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 SOME CASES IDENTIFIED BY THE STATE'S PROGRAM INTEGRITY SECTION

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Office of Inspector General

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Report in Brief
Date: May 2024
Report No. A-07-19-02816

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

Colorado Did Not Report and Refund the Correct Federal Share of Medicaid-Related Overpayments for Some Cases Identified by the State's Program Integrity Section

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 provider claims amounts as well as any damages (when assessed). For this audit, we focused on Colorado's actions related to the recoveries of Medicaid overpayments. Colorado is required to report these recoveries to the Centers for Medicare & Medicaid Services (CMS) and to refund the Federal share of those recoveries to the Federal Government.

Our objective was to determine whether Colorado reported and refunded the correct Federal share of Medicaid overpayments that its Program Integrity Section identified during the period October 1, 2014, through December 31, 2020.

How OIG Did This Audit

We reviewed 403 cases with Medicaid overpayments totaling $28.4 million during our audit period. We worked with Colorado to identify what portion of the $28.4 million it reported to CMS for the period October 1, 2014, through December 31, 2020. We obtained documentation related to Medicaid overpayments as well as Colorado's documentation that supported its reporting of those overpayments to determine whether Colorado reported the correct Federal share.

What OIG Found

Colorado did not report and refund the correct Federal share of Medicaid overpayments that its Program Integrity Section identified during the period October 1, 2014, through December 31, 2020. Specifically, we determined that Colorado did not report $385,180 ($637,686 Federal share) in Medicaid overpayments for 80 of the 403 cases we reviewed. (The Federal share is greater than the total amount because there were some cases in which the State reported the entire total amount but not the entire Federal share portion that it should have reported.) In addition, Colorado did not report $12.7 million ($8.5 million Federal share) to CMS in a timely manner. Furthermore, the State did not correctly report Medicaid overpayments that either had been recovered or had not been recovered within regulatory timeframes. Although Colorado had policies and procedures for reporting Medicaid overpayments that its Program Integrity Section had identified, we concluded that these policies and procedures were not always adequate to ensure that Colorado reported and refunded all of the overpayments.

What OIG Recommends and Colorado Comments

We recommend that Colorado report and refund $385,180 ($673,686 Federal share) in unreported Medicaid overpayments that were related to paid claims 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 also recommend that Colorado work with CMS to determine the amount of interest, if any, on the Federal share owed, and report that amount; and we make procedural recommendations for the strengthening and updating of policies and procedures to ensure that overpayments are reported correctly and in a timely manner.

Colorado concurred with all of our recommendations and described corrective actions it had taken or planned to take. Colorado said that it would report and return any overpayments that were not already returned and added that it was tracking all provider overpayments to ensure that they are reported and returned in accordance with Federal requirements. Colorado also described corrective actions for the calculation and return of interest owed and said that it had revised its policies and procedures.

The full report can be found on the OIG website.

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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 Department of Health Care Policy and Financing (State agency) actions related to the recoveries of Medicaid overpayments. The 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 refunded the correct Federal share of Medicaid overpayments that its Program Integrity Section 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 State Program Integrity Section

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 multiplied by the FMAP.[2] 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

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

[2] 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.

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.[3]

The State agency's Program Integrity Section combats fraud, waste, and abuse in Medicaid, and is supported by CMS through regular State-level reviews, which are designed to identify risks and vulnerabilities to the Medicaid program and to assist States in strengthening their program integrity operations. The Program Integrity Section is responsible for activities such as regulatory compliance, surveillance and utilization systems, case tracking, prepayment and postpayment reviews, provider enrollment and disclosures, and interactions with the State's Medicaid Fraud Control Unit (MFCU).

Federal Requirements Concerning Reporting of Medicaid Overpayments

Section 1903(d)(3)(A) of the Act states that the Federal share of the net amount of Medicaid funds recovered during any quarter by a State "shall be considered an overpayment."

Implementing Federal regulations specify that State agencies have 1 year from the date of discovery to recover or seek to recover Medicaid overpayments before the Federal share must be reported to CMS (42 CFR § 433.316(a)). For this report, we refer to this timeframe as "1-year recovery period."

