COLORADO
Department of Health Care Policy & Financing

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

November 2, 2020

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;*
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 Analyst, Jill Mullen, at Jill.Mullen@state.co.us or 720-682-3046

Sincerely,

Kim Bimestefer
Executive Director

KB/JG

Enclosure(s): 2020 Improving Medicaid Fraud Prosecution Annual Report

Cc: Senator Faith Winter, Vice Chair, Health and Human Services Committee
Senator Larry Crowder, Health and Human Services Committee
Senator Jim Smallwood, Health and Human Services Committee
Senator Joann Ginal, Health and Human Services Committee
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Tracy Johnson, Medicaid Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Anne Saumur, Cost Control and Quality Improvement Division Director, HCPD
Bonnie Silva, Office of Community Living Division Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF

COLORADO
Department of Health Care Policy & Financing

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

November 2, 2020

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:

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Sincerely,

Kim Bimestefer
Executive Director

KB/JG

Enclosure(s): 2020 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 Kerry Tipper, 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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COLORADO
Department of Health Care Policy & Financing

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

November 2, 2020

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:

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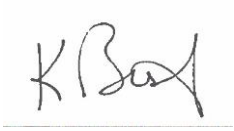
Sincerely,



Kim Bimestefer
Executive Director

KB/JG

Enclosure(s): 2020 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 Sonya Jacquez Lewis, 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
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COLORADO
Department of Health Care Policy & Financing

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

November 2, 2020

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;*
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Sincerely,

Kim Bimestefer
Executive Director

KB/JG

Enclosure(s): 2020 Improving Medicaid Fraud Prosecution Annual Report

Cc: Senator Julie Gonzalez, Vice Chair, Senate Judiciary Committee
Senator John Cooke, Senate Judiciary Committee
Senator Bob Gardner, Senate Judiciary Committee
Senator Robert Rodriguez, Senate 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 2, 2020

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:

a. *Investigations of client/member fraud during the year;*
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Sincerely,

Kim Bimestefer
Executive Director

KB/JG

Enclosure(s): 2020 Improving Medicaid Fraud Prosecution Annual Report

Cc: Representative Leslie Herod, Vice Chair, House Judiciary Committee
Representative Adrienne Benavidez, House Judiciary Committee
Representative Rod Bockenfeld, House Judiciary Committee
Representative Terri Carver, House Judiciary Committee
Representative Serena Gonzales-Gutierrez, House Judiciary Committee
Representative Dylan Roberts, House Judiciary Committee
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Improving Medicaid Fraud Prosecution

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

Due Date November 1, 2020

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 Colorado Revised Statute (C.R.S.) § 25.5-1-115.5 for the period of July 1, 2019 to June 30, 2020. 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 State fiscal year (SFY) 2019-20 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 (C.R.S. 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. When the Department receives a referral, state employees document and refer the case to the county of residence for investigation.

The Social Security Act contains the conditions that must be met in order for individual states to receive federal matching dollars for "State plans for medical assistance" (Medicaid). Title 42 U.S.C. 1396a(a)(61) of the act requires that a state "must demonstrate that it operates a Medicaid fraud and abuse control unit described in section 1396b(q) of this title that effectively carries out the functions and requirements described in such section, as determined in accordance with standards established by the Secretary" in order to receive federal matching funds for their Medicaid program.

To ensure that Medicaid Fraud Control Units are adhering to federal requirements they must be recertified annually and are periodically audited by the Office of the Inspector General of the U.S. Department of Health and Human Services (OIG-HHS). On the 23rd of June 2020, OIG-HHS determined that the Colorado Medicaid Fraud Control Unit ("COMFCU"

or “Unit”) was in compliance with the Federal statutory and regulatory requirements for State Medicaid Fraud Control Units and was recertified for the upcoming fiscal year.

In existence since 1978 and housed within the Colorado Department of Law, the COMFCU operates in accordance with C.R.S. § 24-31-801 et seq., C.R.S. § 25.5-4-303.5 et seq., 42 U.S.C. § 1396b(q), 42 C.F.R. § 1007.1 et seq., and 42 C.F.R. § 455 et seq. As a result, the Unit generally pursues three categories of cases:

1. Fraudulent conduct by Medicaid providers and individuals involved with providing Medicaid services.
2. The abuse, neglect, and exploitation of individuals in health care facilities that receive Medicaid funds or are classified as board and care facilities.
3. The recovery of Medicaid overpayments identified in the investigation of fraud, patient abuse and neglect, and financial exploitation of clients.

