Colorado Department of Health Care Policy and Financing 1570 Grant St., Denver, CO 80203-1818	**NUMBER:** HCPF 12-011 **CROSS REFERENCE:**
DIVISION OR OFFICE: Audits and Compliance	**DATE:** May 7, 2013
SUBJECT AREA: Client Fraud	
SUBJECT: Quarterly Fraud Investigation and Recoveries Reporting **TYPE:** P- Procedural	**APPROVED BY:**

HCPF Agency Letters can be accessed online at:
www.colorado.gov/hcpf

Purpose:

This Agency Letter provides Eligibility Workers, Managers, Administrators, Investigators, and Recovery Agents with procedures for reporting investigations and recovery of Medicaid dollars from clients due to fraudulent actions of the client.

Senate Bill 12-060 established new reporting requirements in order to provide information to the State legislature regarding Medicaid client fraud investigations, prosecutions, and financial recoveries.

Background:

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

Counties have the responsibility, on behalf of the Department of Health Care Policy and Financing (Department), of determining Medicaid and Child Health Plan *Plus* (CHP+) eligibility and for Medicaid redeterminations. Persons who are found to be ineligible for Medicaid due to fraud or error on the part of the applicant must pay back the State for claim payments made on their behalf. As an incentive to recover those funds, the counties receive a portion of the funds recovered. If the individual committed fraud to gain Medicaid eligibility, the Federal portion of the recovery on the claim payment is returned but the counties receive an incentive payment on that recovery of 100% of the State funds paid on the claims. This is a change from previous incentive payments due to Senate Bill 12-060, which was signed into law on May 9, 2012. The enhanced incentive payments do not apply to CHP+ cases.

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

SB 12-060 also details reporting requirements for Medicaid client fraud investigations to the legislature. This new reporting requirement necessitates information gathering from counties as specified below.

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

Definitions:

The following terms are defined for purposes of this Agency Letter only:

Client: An individual who has been determined eligible for Medicaid; a recipient

Confession of Judgment: A plea of guilty or Nolo Contendere in a court setting

Criminal Complaints Requested: Cases referred to the District Attorney

Fines and Penalties: Amount ordered and kept by a court, if known

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

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

Recoveries: Total demands from clients or judgments against clients

Restitution: Repayment of funds ordered by the Court

Reporting

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

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

The report shall be sent by email to HCPFAudit@hcpf.state.co.us

Effective Date: May 7, 2013

Contact Person:

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Annual Activities Report for Client Fraud Investigations
Medicaid Program

County:	State Fiscal Year

Section 1

A	B	C	D	E	F
County Human/Social Services Medicaid Fraud Activity					
Number of Investigations of Client Fraud During the Year	Number of Termination of Client Medicaid Benefits due to Fraud	**Recoveries** Recoveries by County $	Fines and Peanlties $	Restitution Ordered $	Restitution Collected $

Section 2

A	B	C	D	E
District Attorney Investigations				
Number of Criminal Complaints Requested	Number of Cases Dismissed	Number of Cases Acquitted	Number of Convictions	Number of Confessions of Judgment

Completed by: _____ Date _____

Phone number/email address: _____

Report is due July 31st annually; please email to:

HCPFAudit@hcpf.state.co.us