Federal regulations (42 CFR § 433.316(c)) state that for overpayments that result from situations other than fraud, the date of discovery is the earliest of: (1) the date on which any State agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery; (2) the date on which a provider first acknowledges a specific overpayment amount in writing to the State agency; or (3) the date on which any State official or fiscal agent initiates a formal action to recoup a specific overpayment amount from a provider without having first notified that provider in writing.

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 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."

[3] The Medicaid program includes provisions for higher Federal reimbursement for certain specified services, such as family planning services; this higher reimbursement is referred to as Enhanced FMAP. Newly Eligible FMAP applies to people newly enrolled in Medicaid through Medicaid expansion. We provide this information on the different categories of FMAP rates solely for background and context; the differences between these categories do not affect our findings or recommendations.

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."

Reporting of 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 Medicaid overpayments on the Form CMS-64.9C1 feeder form[4] (Form CMS-64.9C1), if collected, or, for overpayments identified but not yet collected within regulatory timeframes, on the Form CMS-64.9O feeder form[5] (Form CMS-64.9O) (chapter 11, §§ 11005 and 11035).[6]

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.

According to CMS officials:

- In FY 2011, CMS revised the Form CMS-64.9O 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-64.9OFWA feeder form (Form CMS-64.9OFWA) to separately track uncollected Medicaid overpayments resulting from fraud, waste, and abuse.

- The Form CMS-64.9OFWA 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

[4] The Form CMS-64.9C1 feeder form is used to provide detailed information about collection efforts. The total from this feeder form carries over to the Form CMS-64 Summary sheet.

[5] Before it was revised (as discussed in the first bullet just below), the Form CMS-64.9O feeder form was used to provide detailed information about overpayments identified but not yet collected. The total from this feeder form carried over to the Form CMS-64 Summary sheet.

[6] 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.

out of business. The Form CMS-64.9OFWA was available in the Medicaid Budget and Expenditure System (MBES) beginning with FY 2011.[7, 8]

State Agency Policies and Procedures for Reporting Medicaid 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), Medicaid overpayments totaled $60,910,067 for 956 cases. We removed 553 of the 956 cases, for reasons provided in Appendix A, and reviewed the remaining 403 cases with Medicaid overpayments totaling $28,442,635.[9]

We worked with the State agency to identify what portion of the $28,442,635 it reported on the Form CMS-64 during the period October 1, 2014, through December 31, 2020. We obtained documentation related to 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 the claims amounts. We determined that the State agency's calculations were materially accurate. For each case, we determined the quarter in which the 1-year recovery 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. We did not calculate the amount of interest on the Federal share due by the State agency. For further details on our analysis, see Appendix A.

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[7] The 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.

[8] The *Medicaid Program Integrity Manual* in effect for most of our audit period did not include guidance for the preparation of the Form CMS-64.9OFWA. 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 Jan. 5, 2024).

[9] For reasons discussed in our findings later in this report, this amount is not the amount that the State agency reported for our audit period.

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 Medicaid overpayments to be refunded.

FINDINGS

The State agency did not report and refund the correct Federal share of Medicaid overpayments that its Program Integrity Section identified during the period October 1, 2014, through December 31, 2020. Specifically, we determined that the State agency did not report $385,180 ($637,686 Federal share) in Medicaid overpayments for 80 of the 403 cases (almost 20 percent) we reviewed.[10] Although the State agency reported $28,057,455 ($20,260,277 Federal share) during this period, we identified $28,442,635 ($20,933,963 Federal share) that it should have reported as overpayments.

The unreported funds that were related to the 80 cases, which the State agency should have refunded, consisted of $385,180 ($673,686 Federal share) (footnote 10) in amounts related to Medicaid overpayments that the State agency's Program Integrity Section had identified and that the State agency should have already reported, including:

- $251,156 ($603,012 Federal share) (footnote 10) in underreported Medicaid overpayments related to reported Medicaid overpayments on the Form CMS-64; and

- $134,024 ($70,674 Federal share) in Medicaid overpayments that the State agency did not report on the Form CMS-64.

