAP rates) for reporting Medicaid overpayments related to fraud, waste, and abuse. In addition, CMS’s “State Budget & Expenditure Reporting for Medicaid and CHIP” website has the CMS-64 forms including the 64.9C1 and 64.9OFWA.¹⁹ When read together, these guidance and forms demonstrate that MFCU-determined Medicaid overpayments that are recovered within regulatory timeframes should be reported on the Form CMS-64.9C1.

¹⁷ Form CMS-64.9OFWA, “Fraud, Waste & Abuse Amounts Overpayments—Federal Credit Due From Medicaid Program Integrity Activities” [Blank Forms CMS-64 \(medicaid.gov\)](#), page 21 (accessed on Feb. 17, 2022).

¹⁸ Form CMS-64.9C1, “Fraud, Waste & Abuse Amounts Credited From Medicaid Program Integrity Activities” [Blank Forms CMS-64 \(medicaid.gov\)](#), page 124 (accessed on Feb. 17, 2022). The titles of this form and the Form CMS-64.9OFWA (footnote 17) (as well as instructions in the MBES) provide information as to the proper uses of each for reporting purposes and show that Form CMS-64.9C1 should be used for Medicaid overpayments that are collected or credited, while Form CMS-64.9OFWA should be used for outstanding Medicaid overpayments where Federal credit is due.

¹⁹ [Blank Forms CMS-64 \(medicaid.gov\)](#) (accessed on Feb. 17, 2022).

RECOMMENDATIONS

We recommend that the Colorado Department of Health Care Policy and Financing:

- report and refund \$3,669,738 (Federal share) in unreported MFCU-determined Medicaid overpayments that related to paid claims and court-ordered awards that have been recovered and collected;
- determine the value of overpayments, including those related to court-ordered awards, identified after our audit period that have been recovered and collected but not reported; report them on the Form CMS-64; and refund the Federal share of the recovered overpayments and collected court-ordered awards;
- strengthen policies and procedures to ensure that overpayments are reported correctly and in a timely manner on the Form CMS-64 in accordance with Federal requirements, to include adding instructions on how to report court-ordered awards that have been collected and the timely reporting of these overpayments; and
- strengthen policies and procedures to ensure that MFCU-determined Medicaid overpayments are reported on line 2 of the Form CMS-64.9C1 if recovered or on line 2 of the Form CMS-64.9OFWA if not recovered within timeframes specified by Federal requirements.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed in part with our first recommendation and agreed with our other recommendations. For our first recommendation, the State agency agreed with the amount (\$3,669,738) of unreported MFCU-determined Medicaid overpayments that related to paid claims and court-ordered awards that have been recovered and collected. However, the State agency disagreed with refunding those funds because, it stated, it believes that some of the overpayments are likely uncollectable. The State agency said that it would review the 126 cases that we identified to ensure that the payments are not considered uncollectable, document any amounts that are uncollectable, and return the applicable Federal share by September 30, 2023.

The State agency agreed with our other three recommendations and described corrective actions that it had taken or planned to take. Specifically, the State agency stated it would identify and review the overpayments related to court-ordered awards identified after the audit period and appropriately report them on the correct forms by September 30, 2023. The State agency also said that it had already made updates to its policies and procedures concerning the proper returning and reporting of the Federal share prior to receiving our draft report findings. The State agency said that it would further review and revise its policies and procedures in the context of our findings to ensure compliance by September 30, 2023. The State agency further stated that it would amend its current policies and procedures to ensure

that MFCU-determined Medicaid overpayments are “reported properly on the [Form] CMS-64 in accordance with CMS guidance.”

The State agency’s comments appear in their entirety as Appendix E.

With respect to the State agency’s comments on our first recommendation, we disagree that the State agency should wait until September 30, 2023, to report and refund the \$3,669,738 of MFCU-determined Medicaid overpayments. Instead, we believe that Federal regulations require the State agency to immediately report the overpayments. These overpayments related to paid claims that are 1 year past the date of discovery but have not been reported, or to court-ordered awards that have been collected but not reported. Therefore, these overpayments should have already been reported as required by section 1903(d) of the Act and Federal regulations at 42 CFR part 433. In addition, the Form CMS-64.90FWA provides a mechanism through which the State agency can reclaim any overpayments reported and refunded to the Federal Government for which the State agency later determines that an overpayment amount is uncollectable because the provider has been determined bankrupt or out of business. Federal regulations at 42 CFR § 433.320(g) convey the requirements for reclaiming refunds under these circumstances.

