COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 1, 2017

The Honorable Jim Smallwood, Chair
Health and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Smallwood:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on improving Medicaid fraud prosecution to the Senate Health and Human Services Committee.

Section 25.5-1-115.5, C.R.S., requires the Department to submit a written report by November 1 of each year regarding Medicaid fraud prosecution that includes:

a. Investigations of client/member fraud during the year;
b. Termination of client/member Medicaid benefits due to fraud;
c. District attorney action, including, at a minimum, criminal complaints requested, cases dismissed, cases acquitted, convictions, and confessions of judgment;
d. Recoveries, including fines and penalties, restitution ordered, and restitution collected;
e. Trends in methods used to commit client/member fraud, excluding law enforcement-sensitive information; and
f. An estimate of the total savings, total cost, and net cost-effectiveness of fraud detection and recovery efforts.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

SEB

Enclosure(s): 2017 Improving Medicaid Fraud Prosecution Annual Report

Cc: Senator Beth Martinez Humenik, Vice-Chair, Health and Human Services Committee
Senator Irene Aguilar, Health and Human Services Committee
Senator Larry Crowder, Health and Human Services Committee
Senator John Kefalas, Health and Human Services Committee
Legislative Council Library
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John Bartholomew, Finance Office Director, HCPF
Gretchen Hammer, Health Programs Office Director & Community Living Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Dr. Judy Zerzan, Client and Clinical Care Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 1, 2017

The Honorable Bob Gardner, Chair
Senate Judiciary Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Gardner:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on improving Medicaid fraud prosecution to the Senate Judiciary Committee.

Section 25.5-1-115.5, C.R.S., requires the Department to submit a written report by November 1 of each year regarding Medicaid fraud prosecution that includes:

a. Investigations of client/member fraud during the year;
b. Termination of client/member Medicaid benefits due to fraud;
c. District attorney action, including, at a minimum, criminal complaints requested, cases dismissed, cases acquitted, convictions, and confessions of judgment;
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Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

SEB

Enclosure(s): 2017 Improving Medicaid Fraud Prosecution Annual Report

Cc: Senator John Cooke, Vice-Chair, Judiciary Committee
Senator Don Coram, Judiciary Committee
Senator Rhonda Fields, Judiciary Committee
Senator Daniel Kagan, Judiciary Committee
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COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 1, 2017

The Honorable Joann Ginal, Chair
Health, Insurance, and Environment Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Ginal:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on improving Medicaid fraud prosecution to the House Health, Insurance, and Environment Committee.

Section 25.5-1-115.5, C.R.S., requires the Department to submit a written report by November 1 of each year regarding Medicaid fraud prosecution that includes:

a. Investigations of client/member fraud during the year;
b. Termination of client/member Medicaid benefits due to fraud;
c. District attorney action, including, at a minimum, criminal complaints requested, cases dismissed, cases acquitted, convictions, and confessions of judgment;
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f. An estimate of the total savings, total cost, and net cost-effectiveness of fraud detection and recovery efforts.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

SEB

Enclosure(s): 2017 Improving Medicaid Fraud Prosecution Annual Report

Cc: Representative Daneya Esgar, Vice Chair, Health, Insurance and Environment Committee
Representative Susan Beckman, Health, Insurance and Environment Committee
Representative Janet Buckner, Health, Insurance and Environment Committee
Representative Phil Covarrubias, Health, Insurance and Environment Committee
Representative Steve Humphrey, Health, Insurance and Environment Committee
Representative Dominique Jackson, Health, Insurance and Environment Committee
Representative Chris Kennedy, Health, Insurance and Environment Committee
Representative Lois Landgraf, Health, Insurance and Environment Committee
Representative Susan Lontine, Health, Insurance and Environment Committee
Representative Kim Ransom, Health, Insurance and Environment Committee
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COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 1, 2017

The Honorable Jonathan Singer, Chair
Public Health Care and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Singer:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on improving Medicaid fraud prosecution to the House Public Health and Human Services Committee.