In addition, of the $28,057,455 ($20,260,277 Federal share) that the State agency reported, it did not report $12,711,166 ($8,465,227 Federal share) in a timely manner.

Furthermore, the State agency did not report Medicaid overpayments on the correct feeder form of the Form CMS-64.9C1, if recovered, or the Form CMS-64.9OFWA, if not recovered within regulatory timeframes.

These errors occurred because although the State agency had policies and procedures for reporting Medicaid overpayments that its Program Integrity Section had identified and recovered, we concluded that these policies and procedures were not always adequate to

[10] 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.

ensure that the State agency reported and refunded all of the Medicaid overpayments, even if those had not been recovered, in accordance with Federal requirements. Specifically, the State agency's policies and procedures did not convey accurate information regarding the correct forms to use for the correct reporting of overpayments 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.

OVERALL FEDERAL REQUIREMENTS AND GUIDANCE REGARDING THE REPORTING OF MEDICAID OVERPAYMENTS

Section 1903(d)(3)(A) of the Act states: "The pro rata share to which the United States is equitably entitled, as determined by the Secretary [of Health and Human Services (HHS)], 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 (42 CFR § 433.316(c)) state:

> *Overpayments resulting from situations other than fraud*. An overpayment resulting from a situation other than fraud is discovered on the earliest of—
>
> (1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;
>
> (2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the [M]edicaid agency; or
>
> (3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing. [Italics in original.]

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

Federal regulations (42 CFR § 433.320(a)(4)) state:

> If the State does not refund the Federal share of such overpayment as indicated in paragraph (a)(2) of this section, the State will be liable for interest on the amount equal to the Federal share of the non-recovered, non-refunded overpayment amount. Interest during this period will be at the Current Value of Funds Rate (CVFR), and will accrue beginning on the day after the end of the

> 1-year period following discovery until the last day of the quarter for which the State submits a CMS–64 report [i.e., Form CMS-64] refunding the Federal share of the overpayment.

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

THE STATE AGENCY DID NOT REPORT THE CORRECT FEDERAL SHARE OF MEDICAID OVERPAYMENTS

Federal Requirements and CMS Guidance for Reporting the Federal Share of 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."

Federal regulations specify that the State agency must report overpayments related to paid claims within 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)). Medicaid overpayments related to paid claims must be reported at the end of the 1-year period specified in 42 CFR § 433.300(b).

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

Medicaid Overpayments That Were Not Reported

During our audit period, the State agency's Program Integrity Section identified, but the State agency did not report, overpayments totaling $385,180 ($673,686 Federal share) (footnote 10) that were related to paid Medicaid claims amounts and that the State agency should have refunded to the Federal Government.

Of this amount, the State agency underreported the Federal share of the overpayments by $251,156 ($603,012 Federal share) (footnote 10) that were related to paid Medicaid claims amounts. For example, the State agency recovered a Medicaid provider overpayment of $3,177,775 on May 25, 2017; of this amount, the Federal share should have been $2,238,014 but the State agency reported $2,216,130. As a result of this error, the State agency reported the correct total computable amount but did not report $21,884 of the Federal share of the overpayment. Furthermore, the State agency reported this overpayment recovery almost 2 years later than it should have.

Additionally, the State agency did not report overpayments of $134,024 ($70,674 Federal share) that were related to paid Medicaid claims amounts. The State agency should have reported all of these amounts on the Form CMS-64, but did not.

These errors occurred because, although the State agency had policies and procedures for reporting Medicaid overpayments that its Program Integrity Section had identified and recovered, these policies and procedures did not address how Medicaid overpayments should be reported when the State agency had not recovered the overpayment. As a result, the State agency did not report Medicaid overpayments related to paid claims totaling $385,180 ($673,686 Federal share) (footnote 10) on the Form CMS-64 as required. Moreover, there is interest associated with these unreported overpayments that were not refunded to the Federal Government.[11] We make a procedural recommendation later in this report that the State agency work with CMS, if it has not already done so, to calculate the interest and report that amount.