COMFCU receives referrals from numerous sources. When the entirety or a portion of a case is determined not to be appropriate for investigation, the COMFCU provides the referring party with resources and assistance to ensure that all of their concerns are addressed. The COMFCU takes great pride in the fact that every entity or individual that refers a matter to the Unit is contacted to ensure that their concerns are addressed.

Matters referred to the COMFCU often require substantial investigation as they can involve hundreds of patients, tens of thousands of pages of documents and can require months or years for their completion. Once fully investigated, it is not uncommon for a referral to not result in the filing of criminal charges. This can occur for a variety of reasons, such as an inability to prove criminal intent, or inconsistencies and vagueness of the applicable rules of the Medicaid program. The Unit endeavors to be as quick and responsive as possible in receiving referrals, opening investigations, and bringing cases through the court system. When cases are not appropriate for criminal investigation, the Unit reviews them promptly for consideration of civil recoveries.

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 a 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 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 be paid as a penalty

Restitution Ordered – Monetary amount ordered by a 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

- **2,817** investigations of member fraud during the fiscal year. This is an increase of 10% from last fiscal year.
- **463** terminations of services of member Medicaid benefits due to fraud. This is a decrease of 8% from last fiscal year.
- Number of District Attorney actions:
    - **53** criminal complaints requested
    - **0** cases dismissed
    - **0** cases acquitted
    - **21** convictions
    - **13** confessions of judgment
- **$1,750,503** of fraud identified as reported by the counties. This is a decrease of 28% from last fiscal year.
- **$497,106** of non-fraud identified as reported by the counties. This is an increase of 34% from last fiscal year.
- **$37,303** of fines and penalties recovered and retained by counties. This is a decrease of 30% from last fiscal year.
- Amount of Restitution:
    - **$783,398** ordered. This is a decrease of 10% from last fiscal year.
    - **$216,286** collected. This is a decrease of 45% from last fiscal year.

Analysis of Investigations and Estimated Member Fraud Cost Avoidance –

During this fiscal year, the number of investigations of member fraud increased by 10%- up from 2,554 last fiscal year. However, the terminations are down 8% and identified fraud is

down 28%, in large part due to the COVID-19 Public Health Emergency declared by the U.S. Department of Health and Human Services. The Families First Coronavirus Response Act was signed into law on March 18, 2020 (FFCRA), and in order for Colorado to be eligible to receive the increased Federal Medical Percentage (FMAP) made available by the FFCRA, coverage for any beneficiary enrolled in Colorado Medicaid on or after March 18, 2020 could not be terminated until the end of the month in which the emergency period ends, unless such individual was no longer a resident of the state or requested voluntary termination. No exceptions for terminating beneficiary eligibility for fraud, waste, and abuse were given under the FFCRA, so during the latter part of the fiscal year, there was no ability for counties to terminate eligibility due to beneficiary fraud, or to collect corresponding overpayments.

As a result, investigators are unable to terminate a case until the federal emergency declaration ends, no matter the result of their investigation. Additionally, many investigators are unable to conduct field investigations, such as home visits, due to the health crisis. Fines, penalties, and restitution ordered from the court are also down due to limitations in the court system as well. Moreover, the negative economic impact of COVID-19 has, and continues to, result in increased Medicaid applications, requiring counties to spend more time and resources on processing eligibility applications than on pursuing recoveries.

However, there was a slight increase in cost avoidance this year, likely the result of the increased number of investigations prior to the start of the COVID-19 health crisis. The terminating of cases due to fraud investigations resulted in a cost avoidance of approximately **$3,281,281**, up from **$3,217,536** identified last fiscal year. As explained further in the Member Fraud Cost Savings Section of this report, this cost avoidance figure reflects those terminations by improved upfront eligibility terminations and procedures.