Section 25.5-1-115.5, C.R.S., requires the Department to submit a written report by November 1 of each year regarding Medicaid fraud prosecution that includes:

a. Investigations of client/member fraud during the year;
b. Termination of client/member Medicaid benefits due to fraud;
c. District attorney action, including, at a minimum, criminal complaints requested, cases dismissed, cases acquitted, convictions, and confessions of judgment;
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e. Trends in methods used to commit client/member fraud, excluding law enforcement-sensitive information; and
f. An estimate of the total savings, total cost, and net cost-effectiveness of fraud detection and recovery efforts.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

SEB

Enclosure(s): 2017 Improving Medicaid Fraud Prosecution Annual Report

Cc: Representative Jessie Danielson, Vice-Chair, Public Health Care and Human Services Committee
Representative Don Coram, Public Health Care and Human Services Committee
Representative Justin Everett, Public Health Care and Human Services Committee
Representative Joann Ginal, Public Health Care and Human Services Committee
Representative Edie Hooton, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Kimmi Lewis, Public Health Care and Human Services Committee
Representative Larry Liston, Public Health Care and Human Services Committee
Representative Dafna Michaelson Jenet, Public Health Care and Human Services Committee
Representative Dan Pabon, Public Health Care and Human Services Committee
Representative Brittany Pettersen, Public Health Care and Human Services Committee
Representative Kim Ransom, Public Health Care and Human Services Committee
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COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 1, 2017

The Honorable Pete Lee, Chair
Judiciary Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Lee:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on improving Medicaid fraud prosecution to the House Judiciary Committee.

Section 25.5-1-115.5, C.R.S., requires the Department to submit a written report by November 1 of each year regarding Medicaid fraud prosecution that includes:

a. Investigations of client/member fraud during the year;
b. Termination of client/member Medicaid benefits due to fraud;
c. District attorney action, including, at a minimum, criminal complaints requested, cases dismissed, cases acquitted, convictions, and confessions of judgment;
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f. An estimate of the total savings, total cost, and net cost-effectiveness of fraud detection and recovery efforts.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

Susan E. Birch, MBA, BSN, RN

Executive Director

SEB

Enclosure(s): 2017 Improving Medicaid Fraud Prosecution Annual Report

Cc: Representative Joe Salazar, Vice-Chair, Judiciary Committee
Representative Adrienne Benavidez, Judiciary Committee
Representative Terri Carver, Judiciary Committee
Representative Mike Foote, Judiciary Committee
Representative Leslie Herod, Judiciary Committee
Representative Paul Lundeen, Judiciary Committee
Representative Jovan Melton, Judiciary Committee
Representative Mike Weissman, Judiciary Committee
Representative Yeulin Willett, Judiciary Committee
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Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF

Improving Medicaid Fraud Prosecution

As required by Section 25.5-1-115.5, C.R.S.

Due Date November 1, 2017

Submitted to:

House Health, Insurance, and Environment Committee
House Judiciary Committee
House Public Health Care and Human Services Committee
Senate Health and Human Services Committee
Senate Judiciary Committee

COLORADO
Department of Health Care Policy & Financing

Summary

This report is submitted pursuant to the provisions of C.R.S. § 25.5-1-115.5 for the period of July 1, 2016 to June 30, 2017. This section requires the Department of Health Care Policy and Financing (Department) to submit a written report by November 1 of each year regarding Medicaid fraud prosecution. The Department compiles the report from self-reported information from the counties and the Colorado Medicaid Fraud Control Unit (COMFCU) report. This provider and client/member fraud report includes:

- Investigations of provider and client/member fraud during the year;
- Termination of client/member Medicaid benefits due to fraud;
- District attorney actions, including, at a minimum, criminal complaints requested, cases dismissed, cases acquitted, convictions, and confessions of judgment;
- Recoveries, including fines and penalties, restitution ordered, and restitution collected;
- Trends in methods used to commit provider and client/member fraud, excluding law enforcement-sensitive information; and
- An estimate of the total savings, total cost, and net cost-effectiveness of fraud detection and recovery efforts.

