COLORADO
Department of Health Care Policy & Financing

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

November 1, 2021

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;*
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, Jo Donlin, at Jo.Donlin@state.co.us or 303-866-2573.

Sincerely,

Kim Bimestefer
Executive Director

KB/JG

Enclosure(s): 2021 Improving Medicaid Fraud Prosecution Annual Report

Cc: Representative Yadira Caraveo, Vice Chair, Health & Insurance Committee
Representative Mark Baisley, Health & Insurance Committee
Representative Ron Hanks, Health & Insurance Committee
Representative Dominique Jackson, Health & Insurance Committee
Representative Chris Kennedy, Health & Insurance Committee
Representative Karen McCormick, Health & Insurance Committee
Representative Kyle Mullica, Health & Insurance Committee
Representative David Ortiz, Health & Insurance Committee
Representative Matt Soper, Health & Insurance Committee
Representative Brianna Titone, Health & Insurance Committee
Representative Tonya Van Beber, Health & Insurance Committee
Representative Dave Williams, Health & Insurance Committee
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Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bettina Schneider, Finance 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
Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

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

November 1, 2021

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;*
b. *Termination of client/member Medicaid benefits due to fraud;*
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If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 303-866-2573.

Sincerely,

Kim Bimestefer
Executive Director

KB/JG

Enclosure(s): 2021 Improving Medicaid Fraud Prosecution Annual Report

Cc: Representative Kerry Tipper, Vice Chair, House Judiciary Committee
Representative Jennifer Bacon, House Judiciary Committee
Representative Adrienne Benavidez, House Judiciary Committee
Representative Rod Bockenfeld, House Judiciary Committee
Representative Terri Carver, House Judiciary Committee
Representative Lindsey Daugherty, House Judiciary Committee
Representative Stephanie Luck, House Judiciary Committee
Representative Mike Lynch, House Judiciary Committee
Representative Dylan Roberts, House Judiciary Committee
Representative Steven Woodrow, House 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, 2021

The Honorable Dafna Michaelson Jenet, Chair
House Public & Behavioral Health & Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Michaelson Jenet:

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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If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 303-866-2573.

Sincerely,

Kim Bimestefer
Executive Director

KB/JG

Enclosure(s): 2021 Improving Medicaid Fraud Prosecution Annual Report

Cc: Representative Emily Sirota, Vice Chair, Public & Behavioral Health & Human Services Committee
Representative Mary Bradfield, Public & Behavioral Health & Human Services Committee
Representative Lisa Cutter, Public & Behavioral Health & Human Services Committee
Representative Serena Gonzales-Gutierrez, Public & Behavioral Health & Human Services Committee
Representative Richard Holtorf, Public & Behavioral Health & Human Services Committee
Representative Iman Jodeh, Public & Behavioral Health & Human Services Committee
Representative Colin Larson, Public & Behavioral Health & Human Services Committee
Representative David Ortiz, Public & Behavioral Health & Human Services Committee
Representative Rod Pelton, Public & Behavioral Health & Human Services Committee
Representative Naquetta Ricks, Public & Behavioral Health & Human Services Committee
Representative Dan Woog, Public & Behavioral Health & Human Services Committee
Representative Mary Young, Public & Behavioral Health & 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, 2021

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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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, Jo Donlin, at Jo.Donlin@state.co.us or 303-866-2573.

Sincerely,

Kim Bimestefer
Executive Director

Kim Bimestefer
Executive Director

KB/JG

KB/JG

Enclosure(s): 2021 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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Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

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

November 1, 2021

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;*
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If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 303-866-2573.

Sincerely,

Kim Bimestefer
Executive Director

KB/JG

Enclosure(s): 2021 Improving Medicaid Fraud Prosecution Annual Report

Cc: Senator Joann Ginal, Vice Chair, Health and Human Services Committee
Senator Janet Buckner, Health and Human Services Committee
Senator Sonya Jaquez Lewis, Health and Human Services Committee
Senator Barbara Kirkmeyer, Health and Human Services Committee
Senator Cleave Simpson, Health and Human Services Committee
Senator Jim Smallwood, Health and Human Services Committee
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Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

Improving Medicaid Fraud Prosecution

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

Due Date November 1, 2021

Submitted to:

House Health and Insurance Committee
House Judiciary Committee
House Public and Behavioral Health 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, 2020 to June 30, 2021. 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 or Unit) report. The reported numbers for State fiscal year 2020-2021 (SFY 2020-21) 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 general policy directives and specific guidance upon request from individual counties. When the Department receives a client/member fraud referral directly, Department staff review and document the referral, retrieve relevant background case information from the Case Benefit Management System (CBMS), and send the referral 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 adhere to federal requirements, states 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). For the 2022 Federal Fiscal Year, OIG-HHS 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 upcoming fiscal year.

