COLORADO
Department of Health Care Policy & Financing

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

November 1, 2018

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 (Department'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;
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, David DeNovellis, at David.DeNovellis@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/JG

Enclosure(s): 2018 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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Laurel Karabatsos, Health Programs Office Director & Interim Medicaid Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bonnie Silva, Community Living Interim Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Stephanie Ziegler, Cost Control Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, 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, 2018

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

Dear Representative Lee:

Enclosed please find the Department of Health Care Policy and Financing's (Department'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:

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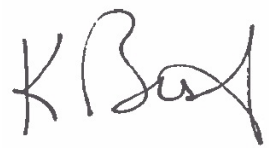
Sincerely,



Kim Bimestefer
Executive Director

KB/JG

Enclosure(s): 2018 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 Leslie Herod, Judiciary Committee
Representative Paul Lundeen, Judiciary Committee
Representative Jovan Melton, Judiciary Committee
Representative Dylan Roberts, Judiciary Committee
Representative Mike Weissman, Judiciary Committee
Representative Yeulin Willett, Judiciary Committee
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David DeNovellis, 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, 2018

The Honorable Jim Smallwood, Chair
Senate 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 (Department'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:

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Sincerely,

Kim Bimestefer
Executive Director

KB/JG

Enclosure(s): 2018 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
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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, 2018

The Honorable Jonathan Singer, Chair
House 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 (Department'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;
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Sincerely,

Kim Bimestefer
Executive Director

KB/JG

Enclosure(s): 2018 Improving Medicaid Fraud Prosecution Annual Report

Cc: Representative Jessie Danielson, Vice-Chair, Public Health Care and Human Services Committee
Representative Susan Beckman, Public Health Care and Human Services Committee
Representative Marc Catlin, 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 Susan Lontine, Public Health Care and Human Services Committee
Representative Dafna Michaelson Jenet, 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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David DeNovellis, 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, 2018

The Honorable Joann Ginal, Chair
House 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 (Department'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;
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Sincerely,

Kim Bimestefer
Executive Director

KB/JG

Enclosure(s): 2018 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 Edie Hooton, 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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Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, Legislative Liaison, HCPF

Improving Medicaid Fraud Prosecution

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

Due Date November 1, 2018

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, 2017 to June 30, 2018. 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, for 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 applicant must pay back the State for claim payments made on their behalf. No recovery shall be made where the overpayment occurred through no fault of the client/member (Colorado Revised Statute 25.5-4-301(2)(a)(II). Fraud is investigated by each of the counties with the assistance of the Department.

Title 42 USC 1396a(a)(61) of the Social Security Act requires that Colorado operates a Medicaid Fraud Control Unit in order to receive Federal matching dollars for the state Medicaid program. Additionally, the Medicaid Fraud Control Unit is required to conduct a statewide program for the investigation and prosecution of both Medicaid fraud and the abuse or neglect of patients. 42 USC 1396b(q). Medicaid Fraud Control Units are jointly funded by the Federal government, which contributes 75 percent of its total expenditure and the State government, which contributes the remaining 25 percent.

The Colorado Medicaid Fraud Control Unit, housed within the Criminal Justice Section of the Colorado Office of the Attorney General, 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 in board and care facilities that may not receive Medicaid dollars.

As a result, on the 19th of June 2018, the Office of the Inspector General for the Department of Health and Human Services determined that the COMFCU met the Federal requirements for operation of a State Medicaid Fraud Control Unit and was recertified the unit for the upcoming Federal fiscal year.

This report was compiled by the Department with self-reported information from each of the 64 counties in Colorado and information provided by the COMFCU. The reported numbers for the 2017-2018 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 – Recovery amount that Medicaid has established as an overpayment due Medicaid fraud, whether or not a prosecution occurred

Non-fraud Recoveries - Recovery amount that Medicaid has established as an overpayment due to 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 – As reported by the counties

- 4,564 investigations of member fraud during the fiscal year. This is an increase of 82% up from 2,507 last fiscal year
- 1,948 terminations of services of member Medicaid benefits due to fraud. This is an increase of 353% up from 430 last fiscal year
- Number of District Attorney actions:
    - 58 criminal complaints requested
    - 3 cases dismissed
    - 0 cases acquitted
    - 39 convictions
    - 13 confessions of judgment
- $1,983,869.20 of fraud identified as reported by the counties
- $108,983.22 of non-fraud identified as reported by the counties
- $95,294.38 of fines and penalties recovered and retained by counties which is up from $35,234.26 from last fiscal year
- Amount of Restitution:
    - $699,553.97 ordered
    - $189,353.02 collected
- In addition to monies recovered, we anticipate that terminating cases due to our fraud investigations resulted in a cost avoidance of approximately $11,695,733.56. This is a substantial increase from the $2,263.743.00 from last fiscal year