Provider Fraud – As reported by the COMFCU

Between the 1st of July 2019 and the 30th of June 2020, the COMFCU received **312 case referrals**, of that number 26 were received from the Department of Health Care Policy and Financing. The remaining 286 referrals are a testament to the outreach activities and the relationship building conducted by the COMFCU. Those referrals were received from an incredibly diverse group that includes, but is not limited to: medical professionals, local law enforcement agencies, Statewide agencies, such as Adult Protective Services, the Office of the State Ombudsman, the Department of Public Health and Environment, as well as Medicaid clients and their caregivers. The Unit was active across Colorado as referrals received were along the Front Range but also from Grand Junction, Pueblo, Animas, and Trinidad.

As a result of staffing levels, of the 312 case referrals received during this review period, 70 matters remain queued for a preliminary investigation to determine whether or not a formal investigation should be opened by the COMFCU. After a preliminary investigation, the Unit opened **166 new cases for formal investigation** of which **80 were criminal** and **86 were civil matters**. The criminal cases opened during the SFY 2019-20 consist of **54 fraud cases**, **20 abuse and neglect cases**, and **6 drug diversion cases**.

During SFY 2019-20, the MFCU filed **16 criminal cases** and 13 defendants were sentenced in criminal court. The criminal matters involved conduct as varied as a speech therapist billing for over one million dollars in care that was not provided, a nurse practitioner that operated an opioid "pill-mill", a nursing home patient that suffered severe burns when her caregiver assisted in lighting a cigarette that the patient held in her mouth while on oxygen, to a pediatrician that falsified patient medical records in order to support billing the Medicaid program for treatments that were never provided.

As a result of these convictions, the Courts ordered a total of **$1.05 million in criminal restitution** be paid to the Department of Health Care Policy and Financing, along with **$3,000 in felony fines** to be paid to the State of Colorado. A defendant was also ordered to donate $10,000 to a non-profit drug treatment program in Alamosa, CO. During SFY 2019-20, COMFCU **collected $44,407 in criminal restitution** and closed 50 criminal investigations. These case closures were not the result of the dismissal of a filed case or an acquittal, and 13 closures were the result of the successful prosecution that were previously mentioned.

In addition to criminal prosecutions, COMFCU **recovered $3.58 million in civil matters** and **collected $1.61 million**. While no litigation costs were recovered during the review period, it should be noted that $1.68 million of the $3.58 million in recoveries consisted entirely of damages, including penalties and interest.

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 **463** terminations stemming from fraud investigations. The average cost per Medicaid member, per month, is **$590.58**, or **$7,087**[1] per year. Therefore, the estimated savings is **$3,281,281**. This is in addition to the recovery amounts we have collected.

The formula is laid out below:

Average Yearly Cost Per Person x Number of Terminations = Total Cost Avoidance
$7,087 x 463 = $3,281,281

During the majority of SFY 2019-20, 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

[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 SFY 2019-20 yearly average Medicaid member cost per month, excluding financing and supplemental payments.

Department's cost avoidance figure was over **$3.28 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 helped county investigators with investigation questions and support 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 continued to work closely with the Colorado Welfare Fraud Council.

At the Department, member and provider fraud are both housed within the Program Integrity and Contract Oversight Section (PICO). The Department will continue to support training programs for the counties and provide technical guidance while working to ensure that 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 continued its efforts to prevent fraud, waste, and abuse upfront. The Department successfully streamlined the Public Assistance Fraud Waste and Abuse (PARIS) system in order to remove individuals receiving medical assistance in multiple states, and also continued to collaborate 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 20 staff members with the investigation and civil or criminal prosecutions to protect the funds and beneficiaries of Colorado's $10 billion Medicaid program. By any analysis, COMFCU is one of the most efficient and effective recipients of Colorado funding. COVID-19 significantly impacted the work of the COMFCU during the last three months of the SFY 2019-20. It limited, or in some instances eliminated the possibility of visiting health care facilities in-person. It also had the same impact with regards to visits with and interviews with Medicaid clients and other potential witnesses. While technology could be used to address those issues, it is not a perfect solution. Interviews can be conducted by phone, but that does not provide the ability to share and discuss documents with individuals. Videoconferencing solutions such as Zoom or Microsoft Teams can be used, but those solutions are dependent upon the technology and internet connectivity available to the Medicaid client.