Created in 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. The Unit generally pursues three categories of cases:

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

The 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 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 may involve hundreds of patients, tens of thousands of pages of documents, and 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 fiscal year

Overall Totals

Member Fraud – As reported by the counties

- **3,458** investigations of member fraud during the fiscal year. This is an increase of 23% from last fiscal year.
- **355** terminations of services of member Medicaid benefits due to fraud. This is a decrease of 23% from last fiscal year.
- Number of District Attorney actions:
    - 42 criminal complaints requested
    - 11 cases dismissed
    - 0 cases acquitted
    - 32 convictions
    - 24 confessions of judgment
- **$2,130,300** of fraud identified as reported by the counties. This is an increase of 22% from last fiscal year.
- **$1,048,012** of non-fraud identified as reported by the counties. This is an increase of 111% from last fiscal year.
- **$28,636** of fines and penalties recovered and retained by counties. This is a decrease of 23% from last fiscal year.
- Amount of Restitution:
    - **$548,244** ordered. This is a decrease of 30% from last fiscal year.
    - **$223,755** collected. This is an increase of 3% from last fiscal year.

Analysis of Investigations and Estimated Member Fraud Cost Avoidance

During SFY 2020-21, the number of investigations of member fraud increased by 23% from last fiscal year, accompanying a 22% increase in fraud recoveries and a 111% increase in non-fraud recoveries. This increase in both investigations and recoveries reflects counties now having familiarity with the policies and procedures necessary to effectively pursue fraud investigations and recoveries during the COVID-19 Public Health Emergency, as declared by the U.S. Department of Health and Human Services (PHE). Further, the Families First Coronavirus Response Act was signed into law on March 18, 2020 (FFCRA), and following related Department policy guidance, during SFY 2020-21, the only overpayments allowed to be collected from clients/members were those from ineligibility periods outside of the PHE period, meaning prior to March 18, 2020. While the time periods for investigations were limited by the PHE, counties were able to leverage their exclusive focus on pre-PHE time periods to conduct more investigations and increase recoveries from last fiscal year, during which the PHE was first declared.

Eligibility terminations are down 23% this fiscal year. The decrease in terminations is due largely to the continuation of the PHE. 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. The PHE was in place for the entirety of SFY 2020-21, and no exceptions for terminating eligibility for fraud, waste, or abuse were given under the FFCRA. Additionally, many investigators continued to be limited, or altogether unable to conduct field investigations, such as home and business visits, due to the ongoing health crisis.

Fines, penalties, and restitution ordered from the court are also down due to ongoing limitations in the court system. Moreover, the negative economic impact of COVID-19 resulted in increased Medicaid applications, requiring counties to spend more time and resources on processing the large increase in eligibility applications than on pursuing criminal recoveries.

Cost avoidance decreased this year, directly reflecting the decrease in terminations due to the limitations of the ongoing PHE. For the terminations that were permissible, there was still a resulting cost avoidance of approximately **$2,344,775**, down from **$3,281,281** identified last fiscal year. This calculation is explained further in the Member Fraud Cost Savings Section of this report.

Provider Fraud – As reported by the COMFCU

Between July 1, 2020, and June 30, 2021, the COMFCU received **211** case referrals. Of that number, **17** were received from the Department of Health Care Policy and Financing. The remaining referrals are due 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, and 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 **211** case referrals received during this review period, **78** 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 **141** new cases for formal investigation, of which **79** were criminal matters and **62** were civil matters. The cases opened during the reporting period consisted of **90** fraud cases, **48** abuse and neglect cases, and **3** drug diversion cases. Additionally, COMFCU has **478** active investigations with **159** criminal cases, of which **62** are abuse/neglect matters, **11** are drug diversion matters, and **86** are fraud matters.