THE STATE AGENCY REPORTED THE FEDERAL SHARE OF MEDICAID OVERPAYMENTS LATE AND ON THE 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 (42 CFR § 433.316(c)) state:

> *Overpayments resulting from situations other than fraud*. An overpayment resulting from a situation other than fraud is discovered on the earliest of—
>
> (1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;
>
> (2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the [M]edicaid agency; or
>
> (3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing. [Italics in original.]

Federal regulations specify that the State agency must report overpayments related to paid claims within 1 year from the date of discovery regardless of whether recovery has been made,

[11] Although the State agency is liable for interest on the Federal share of the overpayments that the State agency either did not report on the Form CMS-64 or (as discussed in the next section of this report) did not report in a timely manner, we did not calculate the amount of interest that is due on the Federal share of those overpayments that were not refunded in accordance with requirements. Accordingly, we did not determine whether the State calculated and reported the correct interest that should have been reported on the Form CMS-64.

unless the provider is bankrupt or out of business (42 CFR § 433.300(b)). Medicaid overpayments related to paid claims must be reported at the end of the 1-year period specified in 42 CFR § 433.300(b).

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

Medicaid Overpayments Reported Late

Of the $28,057,455 ($20,260,277 Federal share) in Medicaid overpayments that the State agency reported on the Form CMS-64, it did not report $12,711,166 ($8,465,227 Federal share) on the Form CMS-64 for the quarter ending 1 year after the date on which the State agency first notified the provider of the overpayment 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, 481 days late (footnote 11). Table 1 breaks out the reporting timeframes, and associated dollar amounts, for these Medicaid overpayments.

Table 1: Timeframes and Total Dollar Amounts of Medicaid Overpayments Reported Late

Medicaid Overpayments Reported Late[12]	Number of Cases	Total Amount	Federal Share
Less than 1 year late	40	$4,676,805	$3,272,909
1 to less than 2 years late	34	7,344,021	4,815,618
2 to less than 3 years late	18	564,084	309,197
3 to less than 4 years late	9	126,256	67,503
Total Cases and Amounts Late	**101**	**$12,711,166**	**$8,465,227**

In response to our questions about these refunds, the State agency replied that several issues could have caused these delays, such as: (1) the need to calculate the FFP, (2) provider payments whose amounts did not match the claims identified in the overpayments, and (3) inactive provider identification numbers that were associated with the claims. Additionally, while the State agency was spending time attempting to resolve these issues, it learned that checks submitted by providers as payment had expired because they had not been deposited promptly, which caused more delays while the State agency worked to get replacement checks. The State agency added that it has revised its procedures to immediately deposit checks.

Medicaid Overpayments Reported on Incorrect Feeder Forms of the Form CMS-64

For the Medicaid overpayments that the State agency reported, its practice was generally to report the amounts on the Form CMS-64.9OFWA. This form is used to report Medicaid

[12] The timeframes in this table are after the 1-year period that started when the State agency first notified the provider of the overpayment.

overpayments related to fraud, waste, and abuse that have not been recovered within regulatory timeframes.[13] However, all Medicaid overpayments that were recovered within regulatory timeframes should have been reported on the Form CMS-64.9C1.[14] By using the Form CMS-64.9OFWA to report all Medicaid overpayments as well as other recoveries from other individual sources (such as MFCU Medicaid overpayments 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. 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.

These errors occurred because although the State agency had policies and procedures for reporting Medicaid overpayments that its Program Integrity Section had identified and recovered, we concluded that these policies and procedures were not always adequate to ensure that the State agency reported the overpayments in accordance with Federal requirements. Specifically, the State agency's policies and procedures did not convey accurate information regarding the correct forms to use for the correct reporting of overpayments 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.

The MBES (footnote 7) 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. When read together, these guidance and forms demonstrate that Medicaid overpayments that are recovered within regulatory timeframes should be reported on the Form CMS-64.9C1.