Each of the 64 counties have the responsibility, on behalf of the Department, of determining eligibility for medical assistance programs. Persons who are found to be ineligible for Medicaid due to fraud or error on the part of the application must pay back the State for claim payments made on their behalf. Fraud is investigated by each of the counties with the assistance of the Department.

Colorado is required by the Social Security Act to have a Medicaid Fraud Control Unit in order to receive Federal matching dollars for the state Medicaid program. Additionally, each Medicaid Fraud Control Unit is required to have a multi-disciplinary staff that consists of investigators, an auditor, and attorneys. Medicaid Fraud Control Units are jointly funded by the Federal government, receiving financial participation equivalent to 75 percent of its total expenditures, and the State government contributing the remaining 25 percent.

COMFCU has been housed within the Criminal Justice Section of the Colorado Office of the Attorney General since 1987 and has statewide jurisdiction to investigate waste, fraud, and financial abuse within the Colorado Medicaid program. Furthermore, the

COMFCU has jurisdiction to investigate patient abuse, neglect, and exploitation cases that occur in facilities that receive Medicaid dollars, as well as board and care facilities that may not receive Medicaid dollars.

This report is due November 1, 2017 and is based on information requested in the statute. It was compiled by the Department with self-reported information from each of the 64 counties in Colorado and information provided by the Colorado Medicaid Fraud Control Unit ("COMFCU"). The reported numbers for the 2016-2017 fiscal year are available in Appendix A and Appendix B.

Definitions

Total member case count – Total number of Medicaid members

Cases Investigated by County – Total number of Medicaid member fraud cases that were investigated

Criminal Complaints Requested – Total number of criminal complaints concerning Medicaid member fraud that were requested

Criminal Complaints Dismissed - Total number Medicaid member fraud criminal cases that were dismissed without conviction

Criminal Complaints Acquitted - Total number Medicaid member fraud criminal cases in which the member was acquitted

Criminal Complaint Convictions - Total number Medicaid member fraud criminal cases that resulted in criminal conviction

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

Fraud Recoveries – Monetary amount that Medicaid has recovered from Medicaid fraud, whether or not a prosecution occurred

Non-fraud Recoveries - Monetary amount that Medicaid has recovered from reasons other than fraud, such as member error or mistake

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

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

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

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

Overall Totals

Member Fraud – Reported by the counties

- 2,507 investigations of member fraud during the fiscal year
- 430 terminations of services of member Medicaid benefits due to fraud
- Number of District Attorney actions:
    - 65 criminal complaints requested
    - 3 cases dismissed
    - 0 cases acquitted
    - 34 convictions
    - 21 confessions of judgment
- $2,131,586.32 of fraud identified as reported by the counties
- $527,706.09 of non-fraud identified as reported by the counties
- $35,234.26 of fines and penalties recovered and retained by counties
- Amount of Restitution:
    - $762,142.38 ordered
    - $248,970.85 collected
- In addition to monies recovered, we anticipate that terminating cases due to our fraud investigations have saved the Department approximately $2,263,743.00

Provider Fraud – As reported by COMFCU

- 54 criminal investigations
    - 9 criminal complaints
    - 0 cases dismissed
    - 0 cases acquitted
    - 3 criminal convictions
    - During the reporting period, the Unit closed 23 criminal cases and collected $42,283.70
- 133 civil cases
    - During the reporting period the Unit closed 125 civil cases recovered $1,347,955.24 in civil matters and collected $973,299.40 directly
    - $384,064.15 in recoveries
    - No Provider civil actions limited to Colorado fraud were filed. During the 2017 State Fiscal Year, 60 cases were served on Colorado by qui tam relators, in which Colorado was named as a plaintiff in United States federal courts. In addition, the COMFCU closed 40 qui tam cases. These

are cases that likely would not have been pursued in the absence of the False Claims Act

Cost Savings - Members

Calculating the cost of Medicaid member fraud and the benefits of our fraud efforts is no small task, and we reviewed multiple ways to determine a figure. Using the number of terminations from the county, we settled on calculating the average monthly Medicaid amount of all state Medicaid members and multiplying it by 12, so that we can obtain a yearly amount of Medicaid dollars saved. This year, we had 430 terminations stemming from fraud investigations. The average cost per Medicaid member, per month, is $438.71[1], or $5264.52 per year. Therefore, the estimated savings is $2,263,743.00. This is in addition to the recovery amount we have collected.