During SFY 2020-21, the COMFCU filed **22** criminal cases. Of that number, due to the impact of the COVID-19 pandemic on the courts, **16** remain pending. As of the end of the SFY 2020-21, **6** defendants were sentenced in criminal court, **5** of which were sentenced on abuse/neglect charges. The criminal matters involved conduct as varied as a CNA in Jefferson County that punched an 84 year old nursing home resident, a facility employee in Adams County that lit a cigarette for a resident that was on oxygen which resulted in second and third degree burns to the resident's face and tongue, a group home employee in Mesa County that simply stopped changing a resident that wore incontinence briefs, and a facility employee in Prowers County that repeatedly sexually assaulted a resident.

During SFY 2020-21, the COMFCU collected **$15,516.98** in criminal restitution and closed **82** criminal investigations. The criminal convictions during the SFY 2020-21 did not result in any restitution being ordered for the Department.

In addition to criminal prosecutions, the COMFCU recovered **$7.13 million** in civil matters and collected **$4.59 million**. While no litigation costs were recovered during the review period, it should be noted that **$3.56 million** of the **$7.13 million** in recoveries consisted entirely of damages, including penalties and interest.

Total Cost Savings from Members and Providers

In SFY 2020-21, the total aggregate Medicaid savings for members and providers was **$13,245,484**[1]. Additional details on cost savings are presented separately below for both members and providers.

Cost Savings - Members

Using the number of terminations from the counties, the Department calculated the average yearly Medicaid amount of all state Medicaid clients/member in order to obtain a yearly amount of Medicaid dollars saved. This year, there were 355 terminations. The

[1] From the member side, this total cost savings figure includes **$2,130,300** in fraud recoveries, **$1,048,012** in non-fraud recoveries, **$28,636** in fines and penalties, **$548,244** in restitution ordered, and **$2,344,775** in estimated cost savings from terminating ineligible members. On the provider side, the total cost saving figure reflects **$15,516.98** in criminal restitution, and **$7.13** million in civil recoveries.

average cost per Medicaid client/member for this past fiscal year, per month, was $550.42, or $6,605[2] per year. Therefore, the estimated cost savings is **$2,344,775**. This savings is in addition to the **$2,130,300** fraud recovery amount.

The cost savings formula is laid out below:

Average Yearly Cost Per Client/Member x Number of Terminations = Total Cost Avoidance
$6,605 x 355 = **$2,344,775**

During SFY 2020-21, the Department had one full time Equivalent (FTE) who was dedicated to client/member fraud, waste, and abuse, allowing for additional investigation resources at the State level. The position assisted county investigators, worked to develop training, and provided resources to the counties. With the FTE position, the Department's cost avoidance figure was over **$2.3 million dollars** as the Department issued guidance and provided investigation assistance. This position helped work on client/member fraud cases by assisting county investigators and ensuring compliance with the FFCRA and related Department PHE policy. During this time period, this position, along with the Program Integrity Manager, continued to work closely with county representatives throughout the State and helped county investigators with investigation questions and support. The FTE position served as the chair of the nation-wide Beneficiary Fraud Technical Assistance Subgroup. This subgroup shares national best practices and collaborates with other states and CMS representatives to answer questions and address issues involving beneficiary fraud. This position also continued to work closely with the Colorado Welfare Fraud Council, a nonprofit organization dedicated to the prevention and detection of Colorado public assistance fraud. 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 and policy guidance while working to ensure that best practices are followed, and that investigations are consistent across the state.

The Department has also continued proactive efforts to assist counties in fighting client/member fraud and promoting cost avoidance. PICO's work is complemented by accurate eligibility determinations limiting 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, the COMFCU is one of the most efficient and effective recipients of Colorado funding. COVID-19 has significantly impacted the work of the COMFCU. 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 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

[2] Source of data for average monthly cost provided in the Department's November 1, 2021 budget request R-1, Exhibit Q.

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 SFY 2020-21, the COMFCU was able to recover a total of **$7.13 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 was authorized in 2010, the recoveries by 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 **141.12%** while funding for the COMFCU has risen **61.37%**. As a result, in 2010 there was one COMFCU staff member for every **$299,540,361.64** in Medicaid spending. As of 2020, that number stood at one staff member for every **$505,567,353.30** 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 **24.3** investigations per staff member.[3]

With such an investigative case load, triage decisions must continually be made, which may not result in 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.

It should be noted that during the triage process cases that involve allegations of the abuse or neglect of patients, and involve patient harm or death, take priority over cases involving the theft of State funds. In 2010, the Unit investigated 4 abuse and neglect cases, and by 2020 that number had increased to 65. The number of such investigations is only going to increase going forward. Colorado's 65-and-over population grew 29% between 2010 and 2015, the third fastest rate in the nation.[4] This is significant, for though Medicare is

[3] These numbers should be contrasted with the nationwide average of 12.93 investigations per staff member and one staff member for every $357,703,197.12 in Medicaid program spending. These numbers are based upon publicly available information for Federal Fiscal Year 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/fy2020-statistical-chart.pdf .