Though there were COVID-19 related hurdles in place for last quarter of SFY 2019-20, with an expenditure of only $586,956.69 in state funds, the COMFCU was able to recover a total of **$4.64 million** in fraudulent Medicaid billing. Additionally, it should be noted that if the providers responsible for such billings had not been identified, the fraudulent activity would likely have continued and the losses to the Medicaid program would likely have been far higher than the amounts that were recovered. This clearly demonstrates the cost effectiveness of the Unit.

Since Medicaid expansion occurred in 2010, the recoveries from the COMFCU have ranged from a low of 3.1 times the state funding received by the Unit to 57.8 times the state funding received. The average annual recovery over that time frame was 23.1 times the level of funding received from the State. While those numbers are impressive, they mask other developments that have taken place over that time frame.

Since 2010, Colorado funding for the for the Medicaid program has risen 127.2% while funding for the COMFCU has risen 66.2%. As a result, in 2010 there was one COMFCU staff member for every $299,540,361.64 in Medicaid spending. As of 2019, that number stood at one staff member for every $595,383,975.88 in Medicaid spending. Over this same time frame, the number of investigations per member of the Unit has increased from 7.16 investigations per staff member to 26.1 investigations per staff member.[2]

With such an investigative case load, triage decisions must continually be made, which may not result on the most efficient and effective outcomes for the matters being investigated. For example, if interviews with 200 individual patients are required to determine the true dollar loss to the Medicaid program as a result of a provider's fraudulent conduct, the number of interviews conducted may be capped at twenty or thirty, simply to allow a case to be filed and a partial recovery obtained in order to provide the investigator with the opportunity to work on additional matters that have been assigned to them for investigation. Such a tremendous caseload is also troubling as it slows the ability of the Unit to exonerate Medicaid providers when allegations have been made that the provider engaged in fraudulent activities.

For these reasons, additional consideration should be given to better leverage federal dollars to support the fraud detection and recovery efforts within the Colorado's Medicaid program. Funding for the COMFCU is provided in a 25% to 75% manner. See 42 USC 1396b(a)(2)(A). For every $50 in Colorado spending used to fund the COMFCU operations, the federal government provides $150 in funding to the Unit. "Various reports prepared by the federal government indicate that, if resources are directed toward fraud and abuse prevention and recovery, the cost-benefit ratio can be exceptional."[3]

Trends

[2] These numbers should be contrasted with the nationwide average of 11.9 investigations per staff member and one staff member for every $333,616,568.35 in Medicaid program spending. These numbers are based upon publicly available information for Federal Fiscal Year (FFY) 2019 prepared by the Department of Health and Human Services and available at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2019-statistical-chart.pdf .

[3] Office of the Colorado State Auditor. (1999). Medicaid Fraud and Abuse Programs: Performance Audit. Retrieved from: https://leg.colorado.gov/sites/default/files/documents/audits/1050_medicaid_fraud_perf_july_1999.pdf

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 priority for the Department in combatting member fraud, waste, and abuse. It is clear there are cost benefits to the Department's fraud investigation efforts. The state has established only slightly decreased fraud recovery claims from the last fiscal year, with a total of **$1,750,503,** but increased non-fraud recovery claims with a total of **$497,106**, and the state has also still avoided an estimated additional **$3,281,281** by terminating ineligible members.

The COMFCU reports that with provider fraud, there continues to be provider fraud involving the provision of in-home services and off-site services. The specific schemes vary, but generally involve billing the Medicaid program when services were not provided or overbilling for the services actually rendered. These schemes are difficult to investigate in many instances, as the potential witnesses are patients that are unable to provide information or are unwilling to provide information because the provider is a friend or family member. In some instances, potential witnesses have mental or physical limitations. Several of these schemes were observed in speech therapy providers billing for in-home therapy sessions, providers of in-home nursing care, and with dental practitioners providing services in nursing homes.

In the speech therapy category, COMFCU's investigations revealed that providers were billing two to three times the level of services that were provided. The investigations also uncovered in-home care providers that billed for impossible days, for providing care to patients several months after the patient's death, and for billing services provided to groups of individuals as though one-on-one services were provided.