Provider Fraud – As reported by COMFCU

- 60 new criminal investigations which is an increase up from 54 last fiscal year
- Filed 12 criminal cases (with one joint prosecution filed by the U.S. Attorney's Office)
- 12 criminal convictions which is an increase up from 3 last fiscal year
- 1 dismissal
- 33 criminal cases closed which is an increase from 23 last fiscal year
    - $123,341.07 in criminal restitution ordered
    - $20,982.11 collected
- 84 new civil cases
- 57 closed civil cases
    - $7,161,879.11 in restitution ordered
    - $6,642,818.73 collected which is an increase from $1,347,955.24 collected in the last fiscal year
    - $2,184,497.99 of penalties assessed against providers over and above the amounts that were fraudulently billed to Colorado Medicaid

- 45 cases were served on Colorado by qui tam relators, in which Colorado was named as a plaintiff in United States federal courts. These cases likely would not have been pursued in the absence of the False Claims Act.

Cost Savings - Members

Calculating the cost avoidance 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 yearly Medicaid amount of all state Medicaid members so that we can obtain a yearly amount of Medicaid dollars saved. This year, we had 1948 terminations stemming from fraud investigations. The average cost per Medicaid member, per month, is $500.33, or $6,003.97[1] per year. Therefore, the estimated savings is $11,695,733.56. This is in addition to the recovery amount we have collected.

The formula is laid out below:

Average Yearly Cost Per Person x Number of Terminations = Total Cost Avoidance
$6,003.97 x 1948 = $11,695,733.56

During fiscal year 17-18, the Department had two Full time Equivalents (FTE) who were dedicated to member fraud, waste, and abuse, allowing for additional investigation activities at the state level. The positions have two major focuses: assisting county investigators and investigating complicated member integrity cases. The Department investigators also worked to develop training and provide resources to the counties. With the FTE positions, the Department's cost avoidance figure increased to over $11 million dollars as the Department issued guidance and provided investigation assistance for terminations due to fraud, waste, and abuse. These positions worked directly on member fraud cases as well as providing information to the Department of Revenue on possible income tax violations and assisted other States in guidance with their member fraud programs.

During this time period, these position along with the Program Integrity Manager made contact with every member fraud county representative in the State. This county outreach also involved surveying more than 500 county staff involved in member fraud to determine what assistance they need in investigating member fraud and how the Department can best partner with the counties. Responses were received from all counties along with response from Denver Health, Connect for Health Colorado, Pueblo

[1] Source of data for average monthly cost provided in The Department of Health Care Policy and Financing's Title XIX and Title XXI Services Per Capita History by Eligibility Category - Delay Adjusted from the 2017-2018 yearly average Medicaid member cost per month, excluding financing and supplemental payments.

StepUp MA, Denver Indian Health and Family Services, and the Colorado Mental Health Institute at Fort. Logan.

Additionally, these positions presented at a national conference on member fraud and worked to create a nationwide training program with the Medicaid Integrity Institute at the Department of Justice. The Department also chairs the National Beneficiary Technical Assistance Subgroup. This group shares national best practices and is currently working on establishing a national benchmark for member fraud.

For the upcoming 2018-2019 fiscal year, the Department's Program Integrity Section reorganized to include member and provider fraud into one section and developed the Member Integrity Unit. The Department will continue to implement training programs for the counties and provide technical guidance while working to ensure best practices are followed and investigations are consistent across the state. The Department has been proactively making the effort to assist counties in fighting member fraud as we see the potential cost avoidance in this area and strive to be conscientious stewards of tax payer money.