[13] 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 Jan. 5, 2024).

[14] Form CMS-64.9C1, "Fraud, Waste & Abuse Amounts Credited From Medicaid Program Integrity Activities" Blank Forms CMS-64 (medicaid.gov), page 124 (accessed on Jan. 5, 2024). The titles of this form and the Form CMS-64.9OFWA (footnote 13) (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.

RECOMMENDATIONS

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

- report and refund $385,180 ($673,686 Federal share) (footnote 10) in unreported Medicaid overpayments that were related to paid claims that have been recovered and collected;

- determine the value of overpayments 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;

- work with CMS to determine the amount of interest, if any, on the Federal share owed by the State agency and report that amount to the Federal Government;

- 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; and

- update policies and procedures to ensure that Medicaid overpayments are reported on the Form CMS-64.9C1 if recovered or on the Form CMS-64.9OFWA if not recovered within timeframes specified by Federal requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with all of our recommendations and described corrective actions it had taken or planned to take. For our first recommendation, the State agency said that it would report and return any overpayments that were not already returned and document any providers for which the overpayments were uncollectable. For our second recommendation, the State agency said it was already tracking all provider overpayments to ensure that they are reported and returned in accordance with Federal requirements. For our third recommendation, the State agency said that once all recoveries have been reported and the remaining Federal share has been returned, the interest owed would, by December 31, 2024, be calculated and returned. For our fourth recommendation, the State agency said that it had already revised its policies and procedures "based on information learned during the audit process." The State agency added that it had updated policies and system coding to ensure that the Federal share is submitted timely and is correctly reported on the Form CMS-64.

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

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 State agency received final determinations for 956 cases that resulted in Medicaid overpayments totaling $60,910,067. Of the 956 cases, we removed 553 cases from our scope for the following reasons:

- a total of 194 cases had timeframes that extended beyond the timeframe of our audit,
- we reviewed 182 cases in a separate Medicaid Fraud Control Unit report,[15]
- the State agency correctly identified and reported 68 cases,
- forty-nine cases had timeframes that were before the timeframe of our audit,
- the due dates for 34 cases were beyond the scope of our audit,
- nineteen cases were duplicates, and
- seven cases involved providers that had gone bankrupt or out of business.

This audit covered the remaining 403 cases with associated Medicaid overpayments totaling $28,442,635.

We did not audit the State agency's overall internal control structure. Rather, we reviewed only those internal controls related to our objective. We also did not calculate the amount of interest on the Federal share due by the State agency.

Our audit work included on-site fieldwork at the State agency in Denver, Colorado.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- worked with our legal counsel and CMS staff to obtain an understanding of where on the Form CMS-64 State agencies should report Medicaid overpayments;

[15] *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), Oct. 25, 2022.

- obtained documents from the State agency that summarized the Medicaid overpayments for which the State agency received final determinations during our audit period;

- obtained legal documents related to the Medicaid overpayments from the State agency;

- obtained the State agency's case log that it used to track Medicaid overpayments related to fraud, waste, and abuse;

- obtained and evaluated the State agency's documentation supporting its reporting of the 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 Medicaid overpayments;

- interviewed State agency personnel to understand:

    - how information regarding Medicaid overpayments was shared among staff,

    - the staff's understanding of its policies and procedures and their relationship to applicable Federal requirements, and

    - how Medicaid overpayments were reported to the Federal Government;

- obtained documentation from the State agency's payment system that identified which of the 403 cases were reflected on each submitted Form CMS-64 during our audit period and that identified the specific Medicaid overpayment associated with each case;

- reviewed that documentation to determine whether the State agency reported and refunded the correct Federal share of its recoveries;

- evaluated relevant documents to determine the date on which the 1-year recovery period ended for each case and

    - for each case, determined the quarter in which the 1-year recovery 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;

- applied the FMAP rates in effect as of the paid claims dates to the improper claims amounts from the Medicaid overpayments;

- applied the FMAP rates in effect as of the reporting quarter-end dates to the Medicaid overpayments;

- recalculated the Federal share of the total 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 April 12, 2023.

