COLORADO
Department of Health Care Policy & Financing

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

November 1, 2019

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

Dear Senator Lee:

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;*
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, Nina Schwartz, at Nina.Schwartz@state.co.us or 303.866.6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/MK

Enclosure(s): 2019 Improving Medicaid Fraud Prosecution Annual Report

Cc: Senator Julie Gonzalez, Vice Chair, Judiciary Committee
Senator John Cooke, Judiciary Committee
Senator Bob Gardner, Judiciary Committee
Senator Robert Rodriguez, Judiciary Committee
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Tracy Johnson, Medicaid Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bonnie Silva, Community Living Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Stephanie Ziegler, Cost Control and Quality Improvement Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Nina Schwartz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

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

November 1, 2019

The Honorable Mike Weissman, Chair
House Judiciary Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Weissman:

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:

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Sincerely,

Kim Bimestefer
Executive Director

KB/MK

Enclosure(s): 2019 Improving Medicaid Fraud Prosecution Annual Report

Cc: Representative Leslie Herod, Vice Chair, Judiciary Committee
Representative Adrienne Benavidez, Judiciary Committee
Representative Rod Bockenfeld, Judiciary Committee
Representative Terri Carver, Judiciary Committee
Representative Serena Gonzales-Gutierrez, Judiciary Committee
Representative Hugh McKean, Judiciary Committee
Representative Dylan Roberts, Judiciary Committee
Representative Matt Soper, Judiciary Committee
Representative Kerry Tipper, Judiciary Committee
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COLORADO
Department of Health Care Policy & Financing

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

November 1, 2019

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 legislative report on improving Medicaid fraud prosecution to the House Public Health Care 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/MK

Enclosure(s): 2019 Improving Medicaid Fraud Prosecution Annual Report

Cc: Representative Dafna Michaelson Jenet, Vice Chair, Public Health Care and Human Services Committee
Representative Yadira Caraveo, Public Health Care and Human Services Committee
Representative Lisa Cutter, Public Health Care and Human Services Committee
Representative Serena Gonzales-Gutierrez, Public Health Care and Human Services Committee
Representative Cathy Kipp, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Colin Larson, Public Health Care and Human Services Committee
Representative Larry Liston, Public Health Care and Human Services Committee
Representative Kyle Mullica, Public Health Care and Human Services Committee
Representative Rod Pelton, Public Health Care and Human Services Committee
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COLORADO
Department of Health Care Policy & Financing

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

November 1, 2019

The Honorable Susan Lontine, Chair
House Health and Insurance Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Lontine:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on improving Medicaid fraud prosecution to the House Health and Insurance 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/MK

Enclosure(s): 2019 Improving Medicaid Fraud Prosecution Annual Report

Cc: Representative Yadira Caraveo, Vice Chair, Health and Insurance Committee
Representative Mark Baisley, Health and Insurance Committee
Representative Susan Beckman, Health and Insurance Committee
Representative Janet Buckner, Health and Insurance Committee
Representative Dominique Jackson, Health and Insurance Committee
Representative Sonya Jaquez Lewis, Health and Insurance Committee
Representative Kyle Mullica, Health and Insurance Committee
Representative Matt Soper, Health and Insurance Committee
Representative Brianna Titone, Health and Insurance Committee
Representative Perry Will, Health and Insurance Committee
Representative Mary Young, Health and Insurance Committee
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Nina Schwartz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

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

November 1, 2019

The Honorable Rhonda Fields, Chair
Senate Health and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Fields:

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;*
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If you require further information or have additional questions, please contact the Department's Legislative Liaison, Nina Schwartz, at Nina.Schwartz@state.co.us or 303.866.6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/MK

Enclosure(s): 2019 Improving Medicaid Fraud Prosecution Annual Report

Cc: Senator Brittany Pettersen, Vice Chair, Health and Human Services Committee
Senator Larry Crowder, Health and Human Services Committee
Senator Jim Smallwood, Health and Human Services Committee
Senator Faith Winter, Health and Human Services Committee
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Rachel Reiter, External Relations Division Director, HCPF
Nina Schwartz, Legislative Liaison, HCPF

Improving Medicaid Fraud Prosecution

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

Due Date November 1, 2019

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, 2018 to June 30, 2019. 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 each of Colorado's 64 counties and the Colorado Medicaid Fraud Control Unit (COMFCU) report. The reported numbers for the 2018-2019 fiscal year are available in Appendix A and Appendix B.