[4] Colorado State Demography Office. *Aging in Colorado Part 1: Why is Colorado Aging So Quickly?* (October 2016). Retrieved from: https://demography.dola.colorado.gov/crosstabs/aging-part-1/

considered the insurance program for the elderly, it does not cover long-term nursing home care, and as of 2019, three in five nursing home patients in Colorado were covered by Medicaid.[5]

For these reasons, additional consideration should be given to better leveraging federal dollars to support the fraud detection and recovery efforts within Colorado's Medicaid program. Funding for the COMFCU is provided in a 25% to 75% manner. 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."[6]

Trends

In regard to client/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 clients/members leaving Colorado without reporting their change in residency. These cases stem from both fraudulent applications and confusion by clients/members as to what changes they must report and when they must report it. This is why focusing on training and education remains a priority for the Department in combatting client/member fraud, waste, and abuse.

It is clear there are cost benefits to the Department's fraud investigation efforts. The Department has established an increased fraud recovery totaling $**2,130,300**, and an increased non-fraud recovery totaling **$1,048,012**. This was while still avoiding an estimated additional **$2,344,775** in unnecessary costs 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 with speech therapy providers billing for in-home therapy sessions, with providers of in-home nursing care, and with dental practitioners providing services in nursing homes.

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 prevent, and make it easier to uncover, fraud in the provision of such services. Such a registration requirement was

[5] Henry J. Kaiser Family Foundation. *Colorado Medicaid Fact Sheet*. Retrieved from: http://files.kff.org/attachment/fact-sheet-medicaid-state-CO

[6] 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

initially proposed by OIG-HHS in 2012 as a requirement that would reduce fraud in the Medicaid Program.[7]

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.

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.

[7] 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

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	167,691	810	0	0	0	0	0	0	$75,333.00	0	0	0	266
Alamosa	7,834	16	2	0	0	0	0	0	0	0	0	0	0
Arapahoe	167,281	414	6	1	0	4	0	$93,655.51	0	0	$232,520.00	$4,746.28	0
Archuleta	4,250	7	0	0	0	0	0	0	0	0	0	0	0
Baca	1,483	17	0	0	0	0	0	0	0	0	0	0	0
Bent	1,973	0	0	0	0	0	0	0	0	0	0	0	0
Boulder	59,697	168	0	0	0	0	0	0	$12,055.94	0	0	0	0
Broomfield	8,885	0	0	0	0	0	0	0	0	0	0	0	0
Chaffee	4,608	0	0	0	0	0	0	0	0	0	0	0	0
Cheyenne	519	0	0	0	0	0	0	0	0	0	0	0	0
Clear Creek	1,739	0	0	0	0	0	0	0	0	0	0	0	0
Conejos	3,613	7	0	0	0	0	0	0	0	0	0	0	0
Costilla	2,357	0	0	0	0	0	0	0	0	0	0	0	0
Crowley	1,553	0	0	0	0	0	0	0	0	0	0	0	0
Custer	1,126	0	0	0	0	0	0	0	0	0	0	0	0
Delta	11,284	3	0	0	0	0	0	0	0	0	0	0	0
Denver	226,722	953	6	0	0	0	0	$121,062.22	$33,973.97	0	0	0	3
Dolores	735	0	0	0	0	0	0	0	0	0	0	0	0
Douglas	34,761	122	4	1	0	1	0	$10,800.23	0	0	$19,167.54	0	0
Eagle	8,239	12	5	0	0	0	0	$28,874.03	$3,405.67	0	$106,172.87	$25,270.74	4
Elbert	3,606	0	0	0	0	0	0	0	0	0	0	0	0
El Paso	204,863	19	1	0	0	1	0	$347,601.94	$37,584.71	$363.50	$12,769.21	$12,769.21	19
Fremont	15,458	3	0	0	0	0	0	0	0	0	0	0	0
Garfield	15,880	15	0	0	0	0	0	$21,546.57	$361,189.23	0	0	0	0
Gilpin	1,310	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 2021.