Cost Savings - Providers

By any analysis, the COMFCU is incredibly cost-effective. During this review period, the State of Colorado expended only $614,756 for the operations of the COMFCU, and the unit was able to recover $7.2 million from providers that were actively engaged in the improper billing of the Medicaid program. Additionally, it is reasonable to believe that if these providers responsible for improper billings were not identified, then the fraudulent activity would have continued and the losses 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, the majority of cases are due to inaccurate reporting of household composition and failure to report income. Other cases involve members leaving Colorado without reporting their change in address. These cases stem from both fraudulent applications and confusion by members as to what changes they must report and when they must report it. This is why focusing on training is a top priority for the Department in combatting member fraud, waste, and abuse. It is clear that there are cost benefits to our fraud investigation efforts. The state has established recovery claims in the amount of $1,983,869.20 for fraud, $108,983.22 for non-fraud, and avoided an estimated $11,695,733.56 by terminating ineligible members.

In regard to provider fraud, there continues to be fraud involving the provision of services in the home. The specific schemes vary, but generally involve billing Medicaid

when services were not provided or overbilling Medicaid for services that were actually provided. During the past year, these schemes were observed in Speech Therapy providers and providers of in-home nursing care. The COMFCU also observed several instances of bill inflation during this review period. These cases are varied and included instances of providers billing for the maximum amount of services that a patient is entitled to, rather than the amount of services that were actually provided, as well as, providers indicating that the patient received more services that they actually did. Some examples of this latter category include dentists that work on one tooth but bill as though a significant amount of dental work were performed throughout the patient's mouth, or the Medicaid client that briefly sees a nurse to receive an immunization while Medicaid is billed as though the patient had a lengthy and complex office visit with a physician.

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
Adams	141,030	2,052	0	0	0	0	0	$171,343.00	0	0	0	0	1,352
Alamosa	7,239	1	0	0	0	0	0	$4,075.75	0	0	0	0	1
Arapahoe	137,959	94	3	0	0	0	1	$55,808.48	0	0	0	0	9
Archuleta	3,459	8	0	0	0	0	0	0	0	0	0	0	0
Baca	1,402	4	0	0	0	0	0	0	0	0	0	0	1
Bent	1,848	2	2	0	0	2	0	$45,536.65	0	0	0	0	2
Boulder	51,115	1	0	0	0	0	0	$1,597.40	$10,387.41	0	0	0	1
Broomfield	7,136	0	0	0	0	0	0	0	0	0	0	0	0
Chaffee	4,005	0	0	0	0	0	0	0	0	0	0	0	0
Cheyenne	511	0	0	0	0	0	0	0	0	0	0	0	0
Clear Creek	1,485	0	0	0	0	0	0	0	0	0	0	0	0
Conejos	3,378	3	0	0	0	0	0	$141,300.98	$506.00	0	0	$4,592.34	0
Costilla	2,047	0	0	0	0	0	0	0	0	0	0	0	0
Crowley	1,572	1	0	0	0	0	0	0	0	0	0	0	1
Custer	961	0	0	0	0	0	0	0	0	0	0	0	0
Delta	10,323	0	0	0	0	0	0	0	0	0	0	0	0
Denver	203,658	708	0	0	0	0	0	$217,467.69	0	0	0	0	12
Dolores	636	0	0	0	0	0	0	0	0	0	0	0	0
Douglas	27,259	76	17	1	0	1	0	$222,927.00	$17,573.00	0	$29,256.90	$7,538.00	35
Eagle	6,406	11	4	0	0	4	0	$103,632.24	$4,345.28	0	$98,960.75	$64,583.02	5
Elbert	3,174	3	3	0		1	1	$268,054.95	0	$388.50	$1,565.78	0	1
El Paso	186,536	0	0	0	0	0	0	0	0	0	0	0	0
Fremont	14,179	0	0	0	0	0	0	0	0	0	0	0	0
Garfield	12,757	127	4	0	0	0	0	$124,889.78	0	$9,346.10	$40,763.75	$35,311.85	34
Gilpin	978	0	0	0	0	0	0	0	0	0	0	0	0

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 For Our Stakeholders › Research, Data and Grants › Budget › Premiums, Expenditures and Caseload Reports. The Document is entitled Health First Colorado Member Caseload by County Reports for Stakeholders using the Medicaid Member Caseload by County, June 2018

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.