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 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 and the Department provides fraud-related education to all counties. The Department also provides specific guidance upon request from individual counties.

The Social Security Act requires states to operate a Medicaid Fraud Control Unit in order to receive Federal funds for their Medicaid programs. 42 USC 1396a(a)(61). Operating within the Department of Law and under the control of the Attorney General, the COMFCU is tasked with the investigation and prosecution of fraud, misuse, waste, and abuse committed by Medicaid providers, and the investigation and prosecution of cases of patient abuse, neglect, and exploitation. C.R.S. § 24-31-802.

On the 20th of June 2019, the Office of the Inspector General for the Department of Health and Human Services determined that the COMFCU was in compliance with the Federal statutory and regulatory requirements for State Medicaid Fraud Control Units and was recertified for the next federal fiscal year.

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 of Medicaid member fraud criminal cases that were dismissed without conviction

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

Criminal Complaint Convictions - Total number of 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 to 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 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

- **2,554** investigations of member fraud during the fiscal year. This is a decrease of 44% down from 4,564 last fiscal year.
- **504** terminations of services of member Medicaid benefits due to fraud. This is a decrease of 74% down from 1,948 last fiscal year.
- Number of District Attorney actions:
    - **66** criminal complaints requested
    - **5** cases dismissed
    - **0** cases acquitted
    - **42** convictions
    - **38** confessions of judgment
- **$2,442,344** of fraud identified as reported by the counties. This is an increase of 23%, up from $1,983,869 last fiscal year.
- **$372,348** of non-fraud identified as reported by the counties. This is an increase of 242% up from $108,983 last fiscal year.
- **$53,237** of fines and penalties recovered and retained by counties. This is a decrease of 44% down from $95,294 last fiscal year.
- Amount of Restitution:
    - **$871,549** ordered. This is an increase of 25% up from $699,554 last fiscal year.
    - **$392,928** collected. This is an increase of 108% up from $189,353 last fiscal year.

Analysis of Investigations and Estimated Member Fraud Cost Avoidance -

The fraud and non-fraud dollars identified and reported by the counties this fiscal year increased by a combined 265%. This substantial increase occurred despite fewer county investigations and fewer terminations, pointing towards increased county efficiency and the prioritization of high dollar cases over volume terminations. In addition to the increased fraud and non-fraud monies recovered, we anticipate that terminating cases due to fraud investigations resulted in a cost avoidance of approximately **$3,217,536**. This is a decrease from the $11,695,734 from last fiscal year and a direct reflection of the decreased number of investigations and terminations mentioned above.

As explained further in the Member Fraud Cost Savings Section of this report, we believe this decrease in cost savings, reflecting the decreased number of investigations and terminations, is due in part to improved upfront eligibility determinations and procedure. Our data suggests that the jump in cost avoidance for last fiscal year, compared with the **$3,217,536** from this fiscal year, is also explained by the Department establishing a member integrity team for the first time in 2017, which helped enable counties to better terminate ineligible members. Lastly, the estimated cost avoidance for fiscal year 2017 was $2,263,743, which further suggests that the initial focus on member integrity investigations in fiscal year 2017 may have helped counties to terminate a large backlog of ineligible members, which has now dropped off.

Provider Fraud – As reported by the COMFCU

During the 2019 State Fiscal Year, the COMFCU opened **72** new criminal investigations and **106** new civil cases. In district courts across Colorado, the COMFCU filed **three (3)** civil actions and **seven (7)** criminal complaints, with **one (1)** criminal filing on an abuse and neglect matter in an assisted living facility.

In the same period, the COMFCU obtained a total of **eight (8)** criminal convictions, **one (1)** of which was the result of a joint prosecution with the US Attorney's Office. Of the criminal convictions, **six (6)** involved Medicaid providers that were fraudulently billing the Colorado Medicaid program and **two (2)** involved the negligent homicide of a patient in a facility that received Medicaid dollars. During the review period, the COMFCU closed **15** criminal investigations and the Courts ordered a total of **$1,370,665** in criminal restitution be paid to the Department of Health Care Policy and Financing, along with **$200** in felony fines to be paid to the State of Colorado.