It is hoped that the impending rollout of electronic visit verification will reduce fraud in this area, but a requirement that all in-home care providers receive some form of provider ID or registration number to provide such services would also both prevent and make it easier to uncover fraud in the provision of such services. Such a registration requirement was initially proposed by OIG-HHS in 2012 as a requirement that would reduce fraud in the Medicaid Program.[4]

There has been an uptick in flagrant and fraudulent billing by larger public and private entities that exhibit a business philosophy of billing for what they can and then fighting to hold on to those funds. It is anticipated that this type of behavior will only intensify. During one investigation this year, it was discovered that a Medicaid provider had a staff member that was tasked with reviewing state and federal health care rules and regulations for the sole purpose of finding gaps and inconsistencies that could be exploited for their benefit.

[4] U.S. Department of Health and Human Services – Office of Inspector General. (2010). Personal Care Services: Trends, Vulnerabilities and Recommendations for Improvement. Retrieved from: https://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf

While an uptick in telehealth billing was anticipated as a result of COVID-19, several investigations have been opened involving providers that have started billing dollar amounts that are significantly above their past billing in that area.

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	141,846	820	0	0	0	0	0	0	$74,525.00	0	0	0	275
Alamosa	7,012	2	0	0	0	0	0	0	0	0	0	0	0
Arapahoe	140,213	133	5	0	0	0	0	$310,763.00	0	0	0	0	0
Archuleta	3,616	7	0	0	0	0	0	0	0	0	0	0	0
Baca	1,330	10	0	0	0	0	0	0	0	0	0	0	0
Bent	1,804	4	2	0	0	0	1	0	0	0	$6,964.00	0	1
Boulder	50,861	180	0	0	0	0	0	$17,424.90	$9,521.32	0	0	$456.00	0
Broomfield	7,345	7	0	0	0	0	0	$3,031.32	0	0	0	0	1
Chaffee	3,888	0	0	0	0	0	0	0	0	0	0	0	0
Cheyenne	464	0	0	0	0	0	0	0	0	0	0	0	0
Clear Creek	1,524	0	0	0	0	0	0	0	0	0	0	0	0
Conejos	3,197	1	0	0	0	0	0	0	0	0	0	0	0
Costilla	2,061	0	0	0	0	0	0	0	0	0	0	0	0
Crowley	1,447	0	0	0	0	0	0	0	0	0	0	0	0
Custer	970	0	0	0	0	0	0	0	0	0	0	0	0
Delta	9,833	1	0	0	0	0	0	$4,141.17	0	0	0	0	1
Denver	198,741	880	0	0	0	0	0	$18,402.84	$37,750.01	0	0	0	5
Dolores	617	0	0	0	0	0	0	0	0	0	0	0	0
Douglas	28,474	57	5	0	0	0	0	$89,259.00	0	0	$76,624.00	$15,289.00	34
Eagle	6,598	19	8	0	0	3	0	$17,449.14	$2,351.08	0	$122,641.38	$17,449.14	3
Elbert	3,058	0	0	0	0	0	0	0	0	0	0	0	0
El Paso	177,920	8	3	0	0	2	2	$37,680.89	0	$19,219.55	$101,765.79	$18,619.55	11
Fremont	13,773	2	0	0	0	0	0	0	0	0	0	0	0
Garfield	12,975	30	0	0	0	0	0	$5,787.00	$3,663.42	0	0	0	2
Gilpin	1,110	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 2020

