COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

November 1, 2022

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 Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7796.

Sincerely,

Kim Bimestefer

Executive Director

Cc: Senator Joann Ginal, Vice Chair, Senate Health and Human Services Committee
Senator Janet Buckner, Senate Health and Human Services Committee
Senator Sonya Jaquez Lewis, Senate Health and Human Services Committee
Senator Barbara Kirkmeyer, Senate Health and Human Services Committee
Senator Cleave Simpson, Senate Health and Human Services Committee
Senator Jim Smallwood, Senate Health and Human Services Committee
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Ralph Choate, Medicaid Operations Office Director, HCPF
Charlotte Crist, Cost Control & Quality Improvement Office Director, HCPF
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Parrish Steinbrecher, Health Information Office 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 and Financing
1570 Grant Street
Denver, CO 80203

November 1, 2022

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:*

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Sincerely,

Kim Bimestefer

Executive Director

Cc: Senator Julie Gonzales, 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 and Financing
1570 Grant Street
Denver, CO 80203

November 1, 2022

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 & Behavioral Health & 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;*
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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 720-610-7795.

Sincerely,

Kim Bimestefer

Executive Director

Cc: Representative Emily Sirota, Vice Chair, House Public & Behavioral Health & Human Services Committee
Representative Judy Amabile, House Public & Behavioral Health & Human Services Committee
Representative Mary Bradfield, House Public & Behavioral Health & Human Services Committee
Representative Lisa Cutter, House Public & Behavioral Health & Human Services Committee
Representative Serena Gonzales-Gutierrez, House Public & Behavioral Health & Human Services Committee
Representative Ron Hanks, House Public & Behavioral Health & Human Services Committee
Representative Richard Holtorf, House Public & Behavioral Health & Human Services Committee
Representative Iman Jodeh, House Public & Behavioral Health & Human Services Committee
Representative Rod Pelton, House Public & Behavioral Health & Human Services Committee
Representative Naquetta Ricks, House Public & Behavioral Health & Human Services Committee
Representative Dave Williams, House Public & Behavioral Health & Human Services Committee
Representative Mary Young, House Public & Behavioral Health & Human Services Committee
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COLORADO
Department of Health Care Policy & Financing
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1570 Grant Street
Denver, CO 80203

November 1, 2022

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

Dear Representative Susan Lontine:

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

Cc: Representative David Ortiz, Vice Chair, House Health & Insurance Committee
Representative Mark Baisley, House Health & Insurance Committee
Representative Chris Kennedy, House Health & Insurance Committee
Representative Karen McCormick, House Health & Insurance Committee
Representative Kyle Mullica, House Health & Insurance Committee
Representative Patrick Neville, House Health & Insurance Committee
Representative Emily Sirota, House Health & Insurance Committee
Representative Matt Soper, House Health & Insurance Committee
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COLORADO
Department of Health Care Policy & Financing
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 1, 2022

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

Dear Representative Mike 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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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 720-610-7795.

Sincerely,

Kim Bimestefer
Executive Director

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
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Jo Donlin, Legislative Liaison, HCPF

# Improving Medicaid Fraud Prosecution

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

**Due Date: Nov. 1, 2022**

**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

# Contents





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, 2021 to June 30, 2022. This section requires the Department of Health Care Policy & Financing (Department) to submit a written report by Nov. 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 from the Colorado Medicaid Fraud Control Unit (COMFCU or Unit) report. The reported numbers for state fiscal year 2021-2022 (SFY 2021-22) are available in Appendix A and Appendix B.

This provider and member fraud report includes:

- Investigations of provider and member fraud during the year;
- Termination of 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 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 has 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 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 policy directives and specific guidance upon request from individual counties. When the Department receives a member fraud referral directly, Department staff review and document the referral, retrieve relevant 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 its 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 2022-23 Federal Fiscal Year, OIG-HHS determined that the COMFCU is 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 members.

The COMFCU's jurisdiction does not extend to the investigation of fraud by members; for example, false statements of income or eligibility for Medicaid.

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. In the appropriate circumstances, the COMFCU will refer a matter to a different governmental agency with jurisdiction to address the situation presented.

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 matter 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 Judgment** - 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

- **1,992** investigations of member fraud during the fiscal year. This is a decrease of 42% from last fiscal year.
- **111** terminations of services of member Medicaid benefits due to fraud. This is a decrease of 69% from last fiscal year.
- Number of District Attorney actions:
    - 28 criminal complaints requested
    - 2 cases dismissed
    - 0 cases acquitted
    - 16 convictions

    - 10 confessions of judgment
- **$2,367,645** of fraud identified, as reported by the counties. This is an increase of 11% from last fiscal year.
- **$250,372** of non-fraud identified as reported by the counties. This is a decrease of 76% from last fiscal year.
- **$13,185** of fines and penalties recovered and retained by counties. This is a decrease of 54% from last fiscal year.
- Amount of Restitution:
    - **$711,311** ordered. This is an increase of 30% from last fiscal year.
    - **$402,426** collected. This is an increase of 80% from last fiscal year.