With respect to our other recommendations, we believe that the State agency should implement corrective actions as soon as possible to ensure that the Federal share of the MFCU-determined Medicaid overpayments is immediately reported in a timely and accurate manner.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

According to information provided by the State agency, during our audit period (October 1, 2014, through December 31, 2020) the Colorado MFCU received final determinations for 229 cases that resulted in MFCU-determined Medicaid overpayments totaling \$24,321,883. Of the 229 cases, we removed 50 cases from our scope for the following reasons:

- Twenty-seven cases involved only court fees, fines, or both, and did not involve restitution.
- Seven cases had timeframes that extended beyond the timeframe of our audit.
- Six cases were duplicates.
- Five of the cases involved only the State share because the Federal Government pursued its share separately (through mechanisms unrelated to the current audit).²⁰
- Two cases did not involve Medicaid funds.
- Two cases had been combined with other cases that had related case numbers.
- For one case, the provider reversed the claims in the MMIS before the case reached the State agency.

This audit covers the remaining 179 MFCU cases with associated MFCU-determined Medicaid overpayments totaling \$23,129,078.

We did not audit the State agency's overall internal control structure. Rather, we reviewed only those internal controls related to our objective.

We performed our audit work, which included on-site fieldwork at the State agency in Denver, Colorado, from June 2019 to August 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

²⁰ According to the SHO Letter, a State may seek to recover only the State share of computed fraud damages if appropriate Federal and State authorities agree to "sever" the Federal and State portions of the overpayment and pursue them as separate actions.

- worked with our legal counsel and CMS staff to obtain an understanding of where on the Form CMS-64 State agencies should report MFCU-determined Medicaid overpayments;
- obtained documents from the Colorado MFCU that summarized the MFCU-determined Medicaid overpayments for which Colorado received final determinations during our audit period;
- obtained legal documents related to the MFCU-determined Medicaid overpayments from the Colorado MFCU and the State agency;
- obtained the State agency's case log that it used to track MFCU-determined Medicaid overpayments related to fraud, waste, and abuse;
- obtained and evaluated the State agency's documentation supporting its reporting of the MFCU-determined Medicaid overpayments on the Form CMS-64;
- obtained and evaluated the State agency's policies and procedures regarding the receipt and deposit of State recoveries to include MFCU-determined Medicaid overpayments;
- interviewed State agency personnel to understand:
 - how information regarding MFCU-determined Medicaid overpayments was shared among staff,
 - the staff's understanding of its policies and procedures and their relationship to applicable Federal requirements, and
 - how MFCU-determined Medicaid overpayments were reported to the Federal Government;
- obtained documentation from the State agency's payment system that identified which of the 179 MFCU cases were reflected on each submitted Form CMS-64 and that identified the specific MFCU-determined Medicaid overpayment associated with each case;
- reviewed that documentation to determine whether the State agency returned the correct Federal share of its recoveries;
- evaluated relevant court documents to determine the date on which the 30-day collection period ended for each MFCU case and
 - for each case, determined the quarter in which the 30-day period ended and

- identified that quarter as the quarter for which the State agency should have reported the associated overpayments on the Form CMS-64;²¹
- applied the FMAP rates in effect as of the paid claims dates to the improper claims amounts from the MFCU-determined Medicaid overpayments;
- applied the FMAP rates in effect as of the reporting quarter-end dates to the court-awarded damages amounts from the MFCU-determined Medicaid overpayments;
- calculated the Federal share of the total MFCU-determined Medicaid overpayments that should have been reported on the Form CMS-64;
- calculated the difference in overpayments between what the State agency reported to CMS and what it should have reported; and
- discussed the results of our audit with State agency officials on January 13, 2022.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

²¹ To be conservative, if the 30-day collection period ended within or during the last week of a quarter, we identified the following quarter as the quarter for which the State agency should have reported the associated overpayments.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Texas Did Not Report and Return All Medicaid Overpayments for the State’s Medicaid Fraud Control Unit’s Cases</i>	<u>A-06-20-04004</u>	5/25/2022
<i>Nebraska Did Not Report and Refund the Correct Federal Share of Medicaid-Related Overpayments for 76 Percent of the State’s Medicaid Fraud Control Unit Cases</i>	<u>A-07-18-02814</u>	6/10/2021
<i>Wisconsin Did Not Report and Refund the Full Federal Share of Medicaid-Related Settlements and a Judgment</i>	<u>A-05-17-00041</u>	12/13/2018

APPENDIX C: FEDERAL SHARE OF MEDICAID FRAUD CONTROL UNIT-DETERMINED MEDICAID OVERPAYMENTS NOT REPORTED AND NOT REPORTED IN A TIMELY MANNER

Table 2: MFCU-Determined Medicaid Overpayments Not Reported (Total and Federal Share)		
Federal Fiscal Year	Total Not Reported	Federal Share of Total Not Reported
2015	\$13,639	\$7,198
2016	690,172	395,995
2017	21,186	6,674
2018	63,748	32,570
2019	5,390,914	2,704,050
2020	1,034,866	523,251
2021	0	0
Totals	\$7,214,525	\$3,669,738