The formula is laid out below:

Average Medicaid Monthly Cost x 12 (months) = Average Yearly Cost Per Person
$438.71 x 12 = $5,264.52

Average Yearly Cost Per Person x Number of Terminations = Total Cost Avoidance
$5,264.52 x 430= $2,263,743.00

During fiscal year 16-17, the Department did not have any full-time employees (FTEs) dedicated to member fraud, waste, and abuse as this has been predominately the responsibility of the counites. The Department did dedicate resources to decrease member fraud, waste, and abuse and the Department has been managing the workload as additional responsibilities of the staff in the Audit Investigation Recovery (AIR) team. The AIR Team, has worked ensure that there has been no gap in duties while working to assist the counties in their investigative efforts. The Department has been proactively making the effort to assist counties in fighting member fraud as we see the potential cost savings in this area and want to be conscientious stewards of tax payer money.

From the FY 17-18 budget request, the Department received approval of two FTEs who will be dedicated to member fraud, waste, and abuse. The Department anticipates that there will be additional investigation activities in the coming year with the added staff. In future reports, the Department will account for the increased costs associated with the new FTEs. However, the Department believes

[1] Source of data for average monthly cost provided in The Department of Health Care Policy and Financing's Line Item Description and Department Reference Resource and compiled from prior year, 2015-2016 average Medicaid member cost per month.

that the additional FTE will also increase the cost savings. The new FTE positions are Investigators who will be pursuing fraud, waste, and abuse investigations in conjunction with the counties. The proposed positions will have two major focuses: assisting outside investigators and investigating complicated client integrity cases.

These positions will work closely with counties' investigators, Department eligibility and program staff, law enforcement, other state agencies, and other external agencies investigating allegations of client fraud, waste, and abuse. They will provide Medicaid claims payment data to outside investigators or law enforcement, testify on behalf of the Department and represent the Department in external meetings. They will also provide training and technical guidance and support to Colorado's 64 counties with the goals of improving information sharing, implementing best practices, and encouraging consistency in investigations across counties. With the additional FTE positions, the Department plans to develop Best Practices to assist the counties in their fraud efforts.

Cost Savings - Providers

It is difficult to determine the net cost-effectiveness of the fraud detection and recovery efforts of the COMFCU. The COMFCU recovered over $1.3 million from providers that were actively engaged in improper billing of the Medicaid program. It is reasonable to believe that if these providers responsible for improper billings had not been identified, then the fraudulent activity would have continued and the waste to the Medicaid program would have been far higher than the amounts that were recovered. The Legislature's appropriation has been used effectively with the results in monetary value returned to the State and a reduction in fraud to the Medicaid Program.

Trends

In regard to member fraud investigations, most cases are due to unreported income or resources and inaccurate household composition. Some cases involve members leaving the state without reporting the move. Other cases involve residency and forged documents. Even without exact numbers, it is quite clear that there are cost benefits to our fraud investigation efforts. The state has made recovery claims in the amount of $2,131,586.32 and avoided an estimated $2,263,743.00.

In regard to provider fraud, there continues to be fraud within the home health care arena. The specific schemes vary but the general themes involve billing Medicaid when services are not provided or overbilling Medicaid for services. These individual practitioners that bill for services not provided vary significantly and can include, but aren't limited to pharmacists, speech therapists, and dentists.

Until the False Claims Act revised key language in C.R.S. § 25.5-4-305, the COMFCU had essentially been focused solely on pursuing provider fraud and abuse under criminal law. Criminal law is effective in many cases, but not every fraudulent act rises to the level of a criminal charge. In some instances, fraudulent actions by a provider does not fit within the Colorado criminal statutes or permit the State to recover its lost Medicaid expenditures from the business entities and others who are truly responsible for fraud. The Act provided a powerful tool to allow the COMFCU to pursue fraud and overpayments in the civil arena. The COMFCU criminal litigation group often investigates allegations and makes referrals to the civil litigation group.