During the 2019 State Fiscal Year, the COMFCU opened **33** civil investigations limited to activity that only occurred in Colorado. In that time period a total of **$21,564,976 was recovered** in civil matters, and **$3,437,051 was collected**. While no litigation costs were recovered during the review period, it should be noted that **$13,553,558** of the recoveries consisted entirely of penalties and interest assessed over and above the amounts that were fraudulently billed to the Colorado Medicaid program.

During the review period, the COMFCU filed **three (3)** civil actions relating to provider fraud, while **73** cases in which Colorado was named as a plaintiff in United States Federal Courts, were served by *qui tam* relators. These cases likely would not have been pursued in the absence of the False Claims Act. This fiscal year, the COMFCU obtained a civil judgment against a pharmacy and its principal who fled the jurisdiction after the COMFCU filed criminal charges against him. The judgment amounting to over **$14 million** is the largest recovery in the COMFCU's history.

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 counties, 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 **504** terminations stemming from fraud investigations. The average cost per Medicaid member, per month, is **$532**, or **$6,384**[1] per year. Therefore, the estimated savings is **$3,217,536**. This is in addition to the recovery amount we have collected.
The formula is laid out below:

[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 2018-2019 yearly average Medicaid member cost per month, excluding financing and supplemental payments.

Average Yearly Cost Per Person x Number of Terminations = Total Cost Avoidance
$6,384 x 504 = $3,217,536

During fiscal year 18-19, the Department had two Full time Equivalents (FTE) who were dedicated to member fraud, waste, and abuse, allowing for additional investigation resources at the state level. The positions assist county investigators, work to develop training, and provide resources to the counties. With the FTE positions, the Department's cost avoidance figure was over **$3 million dollars** as the Department issued guidance and provided investigation assistance for terminations due to fraud, waste, and abuse. These positions also worked directly on member fraud cases, provided 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 positions, along with the Program Integrity Manager, continued to work closely with county representatives throughout the State. These positions presented at the 2019 Colorado Welfare Fraud Council/Social Services Technical And Business Staffs Training Conference and continued to participate in the National Beneficiary Technical Assistance Subgroup, chaired by the Department. This subgroup shares national best practices and collaborates with other states and CMS representatives to answer questions and address issues involving beneficiary fraud. These positions also conducted a nationwide survey of state investigators and beneficiary fraud workers to further explore a national benchmark for member fraud.

The Department's Audits and Compliance Division has been successfully reorganized to include member and provider fraud in one section, the Program Integrity and Contract Oversight Section (PICO). Within the PICO Section is 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 taxpayer money.

Furthermore, the Department has increased its efforts to prevent fraud, waste, and abuse upfront. The Department has worked to streamline the Public Assistance Reporting Information System (PARIS) in order to remove individuals receiving medical assistance in multiple states and has also collaborated with staff on the front end (eligibility) to bring heightened awareness to the areas of fraud, waste, and abuse, in order to proactively address potential member fraud. The Department continues to work to bring awareness to preventative actions in an effort to limit the number of ineligible individuals obtaining medical assistance in the first place.

Cost Savings – Providers

During this review period, the State of Colorado tasked a law enforcement team of 17 staff members with protecting the funds and beneficiaries of Colorado's $10 billion Medicaid program. By any analysis, the COMFCU is one of the most efficient and effective recipients of Colorado funds. Receiving **$540,932** in state funding for its operations, the COMFCU was able to recover **$22.9 million** from providers that were actively engaged in fraudulently

billing the Medicaid program. Additionally, if the providers responsible for such billings had not been identified, 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 size, complexity, geographic diversity, and number of cases investigated by the COMFCU has continued to increase, while the COMFCU's size has remained unchanged since 2011, leaving the COMFCU ill equipped to address these changes. During this review period, the COMFCU opened 111 more cases than it closed. This is an increase from the 2017–2018 review period when the COMFCU opened 54 more cases than it closed. This year, due in large part to support from and sacrifices made by the Department of Health Care Policy and Financing, the legislature awarded the COMFCU three additional FTEs along with the funding to fill those positions. It is hoped that the addition of these individuals will move the COMFCU to a position where the disparity between the number of cases opened and the number of cases closed diminishes, while also increasing the funds returned to Colorado taxpayers.