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Grand	2,421	0	0	0	0	0	0	0	0	0	0	0	0
Gunnison	3,540	0	0	0	0	0	0	0	0	0	0	0	0
Hinsdale	175	0	0	0	0	0	0	0	0	0	0	0	0
Huerfano	3,285	0	0	0	0	0	0	0	0	0	0	0	0
Jackson	329	0	0	0	0	0	0	0	0	0	0	0	0
Jefferson	108,343	263	9	9	0	18	18	$615,318.32	$0	$28,272.50	$139,002.51	$102,630.36	0
Kiowa	522	0	0	0	0	0	0	0	0	0	0	0	0
Kit Carson	2,347	0	0	0	0	0	0	0	0	0	0	0	0
La Plata	14,574	0	0	0	0	0	0	0	0	0	0	0	0
Lake	1,910	0	0	0	0	0	0	0	0	0	0	0	0
Larimer	75,142	330	0	0	0	6	6	$35,594.00	0	0	0	0	0
Las Animas	6,586	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln	1,673	0	0	0	0	0	0	0	0	0	0	0	0
Logan	5,942	36	3	0	0	0	0	$115,701.75	$358,849.56	0	0	0	10
Mesa	49,728	25	0	0	0	2	0	$38,612.15	$2,155.75	0	$38,612.15	$1,324.38	13
Mineral	204	0	0	0	0	0	0	0	0	0	0	0	0
Moffat	4,254	0	0	0	0	0	0	0	0	0	0	0	0
Montezuma	10,593	69	2	0	0	0	0	$199,252.16	$92,268.51	0	0	$1,565.00	15
Montrose	14,008	3	0	0	0	0	0	0	0	0	0	0	0
Morgan	9,831	11	0	0	0	0	0	$118,804.14	0	0	0	0	1
Otero	8,648	9	0	0	0	0	0	$14,777.48	0	0	0	0	5
Ouray	814	0	0	0	0	0	0	0	0	0	0	0	0
Park	3,676	0	0	0	0	0	0	0	0	0	0	0	0
Phillips	1,233	0	0	0	0	0	0	0	0	0	0	0	0
Pitkin	1,854	0	0	0	0	0	0	0	0	0	0	0	0
Prowers	5,477	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.

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Pueblo	75,703	18	0	0	0	0	0	0	0	0	0	0	0
Rio Blanco	1,598	0	0	0	0	0	0	0	0	0	0	0	0
Rio Grande	4,876	0	0	0	0	0	0	0	0	0	0	0	0
Routt	3,780	0	0	0	0	0	0	0	0	0	0	0	0
Saguache	2,865	0	0	0	0	0	0	0	0	0	0	0	0
San Juan	226	0	0	0	0	0	0	0	0	0	0	0	0
San Miguel	1,303	1	0	0	0	0	0	0	0	0	0	0	0
Sedgwick	826	0	0	0	0	0	0	0	0	0	0	0	0
Summit	4,600	0	0	0	0	0	0	0	0	0	0	0	0
Teller	6,504	0	0	0	0	0	0	0	0	0	0	0	0
Washington	1,358	0	0	0	0	0	0	0	0	0	0	0	0
Weld	86,361	127	4	0	0	0	0	$368,699.25	$71,196.08	0	0	$75,448.53	19
Yuma	3,151	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**1,487,727**	**3,458**	**42**	**11**	**0**	**32**	**24**	**$2,130,299.75**	**$1,048,012.42**	**$28,636.00**	**$548,244.28**	**$223,754.50**	**355**

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:
INVESTIGATIONS OF PROVIDER FRAUD (7/1/2020 TO 6/30/2021)

Type of Investigation	# of Closed Investigations	# of New Investigations
Fraud	87	90
Drug Diversion	10	3
Abuse, Neglect, & Financial Exploitation	39	48
TOTAL	**136**	**141***

* This number does not include the 78 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
22	0	1	6

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

Civil Complaints	Cases Dismissed	Civil Claims	Confessions of Judgment
1	0	27	0

CRIMINAL RECOVERIES, RESTITUTION ORDERED, AND RESTITUTION COLLECTED

Total Criminal Recoveries	Restitution Ordered	Fines and Penalties	Restitution Collected
$0.00	$0.00	$0.00	$15,516.98

CIVIL RECOVERIES AND CIVIL COLLECTIONS

Total Civil Recoveries	Principal State Recovery	Fines, Penalties, and Interest	Recoveries Collected
$7,136,382.41	$3,569,555.15	$3,566,827.26	$4,590,990.79