Appendix A

The information presented below regarding medical assistance member fraud is presented in compliance with the requirement stipulated in Section 25.5-1-115.5, C.R.S. This information is self-reported by each county.

County	Total Members	Investigations	Criminal Complaints	Criminal Cases Dismissed	Criminal Cases Acquitted	Criminal Convictions	Confessions of Judgment	Fraud Recoveries	Non-fraud Recoveries	Fines and Penalties	Restitution Ordered	Restitution Collected	Terminations	Cost Avoidance
Adams	153,096	44	0	0	0	0	0	$0.00	$247,010.53	$0.00	$0.00	$0.00	0	$0.00
Alamosa	7,356	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Arapahoe	146,609	5	2	0	0	0	0	$0.00	$32,438.94	$0.00	$33,443.21	$32.57	2	$10,529.04
Archuleta	3,786	2	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Baca	1,397	3	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	2	$10,529.04
Bent	1,900	4	4	0	0	0	0	$152,391.00	$69,337.00	$0.00	$0.00	$0.00	4	$21,058.08
Boulder	54,904	3	0	0	0	0	0	$35,993.66	$0.00	$0.00	$0.00	$0.00	3	$15,793.56
Broomfield	7,088	14	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Chaffee	4,141	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Cheyenne	495	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Clear Creek	1,713	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Conejos	3,519	3	3	0	0	0	0	$177,030.09	$0.00	$0.00	$7,836.72	$0.00	1	$5,264.52
Costilla	2,036	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Crowley	1,572	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Custer	993	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Delta	10,573	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Denver	215,085	599	0	0	0	0	0	$19,785.13	$0.00	$0.00	$0.00	$0.00	2	$10,529.04
Dolores	633	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Douglas	28,702	51	2	0	0	2	2	$24,468.72	$0.00	$0.00	$248,927.20	$24,468.72	3	$15,793.56
Eagle	7,055	34	7	0	0	7	0	$93,753.00	$4,080.00	$0.00	$164,575.70	$29,999.02	8	$42,116.16
Elbert	3,355	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
El Paso	192,288	3	1	0	0	1	0	$1,748.80	$0.00	$0.00	$868.36	$22,881.08	0	$0.00
Fremont	14,102	1	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Garfield	13,765	81	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Gilpin	1,040	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00

The above data is self-reported by the counties. Some counties state they do not have resources to pursue suspected fraud cases and others state they have difficulty bringing cases to prosecution.

*Source of data for member caseload is officially published via the Department's website www.colorado.gov/hcpf under the Research, Data and Grants Page. The Document is entitled Health First Colorado Member Caseload by County Reports for Stakeholders using the last month of the fiscal year, June 2017.

Appendix A

The information presented below regarding medical assistance member fraud is presented in compliance with the requirement stipulated in Section 25.5-1-115.5, C.R.S. This information is self-reported by each county.

County	Total Members	Investigations	Criminal Complaints	Criminal Cases Dismissed	Criminal Cases Acquitted	Criminal Convictions	Confessions of Judgment	Fraud Recoveries	Non-fraud Recoveries	Fines and Penalties	Restitution Ordered	Restitution Collected	Terminations	Cost Avoidance
Grand	2,100	1	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Gunnison	3,491	3	0	1	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	1	$5,264.52
Hinsdale	179	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Huerfano	3,085	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Jackson	336	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Jefferson	102,268	231	15	1	0	11	11	$444,891.70	$0.00	$7,673.50	$125,235.66	$43,361.66	10	$52,645.20
Kiowa	456	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Kit Carson	2,005	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
La Plata	12,219	2	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Lake	1,693	96	12	0	0	6	0	$108,338.29	$0.00	$0.00	$0.00	$0.00	20	$105,290.40
Larimer	67,968	799	2	1	0	1	0	$538.27	$3,230.39	$0.00	$538.27	$0.00	114	$600,155.28
Las Animas	6,064	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Lincoln	1,456	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Logan	4,959	4	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Mesa	46,479	75	3	0	0	0	3	$44,610.14	$97,318.39	$0.00	$32,145.84	$29,492.49	64	$336,929.28
Mineral	189	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Moffat	3,970	7	1	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	5	$26,322.60
Montezuma	9,976	22	0	0	0	0	0	$0.00	$74,290.84	$0.00	$0.00	$0.00	22	$115,819.44
Montrose	13,220	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Morgan	8,830	9	0	0	0	0	0	$64,697.87	$0.00	$0.00	$0.00	$0.00	6	$31,587.12
Otero	8,279	3	0	0	0	0	0	$50,508.04	$0.00	$0.00	$0.00	$0.00	3	$15,793.56
Ouray	791	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Park	3,401	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Phillips	1,023	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Pitkin	1,602	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Prowers	5,311	2	0	0	0	0	0	$44,707.53	$0.00	$0.00	$0.00	$0.00	2	$10,529.04