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 B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

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

APPENDIX C: FEDERAL SHARE OF THE MEDICAID OVERPAYMENTS TO BE REFUNDED

Table 2: Medicaid Overpayments Not Reported (Total and Federal Share) (footnote 10)		
Federal Fiscal Year	**Total Not Reported**	**Federal Share of Total Not Reported**
2015	$792	$8,230
2016	15,451	7,837
2017	3,322	23,815
2018	117,535	90,336
2019	230,211	520,771
2020	17,869	22,697
2021	0	0
Totals	**$385,180**	**$673,686**

APPENDIX D: FEDERAL REQUIREMENTS AND GUIDANCE

FEDERAL LAWS

Section 1903(d)(2)(A) of the Act provides that "[t]he Secretary [of 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: "The pro rata share to which the United States is equitably entitled, as determined by the Secretary [of HHS], 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 [(1-year recovery 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 (42 CFR § 433.316(c) state:

> *Overpayments resulting from situations other than fraud*. An overpayment resulting from a situation other than fraud is discovered on the earliest of—

(1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;

(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the [M]edicaid agency; or

(3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing. [Italics in original.]

Federal regulations (42 CFR § 433.320(a)) state:

(1) The agency must refund the Federal share of overpayments that are subject to recovery to CMS through a credit on its Quarterly Statement of Expenditures (Form CMS–64).

(2) The agency must credit CMS with the Federal share of overpayments subject to recovery on the earlier of—

(i) The Form CMS–64 submission due to CMS for the quarter in which the State recovers the overpayment from the provider; or

(ii) (ii) The Form CMS–64 due to CMS for the quarter in which the 1-year period following discovery, established in accordance with § 433.316, ends.

(3) A credit on the Form CMS–64 must be made whether or not the overpayment has been recovered by the State from the provider.

(4) If the State does not refund the Federal share of such overpayment as indicated in paragraph (a)(2) of this section, the State will be liable for interest on the amount equal to the Federal share of the non-recovered, non-refunded overpayment amount. Interest during this period will be at the Current Value of Funds Rate (CVFR), and will accrue beginning on the day after the end of the 1-year period following discovery until the last day of the quarter for which the State submits a CMS–64 report refunding the Federal share of the overpayment.

Federal regulations state that any adjustment in the amount of an overpayment during the 1-year period following the discovery does not affect the 1-year period for the original overpayment amount. However, any upward adjustments above the original overpayment begin a new 1-year period for the incremental amount only, which begins on the date that the State agency notifies the provider in writing of the upward adjustment (42 CFR § 433.316(f)).

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).

The *State Medicaid Manual*, section 2500D.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 [Forms 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 in part:

> 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. . . .

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

April 26, 2024

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-07-19-02816

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 Some Cases Identified by the State's Program Integrity Section*.

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 Some Cases Identified by the State's Program Integrity Section*.

(A-07-19-02816)

OIG Recommendations and Department Responses

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

- *report and refund $385,180 ($673,686 Federal share) in unreported Medicaid overpayments that were related to paid claims that have been recovered and collected.*

  Response: The Department concurs and will review the identified unreported amounts, report and return any overpayments that were not already returned, and document any providers where the overpayments were uncollectable. This will be completed by 09/30/2024.

- *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.*

  Response: The Department concurs, and already tracks to make sure that all provider overpayments are now reported and returned promptly within the federal requirements.

- *work with CMS to determine the amount of interest, if any, on the Federal share owed, and report that amount*

  Response: The Department concurs, and once all recoveries are reported and the remaining FFP is returned, the interest owed will be calculated and returned. This will be completed by 12/31/2024.

- *Strengthen and update policies and procedures to ensure that overpayments are reported correctly and in a timely manner.*

  Response: The Department concurs and has already revised its policies and procedures based on information learned during the audit process. This includes updating policies and MMIS coding to ensure that FFP is submitted timely and reported on the CMS-64 correctly.