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Grand	1,918	0	0	0	0	0	0	0	0	0	0	0	0
Gunnison	3,035	0	0	0	0	0	0	0	0	0	0	0	0
Hinsdale	166	0	0	0	0	0	0	0	0	0	0	0	0
Huerfano	3,002	0	0	0	0	0	0	0	0	0	0	0	0
Jackson	289	0	0	0	0	0	0	0	0	0	0	0	0
Jefferson	93,078	265	17	0	0	9	9	$377,681.77	$0	$8,708.45	$154,479.07	$89,314.57	25
Kiowa	468	0	0	0	0	0	0	0	0	0	0	0	0
Kit Carson	2,057	0	0	0	0	0	0	0	0	0	0	0	0
La Plata	12,484	0	0	0	0	0	0	0	0	0	0	0	0
Lake	1,581	0	0	0	0	0	0	0	0	0	0	0	0
Larimer	64,265	227	4	0	0	1	1	$383,665.84	$418.00	0	0	0	9
Las Animas	6,059	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln	1,459	0	0	0	0	0	0	0	0	0	0	0	0
Logan	5,214	12	2	0	0	1	0	$60,141.43	$244,243.16	0	$7,475.02	$7,575.02	11
Mesa	43,552	17	3	0	0	1	0	$46,507.38	$18,898.63	0	$7,309.48	0	15
Mineral	154	0	0	0	0	0	0	0	0	0	0	0	0
Moffat	3,670	0	0	0	0	0	0	$400.00	0	0	0	0	0
Montezuma	9,380	10	0	0	0	0	0	$61,694.38	$27,511.60	0	0	0	11
Montrose	12,034	12	0	0	0	0	0	0	0	0	0	0	1
Morgan	8,448	14	1	0	0	1	0	$96,479.01	$78,224.07	$9,374.50	$179,179.43	0	2
Otero	7,837	3	0	0	0	0	0	$2,746.40	0	0	0	0	1
Ouray	697	1	0	0	0	0	0	0	0	0	0	0	1
Park	3,134	0	0	0	0	0	0	0	0	0	0	0	0
Phillips	1,035	0	0	0	0	0	0	0	0	0	0	0	0
Pitkin	1,569	0	0	0	0	0	0	0	0	0	0	0	0
Prowers	4,811	1	0	0	0	0	0	0	0	0	0	0	1

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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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	68,224	16	1	0	0	1	0	0	0	0	$82,306.42	0	5
Rio Blanco	1,405	0	0	0	0	0	0	0	0	0	0	0	0
Rio Grande	4,341	0	0	0	0	0	0	0	0	0	0	0	0
Routt	3,177	0	0	0	0	0	0	0	0	0	0	0	0
Saguache	2,393	3	0	0	0	0	0	0	0	0	0	0	0
San Juan	175	0	0	0	0	0	0	0	0	0	0	0	0
San Miguel	1,044	0	0	0	0	0	0	0	0	0	0	0	0
Sedgwick	765	0	0	0	0	0	0	0	0	0	0	0	0
Summit	3,602	2	0	0	0	0	0	0	0	0	0	0	0
Teller	5,673	0	0	0	0	0	0	0	0	0	0	0	0
Washington	1,239	1	0	0	0	0	0	0	0	0	0	0	0
Weld	69,895	72	2	0	0	2	0	$217,247.07	0	0	$44,653.53	$67,582.60	48
Yuma	2,710	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**1,276,716**	**2,817**	**53**	**0**	**0**	**21**	**13**	**$1,750,502.54**	**$497,106.29**	**$37,302.50**	**$783,398.12**	**$216,285.88**	**463**

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APPENDIX B:
INVESTIGATIONS OF PROVIDER FRAUD (7/1/2019 TO 6/30/2020)

Type of Investigation	# of Closed Investigations	# of New Investigations
Fraud	99	139
Drug Diversion	4	6
Abuse, Neglect, & Financial Exploitation	12	21
TOTAL	**115**	**166***

* This number does not include the 70 matters referred to the COMFCU that are still queued for an initial review and determination regarding whether a formal investigation should be opened.

CRIMINAL COMPLAINTS REQUESTED, CASES DISMISSED, CASES ACQUITTED, AND CONVICTIONS

Criminal Complaints	Cases Dismissed	Cases Acquitted	Criminal Convictions
16	0	0	13

CIVIL COMPLAINTS REQUESTED, CASES DISMISSED, CIVIL CLAIMS, AND CONFESSIONS OF JUDGMENT

Civil Complaints	Cases Dismissed	Civil Claims	Confessions of Judgment
0	0	24	0

CRIMINAL RECOVERIES, RESTITUTION ORDERED, AND RESTITUTION COLLECTED

Total Criminal Recoveries	Restitution Ordered	Fines and Penalties	Restitution Collected
$1,054,476.73	$1,054,476.73	$13,500.00	$44,407.11

CIVIL RECOVERIES AND CIVIL COLLECTIONS

Total Civil Recoveries	Principal State Recovery	Fines, Penalties, and Interest	Recoveries Collected
$3,583,907.43	$1,907,176.55	$1,676,730.88	$1,608,870.19