The above data is self-reported by the counties. Some counties state they do not have resources to pursue suspected fraud cases and others state they have difficulty bringing cases to prosecution.

*Source of data for member caseload is officially published via the Department's website www.colorado.gov/hcpf under the Research, Data and Grants Page. The Document is entitled Health First Colorado Member Caseload by County Reports for Stakeholders using the last month of the fiscal year, June 2017.

Appendix A

The information presented below regarding medical assistance member fraud is presented in compliance with the requirement stipulated in Section 25.5-1-115.5, C.R.S. This information is self-reported by each county.

County	Total Members	Investigations	Criminal Complaints	Criminal Cases Dismissed	Criminal Cases Acquitted	Criminal Convictions	Confessions of Judgment	Fraud Recoveries	Non-fraud Recoveries	Fines and Penalties	Restitution Ordered	Restitution Collected	Terminations	Cost Avoidance
Pueblo	72,344	10	1	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	3	$15,793.56
Rio Blanco	1,227	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Rio Grande	4,836	1	0	0	0	0	0	$8,000.00	$0.00	$576.00	$0.00	$0.00	2	$10,529.04
Routt	4,071	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Saguache	2,509	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
San Juan	181	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
San Miguel	1,244	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Sedgwick	730	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Summit	3,860	6	1	0	0	1	0	$56,639.24	$0.00	$0.00	$0.00	$0.00	5	$26,322.60
Teller	6,023	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Washington	1,272	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Weld	74,101	389	11	0	0	5	5	$803,484.84	$0.00	$26,984.76	$148,571.42	$98,735.31	148	$779,148.96
Yuma	2,733	0	0	0	0	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00
Totals	**1,363,684**	**2,507**	**65**	**3**	**0**	**34**	**21**	**$2131586.32**	**$527,706.09**	**$35,234.26**	**$762,142.38**	**$248,970.85**	**430**	**$2,263,743.60**

The above data is self-reported by the counties. Some counties state they do not have resources to pursue suspected fraud cases and others state they have difficulty bringing cases to prosecution.

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Appendix B – Provider Fraud

The information presented below regarding medical assistance provider fraud is presented in compliance with the requirement stipulated in Section 25.5-1-115.5, C.R.S. This information is compiled and reported by the Colorado Medicaid Control Fraud Unit.

Investigations of Provider Fraud (7/1/16 to 6/30/17)

Type of Investigation	Number of Closed Investigations	Number of New Investigations
Fraud	143	164
Drug Diversion	0	4
Abuse, Neglect, financial exploitation	5	19
TOTAL	**148**	**187**

Criminal Complaints Requested, Cases Dismissed, Cases Acquitted, Convictions, and Confessions of Judgment

Criminal Complaints	Cases Dismissed	Cases Acquitted	Criminal Convictions	Confessions of Judgment
9	0	0	3	0

Recoveries, Restitution Ordered, and Restitution Collected

Total Recoveries	Recoveries Collected	Restitution Ordered	Restitution Collected
$1,347,955.24	$973,299.40	$2,290.53	$42,283.70