Trends

In regard to member fraud, waste, and abuse 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 remains a top priority for the Department in combatting member fraud, waste, and abuse. It is clear there are cost benefits to our fraud investigation efforts. The state has established significantly increased recovery claims from the last fiscal year, with totals of **$2,442,344** for fraud and **$372,348** for non-fraud, and the state has also still avoided an estimated additional **$3,217,536** by terminating ineligible members. The decrease in the estimated avoidance cost may stem from the Department's increased efforts to prevent fraud, waste, and abuse before it occurs.

The COMFCU reports that with provider fraud, there continues to be a significant amount of fraud involving the provision of services within the home. The specific schemes vary, but generally involve billing Medicaid when services were not provided or overbilling for services that were provided. Once again this year, several of these schemes were discovered involving speech therapy providers and providers of in-home nursing care. In the speech therapy category, the COMFCU's investigations revealed that providers were billing Medicaid for two to three times the level of services that they actually provided. Investigations also uncovered in-home care providers that billed for impossible days, that billed for providing care to patients several months after the patient's death, and that billed for services provided to groups of individuals as though one-on-one services were provided.

Additionally, there has been an uptick in flagrant fraudulent billing by larger public and private entities which are exhibiting a business philosophy of billing for what they can and then fighting to hold on to those funds.

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	135,820	646	0	0	0	0	0	0	$72,143.00	0	0	0	245
Alamosa	6,954	1	1	0	0	0	0	0	0	0	0	0	1
Arapahoe	132,569	71	2	1	0	1	0	$138,672.00	0	0	0	$2,040.00	0
Archuleta	3,430	8	0	0	0	0	0	0	0	0	0	0	0
Baca	1,339	0	0	0	0	0	0	0	0	0	0	0	0
Bent	1,798	0	3	2	0	0	1	0	0	0	0	0	0
Boulder	49,182	22	0	0	0	0	0	0	$13,857.43	0	$451.00	0	0
Broomfield	6,944	20	0	0	0	0	0	0	0	0	0	0	1
Chaffee	3,705	0	0	0	0	0	0	0	0	0	0	0	0
Cheyenne	495	0	0	0	0	0	0	0	0	0	0	0	0
Clear Creek	1,404	0	0	0	0	0	0	0	0	0	0	0	0
Conejos	3,321	1	0	0	0	0	0	$62,567.21	$506.00	0	0	0	0
Costilla	2,015	0	0	0	0	0	0	0	0	0	0	0	0
Crowley	1,539	0	0	0	0	0	0	0	0	0	0	0	0
Custer	891	0	0	0	0	0	0	0	0	0	0	0	0
Delta	9,729	2	0	0	0	0	0	0	0	0	0	0	0
Denver	193,540	751	7	1	0	0	0	$241,693.80	$74,470.92	0	0	0	12
Dolores	614	0	0	0	0	0	0	0	0	0	0	0	0
Douglas	26,814	127	12	0	0	11	11	$84,414.80	0	0	$129,210.00	$28,202.00	96
Eagle	5,947	11	5	0	0	3	0	$47,801.14	$3,380.98	0	$82,258.12	$47,801.14	3
Elbert	2,994	0	0	0	0	0	0	0	0	0	0	0	0
El Paso	171,991	9	4	0	0	4	4	$417,435.51	0	$24,874.61	$1,565.78	$1,565.78	9
Fremont	13,637	0	0	0	0	0	0	0	0	0	0	0	0
Garfield	12,195	59	0	0	0	0	0	$64,719.26	$14,764.22	0	0	0	8
Gilpin	1,017	1	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 2019