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Grand	1,969	0	0	0	0	0	0	0	0	0	0	0	0
Gunnison	3,223	0	0	0	0	0	0	0	$204.00	0	0	0	0
Hinsdale	158	0	0	0	0	0	0	0	0	0	0	0	0
Huerfano	2,993	4	0	0	0	0	0	$31,415.78	0	0	0	0	3
Jackson	298	0	0	0	0	0	0	0	0	0	0	0	0
Jefferson	93,922	58	9	1	0	11	11	$205,132.48	0	$11,797.00	$78,303.43	$39,092.53	7
Kiowa	414	0	0	0	0	0	0	0	0	0	0	0	0
Kit Carson	2,051	0	0	0	0	0	0	0	0	0	0	0	0
La Plata	11,981	0	0	0	0	0	0	0	0	0	0	0	0
Lake	1,605	87	2	0	0	0	0	0	$1,160.00	$73,762.78	0	0	12
Larimer	63,727	1,066	7	1	0	6	0	$225.00	$1305.65	0	0	0	340
Las Animas	6,074	1	0	0	0	0	0	0	0	0	0	0	0
Lincoln	1,436	0	0	0	0	0	0	0	0	0	0	0	0
Logan	4,968	30	1	0	0	0	0	0	$50,139.70	0	0	0	30
Mesa	44,564	23	0	0	0	0	0	$20,043.77	$21,535.18	0	$41,578.95	$100.00	5
Mineral	150	0	0	0	0	0	0	0	0	0	0	0	0
Moffat	3,688	7	4	0	0	0	0	$31,768.20	$1,827.00	0	0	0	3
Montezuma	9,865	0	0	0	0	0	0	$47,099.28	0	0	0	0	26
Montrose	12,537	0	0	0	0	0	0	0	0	0	0	0	0
Morgan	8,624	13	0	0	0	0	0	$209,168.02	0	0	0	0	7
Otero	7,980	5	0	0	0	0	0	0	0	0	0	0	0
Ouray	730	0	0	0	0	0	0	0	0	0	0	0	0
Park	3,261	0	0	0	0	0	0	0	0	0	0	0	0
Phillips	1,019	0	0	0	0	0	0	0	0	0	0	0	0
Pitkin	1,571	0	0	0	0	0	0	0	0	0	0	0	0
Prowers	5,081	0	0	0	0	0	0	0	0	0	0	0	0

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 For Our Stakeholders › Research, Data and Grants › Budget › Premiums, Expenditures and Caseload Reports. The Document is entitled Health First Colorado Member Caseload by County Reports for Stakeholders using the Medicaid Member Caseload by County, June 2018

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
Pueblo	70,273	6	1	0	0	0	0	0	0	0	0	0	2
Rio Blanco	1,306	0	0	0	0	0	0	0	0	0	0	0	0
Rio Grande	4,516	2	0	0	0	0	0	$452.83	0	0	0	0	2
Routt	3,538	0	0	0	0	0	0	0	0	0	0	0	0
Saguache	2,472	1	0	0	0	0	0	0	0	0	0	0	0
San Juan	195	0	0	0	0	0	0	0	0	0	0	0	0
San Miguel	1,179	5	0	0	0	0	0	0	0	0	0	0	2
Sedgwick	730	0	0	0	0	0	0	0	0	0	0	0	0
Summit	3,554	11	1	0	0	0	0	0	0	0	0	0	17
Teller	5,777	0	0	0	0	0	0	0	0	0	0	0	0
Washington	1,193	0	0	0	0	0	0	0	0	0	0	0	0
Weld	68,502	154	0	0	0	14	0	$81,929.92	0	0	$409,124.41	$38,135.28	38
Yuma	2,614	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**1,290,791**	**4,564**	**58**	**3**	**0**	**39**	**13**	**$1,983,869.20**	**$108,983.22**	**$95,294.38**	**$699,553.97**	**$189,353.02**	**1,948**

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 For Our Stakeholders › Research, Data and Grants › Budget › Premiums, Expenditures and Caseload Reports. The Document is entitled Health First Colorado Member Caseload by County Reports for Stakeholders using the Medicaid Member Caseload by County, June 2018

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 (7/1/17 to 6/30/18)

Type of Investigation	Number of Closed Investigations	Number of New Investigations
Fraud	82	112
Drug Diversion	0	9
Abuse, Neglect, financial exploitation	8	23
TOTAL	**90**	**144**

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

Criminal Complaints	Cases Dismissed	Cases Acquitted	Criminal Convictions	Confessions of Judgment
13	1	0	12	0

Recoveries, Restitution Ordered, and Restitution Collected

Total Recoveries	Total Recoveries Collected	Criminal Restitution Ordered	Criminal Restitution Collected
$7,285,220.18	$6,663,800.84	$123,341.07	$20,982.11