Table 3: Federal Fiscal Year Amounts That Were and Were Not Reported in a Timely Manner				
Fiscal Year	Amounts Reported in a Timely Manner	Federal Share of Amounts Reported in a Timely Manner	Amounts Not Reported in a Timely Manner	Federal Share of Amounts Not Reported in a Timely Manner
2015	\$625,789	\$326,294	\$603,961	\$341,407
2016	152,944	76,165	3,857,719	2,098,281
2017	31,500	15,886	27,952	16,211
2018	11,115	4,747	280,512	142,705
2019	224,314	114,119	0	0
2020	15,811	8,107	0	0
2021	0	0	0	0
Totals	\$1,061,473	\$545,318	\$4,770,144	\$2,598,604

APPENDIX D: FEDERAL REQUIREMENTS AND GUIDANCE

FEDERAL LAWS

Section 1903(d)(2)(A) of the Act provides that “[t]he Secretary [of Health and Human Services (HHS)] shall . . . pay to the State, in such installments as he may determine, the amount so estimated, reduced, or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.”

Section 1903(d)(3)(A) of the Act states: “[t]he pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.”

FEDERAL REGULATIONS

Federal regulations (42 CFR § 433.300(b)) state:

Section 1903(d)(2)(C) and (D) of the Act . . . provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

Federal regulations define final written notice as “that written communication, immediately preceding the first level of formal administrative or judicial proceedings, from a Medicaid agency official or other State official that notifies the provider of the State’s overpayment determination and allows the provider to contest that determination, or that notifies the State Medicaid agency of the filing of a civil or criminal action” (42 CFR § 433.304).

Federal regulations state: “The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS” (42 CFR § 433.316(a)).

Federal regulations state: “An overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State’s overpayment determination” (42 CFR § 433.316(d)(1)).

Federal regulations (42 CFR § 433.316(d)(2)) state:

When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

CMS GUIDANCE (PROGRAM MANUALS)

The *Medicaid Program Integrity Manual*, September 23, 2011, states: “The form CMS-64.9C1 feeder form is used to provide detail about the fraud, waste, and abuse collection efforts and flows into line 9c of the Form CMS-64” (chapter 11, § 11035).

This manual also provides instructions for reporting MFCU-determined Medicaid overpayments on the Form CMS-64.9C1: “Line 2—MFCU Investigations[:] Used to report overpayment amounts collected from investigations conducted by the State’s MFCU” (chapter 11, § 11035).

The *State Medicaid Manual*, section 2500(D)(2), states:

FMAP Rate Applicable to Expenditures/Recoveries. When reporting expenditures for Federal reimbursement, apply the FMAP rate in effect at the time the expenditure was recorded in your accounting system. An expenditure occurs when a cash payment is made to a provider. Noncash expenditures, such as depreciation, are made when they are recorded in the accounting records in accordance with generally accepted accounting principles. The term ‘State’ means any agency of the State including the State Medicaid agency, its fiscal agents, a State health agency, or any other State or local organization incurring matchable expenditures.

Section 1903(a)(1) of the Act provides that [CMS] reimburse you quarterly an amount equal to the FMAP of the total amount expended during such quarter as Medical Assistance under the approved State plan. It provides that [CMS] reimburse you at the FMAP rate for the quarter in which the expenditure was made, even if the expenditure is not claimed for Federal reimbursement until some later quarter. To establish the FMAP rate applicable to a given expenditure, determine when the expenditure was made. When the expenditure cannot be tied to a specific prior period, compute the Federal share at the current FMAP rate. Make adjustments to reflect the correct FMAP rate in subsequent [Form CMS-64] as adjustments to prior period claims. Do not delay

the refunding of the Federal share simply because you cannot immediately tie the expenditure to a specific prior period.

CMS GUIDANCE (STATE HEALTH OFFICIAL LETTER)

The SHO Letter, dated October 28, 2008, states:

The [Social Security] Act requires that the amounts recovered by a State through a State FCA [False Claims Act] action be refunded at the Federal Medical Assistance Percentage (FMAP) rate. The Act’s broad mandate demands that a State return not only the Federal amount originally paid attributable to fraud or abuse, but also an FMAP-rate proportionate share of any other recovery.

Any State action taken as a result of harm to a State’s Medicaid program must seek to recover damages sustained by the Medicaid program as a whole, including both Federal and State shares. A State may not seek to recover merely the ‘State share’ of computed fraud damages unless appropriate Federal and State authorities formally agree to sever the Federal and State portion of the overpayment and pursue them as separate actions. If there is no formal agreement to sever, a State may not claim in a State FCA case that it is only recovering damages incurred by the State, but not the Federal Government. Nor may a State return merely the Federal portion of ‘single’ damages and retain all other amounts, such as double and treble damages. The Federal Government is entitled to the applicable FMAP share of a State’s entire recovery.