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Grand	1,732	0	0	0	0	0	0	0	0	0	0	0	0
Gunnison	3,028	0	0	0	0	0	0	0	0	0	0	0	0
Hinsdale	170	0	0	0	0	0	0	0	0	0	0	0	0
Huerfano	2,939	6	0	0	0	0	0	0	0	0	0	0	0
Jackson	265	0	0	0	0	0	0	0	0	0	0	0	0
Jefferson	90,298	280	13	0	0	17	17	$1,095,771.92	0	$19,983.00	$476,672.38	$144,721.25	9
Kiowa	436	0	0	0	0	0	0	0	0	0	0	0	0
Kit Carson	2,080	0	0	0	0	0	0	0	0	0	0	0	0
La Plata	11,743	1	0	0	0	0	0	0	0	0	0	0	0
Lake	1,459	34	0	0	0	0	0	0	$1,061.32	$8,378.99	0	0	8
Larimer	61,208	283	10	0	0	3	3	$79,132.00	0	0	0	0	7
Las Animas	6,054	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln	1,377	0	0	0	0	0	0	0	0	0	0	0	0
Logan	4,921	21	2	0	0	0	0	$28,160.60	0	0	0	0	9
Mesa	41,789	54	2	0	0	0	0	$27,074.27	$31,801.44	0	0	0	38
Mineral	158	0	0	0	0	0	0	0	0	0	0	0	0
Moffat	3,572	12	0	0	0	0	0	0	0	0	0	0	0
Montezuma	9,181	24	0	0	0	0	0	$44,041.10	$26,288.32	0	0	0	24
Montrose	11,748	2	0	0	0	0	0	0	0	0	0	0	0
Morgan	8,388	8	0	0	0	0	0	$84,362.82	$50,506.98	0	0	0	1
Otero	7,855	8	0	0	0	0	0	0	0	0	0	0	0
Ouray	649	0	0	0	0	0	0	0	0	0	0	0	0
Park	3,105	4	0	0	0	0	0	0	0	0	0	0	2
Phillips	1,031	0	0	0	0	0	0	0	0	0	0	0	0
Pitkin	1,404	0	0	0	0	0	0	0	0	0	0	0	0
Prowers	4,816	3	0	0	0	0	0	0	0	0	0	0	3

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 2019

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	66,252	14	2	0	0	0	0	$606.23	$810.00	0	0	$606.23	5
Rio Blanco	1,302	0	0	0	0	0	0	0	0	0	0	0	0
Rio Grande	4,322	1	0	0	0	0	0	0	$1,852.85	0	0	0	1
Routt	3,080	0	0	0	0	0	0	0	0	0	0	0	0
Saguache	2,291	0	0	0	0	0	0	0	0	0	0	0	0
San Juan	173	0	0	0	0	0	0	0	0	0	0	0	0
San Miguel	1,002	2	0	0	0	0	0	$3,084.00	0	0	0	0	1
Sedgwick	725	0	0	0	0	0	0	0	0	0	0	0	0
Summit	3,185	9	3	1	0	2	2	0	0	0	$132,259.74	$132,259.74	8
Teller	5,512	0	0	0	0	0	0	0	0	0	0	0	0
Washington	1,193	1	0	0	0	0	0	0	0	0	0	0	1
Weld	65,618	58	0	0	0	1	0	$22,807.41	$80,904.80	0	$49,132.33	$35,732.21	12
Yuma	2,649	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**1,228,594**	**2,554**	**66**	**5**	**0**	**42**	**38**	**$2,442,344.07**	**$372,348.26**	**$53,236.60**	**$871,549.35**	**$392,928.35**	**504**

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 (7/1/18 to 6/30/19)

Type of Investigation	Number of Closed Investigations	Number of New Investigations
Fraud	63	158
Drug Diversion	0	4
Abuse, Neglect, and Financial Exploitation	4	16
TOTAL	**67**	**178**

Criminal Complaints Requested, Cases Dismissed, Cases Acquitted, and Convictions

Criminal Complaints	Cases Dismissed	Cases Acquitted	Criminal Convictions
7	0	0	8

Civil Complaints Requested, Cases Dismissed, Civil Claims, and Confessions of Judgment

Civil Complaints	Cases Dismissed	Civil Claims	Confessions of Judgment
3	0	3	0

Criminal Recoveries, Restitution Ordered, Fines and Penalties, and Restitution Collected

Total Criminal Recoveries	Restitution Ordered	Fines and Penalties	Restitution Collected
$1,370,865.15	$1,370,665.15	$200.00	$117,533.57

Civil Recoveries and Civil Collections

Total Civil Recoveries	Principal State Recovery	Fines, Penalties, and Interest	Recoveries Collected
$21,564,975.84	$8,011,417.71	$13,553,558.13	$3,437,050.92