Ohio Administrative Code

Rule 5160:1-2-04 Medicaid: consumer fraud and erroneous payments.

Effective: August 1, 2016

(A) This rule sets out requirements for the administrative agency to identify and refer consumer fraud and erroneous payments made on behalf of an individual by medicaid.

(B) Investigation of complaints. Upon notification of a complaint of medicaid fraud, abuse or questionable practices, the administrative agency must conduct a preliminary investigation in accordance with 42 C.F.R. 455.14 (as in effect on November 1,2015) to determine if there is sufficient basis to warrant a full investigation.

(1) If the preliminary investigation finds that a full investigation is warranted in accordance with 42 C.F.R. 455.15 (as in effect on November 1, 2015):

(a) And there is reason to believe that a beneficiary has defrauded the medicaid program as described in section 2913.401 of the Revised Code, then the administrative agency must refer the case to the county prosecutor.

(b) And there is reason to believe that a beneficiary has abused the medicaid program, then the agency must conduct a full investigation of the abuse.

(2) The investigation must continue until the investigation is resolved in accordance with 42 C.F.R. 455.16 (as in effect on November 1, 2015).

(C) Recovery of erroneous payments is authorized in section 5162.23 of the Revised Code, subject to rule 5101:9-7-06 of the Administrative Code. The administrative agency must:

(1) Not attempt to recover erroneous payments when:

(a) An individual would have remained eligible under another category of medical assistance even if the individual's circumstances had been reported accurately or a change had been reported promptly;

or

(b) The erroneous payment was a result of an administrative error not caused by the individual; or

(c) An individual has received fair hearing benefits pending a state hearing pursuant to rule 5101:6-4-01 of the Administrative Code, and the individual loses the hearing. The administrative agency may recover the benefits if it requests and obtains authorization from ODM prior to taking any action.

(2) Recover erroneous payments from an individual only:

(a) Through reimbursement. Erroneous payments must not be recovered by reducing benefits or services to the individual.

(b) From the responsible adult or guardian, if the erroneous payment was made on behalf of a child.

(c) To the extent that an actual overpayment resulted. If an individual who reported a change within the ten-day reporting period would have remained eligible for a given month, after allowing a ten-day period for the administrative agency to act on a change and allowing for the adverse action period, there is no overpayment in that month.

(3) Send a notice of medicaid overpayment to the individual.

(D) Amount subject to recovery. If the erroneous payment resulted from:

(1) Fraud, as determined by a county prosecutor, the administrative agency must accept any reimbursement plan ordered by a court or agreed to by the county prosecutor.

(2) Excess resources, the amount subject to recovery is the lesser of:

(a) The amount of the payment made on behalf of the individual; or

(b) The difference between the actual amount of countable resources and the applicable resource standard.

(3) Excess income, the amount subject to recovery is the total amount of payments made on behalf of the individual during the month or months of the erroneous payment period.

(4) For combinations of excess resources and excess income, the amount subject to recovery is the greater of either paragraph (D)(2) or paragraph (D)(3) of this rule.

(5) An incorrect spenddown amount, as calculated according to rule 5160:1-3-04 of the Administrative Code, the amount subject to recovery is the lesser of:

(a) The total amount of payments made on behalf of the individual; or

(b) The difference between the amount of the spenddown liability in effect during the erroneous period and the correct amount of the spenddown liability, added up over the months of the erroneous period.

(6) Receipt of long-term services and supports, waiver services, or intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) services, as a result of:

(a) Improper transfer of resources as outlined in rule 5160:1-3-07.2 of the Administrative Code, the amount subject to recovery is the amount of payments made on behalf of the individual.

(b) Resources in excess of the limit set forth in rule 5160:1-3-05.1 of the Administrative Code:

(i) The amount subject to recovery is the difference between the actual amount of countable resources and the applicable resource standard.

(ii) The individual may choose to increase the patient liability through payment of a lump sum to the nursing facility if the increase will reduce the resources to the appropriate limit. The reduction in resources must be accomplished in one calendar month and in compliance with rule 5160:1-1-58 of the Administrative Code.

(c) Patient liability as outlined in rule 5160:1-3-04.3 and rule 5160:1-3-04.4 of the Administrative

Code, the amount subject to recovery is the difference between the amount of the correct patient liability and the amount of the patient liability that was in effect during the erroneous payment period, added up over the months of the erroneous period.

(E) Individual responsibility. The individual must complete and return the notice of medicaid overpayment within thirty days from the date the form was sent by the administrative agency.