States are also required to return the FMAP percentage on State recoveries based upon actions brought against third parties, such as actions against pharmaceutical companies, alleging inappropriate Medicaid expenditures. Though these third parties are not necessarily directly reimbursed by Medicaid, they may be liable under a State FCA for having caused false or fraudulent claims to be submitted by others. A State may not avoid adhering to the requirements set forth in section 1903(d) of the Act by virtue of pursuing legal action against a person or entity that has caused false or fraudulent claims to be submitted rather than the party that directly submitted false or fraudulent claims.

The FMAP proportionate share of State FCA-based fines, penalties, or assessments imposed against providers or entities are to be refunded. The HHS Departmental Appeals Board has long recognized the Federal Government’s entitlement to its proportionate share of civil penalties assessed by States against providers or other entities

* * * * *

For State FCA legal actions neither the relator's share, nor legal expenses (whether borne by the State or the relator) or other administrative costs arising from such litigation, may be deducted from the Federal portion of the entire proceeds of the litigation. A state must return the Federal portion of such recoveries at its applicable FMAP rate for medical services in recognition of the overpayment that resulted from a payment for Medicaid services. Historically, costs that are in support of the proper and efficient administration of a State's Medicaid program are recognized as administrative costs and not service costs. To the extent attributable to Medicaid recoveries, these costs may be the basis for claims for reimbursement as an administrative cost that benefits the Medicaid program and reimbursed at the regular administrative percentage rate. Federal reimbursement is not available for administrative costs that are not directly related to Medicaid recoveries.



September 22, 2022

Mr. James Korn
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
601 E. 12th Street, Room 0429
Kansas City, MO 64106

Re: Report Number A-07-21-02834

Dear Mr. Korn:

Enclosed is the Department of Health Care Policy and Financing's response and factual changes to the United States Department of Health and Human Services, Office of Inspector General draft report entitled *Colorado Did Not Report and Refund the Correct Federal Share of Medicaid Related Overpayments for 70 Percent of the State's Medicaid Fraud Control Unit Cases*.

If you have any questions or need additional information, please contact Melissa Mull at melissa.mull@state.co.us.

Sincerely,

/Melissa Mull/

Melissa Mull
External Audits Compliance Officer

Cc: Ms. Charlie Arnold, Acting Director Audit & Review Branch, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services

Colorado Department of Health Care Policy and Financing Response to
the Department of Health and Human Services Office of Inspector
General (OIG) Audit Report Titled *Colorado Did Not Report and
Refund the Correct Federal Share of Medicaid Related Overpayments
for 70 Percent of the State’s Medicaid Fraud Control Unit Cases*
(A-07-21-02834)

OIG Recommendations and Department Responses

We recommend that the Colorado Department of Health Care Policy and Financing:

- *report and refund \$3,669,738 (Federal share) in unreported MFCU-determined Medicaid overpayments that related to paid claims and court-ordered awards that have been recovered and collected;*

Response: Partially Agree. The Department agrees with the amount of unreported MFCU-determined Medicaid overpayments. However, the Department disagrees with refunding the \$3,669,738 because some of the overpayments included in this amount likely are uncollectible. The Department will review the remaining 126 cases identified in this report to ensure that the payments are not considered uncollectible, document any amounts that are uncollectible, and return the applicable Federal Share by 9/30/23.

- *determine the value of overpayments, including those related to court-ordered awards, identified after our audit period that have been recovered and collected but not reported; report them on the Form CMS-64; and refund the Federal share of the recovered overpayments and collected court-ordered awards;*

Response: Agree. The Department will identify and review the overpayments related to court-ordered awards identified after the audit period and appropriately report them on the correct forms by 9/30/23.

- *strengthen policies and procedures to ensure that overpayments are reported correctly and in a timely manner on the Form CMS-64 in accordance with Federal requirements, to include adding instructions on how to report court-ordered awards that have been collected and the timely reporting of these overpayments;*

Response: Agree. The Department has already made updates to its policies and procedures around properly returning and reporting FFP prior to receiving the draft findings. Now that we have received the draft findings, we will further review and revise our policies and procedures to ensure that we comply with these findings by 9/30/23.

- *strengthen policies and procedures to ensure that MFCU-determined Medicaid overpayments are reported on line 2 of the Form CMS-64.9C1 if recovered or on line 2 of the Form CMS-64.9OFWA if not recovered within timeframes specified by Federal requirements.*

Response: Agree. The Department will amend its current policies and procedures to ensure MFCU-determined Medicaid overpayments are reported properly on the CMS-64 in accordance with CMS guidance.