**Analysis of Investigations and Estimated Member Fraud Cost Avoidance**

During SFY 2021-22, there was a 11% increase in member fraud recoveries from last fiscal year, up to **$2,367,645**, even with a 42% decrease in the number of investigations of member fraud. Under the COVID-19 Public Health Emergency, as declared and extended by the U.S. Department of Health and Human Services (PHE), the Families First Coronavirus Response Act, signed into law on March 18, 2020, (FFCRA), and Department policy guidance, during SFY 2021-22, the only overpayments allowed to be collected from members continued to just be those from ineligibility periods outside of the PHE period, meaning prior to March 18, 2020. With this multi-year restriction still in place, counties were only able to seek fraud recoveries from the limited and declining pool of discovered pre-PHE ineligibility periods for members, expectedly decreasing investigation numbers this fiscal year. The official end date of the PHE, and of these accompanying restrictions on member overpayment recoveries, remains undetermined.

Eligibility terminations are down 69% this fiscal year. The continuing trend of decreasing eligibility terminations is also due to the ongoing PHE. In compliance with the Federal Medical Percentage (FMAP) made available by the FFCRA, coverage for any beneficiary enrolled in Colorado Medicaid on or after March 18, 2020, cannot 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. However, criminal fraud convictions could also serve to terminate eligibility under federal regulations. The PHE was in place for the entirety of SFY 2021-22, with continuous enrollment severely restricting the ability of counties to terminate members who would otherwise be ineligible for Medicaid. Once the PHE ends, the required redetermination of all Medicaid members will ultimately terminate the Medicaid coverage of those members who are no longer eligible to receive medical assistance benefits. This extensive redetermination process will take place over a twelve-month period (14 months including noticing), beginning on the date on which the PHE officially ends.

Cost avoidance decreased this year, coinciding directly with the decrease in eligibility terminations during the PHE. For the limited terminations that were permissible under the FFCRA, this fiscal year there was a resulting cost avoidance of approximately

**$713,050**, down from **$2,344,775**, identified last fiscal year. This cost avoidance calculation is explained further in the Member Fraud Cost Savings Section of this report.

While court-imposed fines and penalties decreased in SFY 2021-22, restitution ordered and restitution collected increased 30% and 80%, up to **$711,311** and **$402,426**, respectively. Although ineligibility periods subject to court recoveries were limited during the PHE, the court system itself has seen some improved efficiency and accessibility since earlier periods of the PHE.

**Provider Fraud** - As reported by the COMFCU

Between July 1, 2021, and June 30, 2022, the COMFCU received **229** case referrals. Of that number, **15** were received from the Department. The remaining referrals are due to the outreach activities and the relationship building conducted by the COMFCU. Those referrals were received from a 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 & Environment, and Medicaid members and their caregivers. The Unit was active across Colorado, having received referrals from many areas of the state.

As a result of staffing levels, of the **229** case referrals received during this review period, **175** matters remain in preliminary investigation status, without a determination as to whether or not a formal investigation will be opened by the COMFCU. After a preliminary investigation, based on these referrals, the Unit opened **16** new cases for formal investigation, of which **15** were criminal matters and **1** was a civil matter. The cases opened during the reporting period consisted of **5** fraud cases, **11** abuse and neglect cases, and **0** drug diversion cases. Additionally, at the end of the Federal Fiscal Year 2021-2022 (Sept. 30, 2022), the COMFCU has **435** active investigations with **85** criminal cases, of which **29** are abuse and neglect matters, **11** are drug diversion matters, and **45** are fraud matters.

During SFY 2021-22, the COMFCU filed **8** criminal cases. Reflective of the backlog in the courts from the COVID-19 pandemic, many earlier cases were resolved, and **15** defendants were sentenced in criminal court, **11** of whom were sentenced on abuse/neglect charges. The criminal matters filed involved conduct as varied as three caregivers in Grand Junction failing to discover an elder with dementia on a patio in temperatures over 100 degrees for six hours, resulting in the death of the elder; a nursing home administrator in Denver who is accused of forging state financial forms to embezzle Medicaid money from the home; and a substitute caregiver in Mesa County who severely neglected an at-risk adult under her care following the death of her father, the primary caregiver.

During SFY 2021-22, the COMFCU collected **$283,505.05** in criminal restitution, both directly through checks sent to the Unit, and indirectly through checks sent to the

Department from the courts based on COMFCU cases. Of this amount, **$251,039.17** represents restitution collected from criminal convictions during SFY 2021-22.

In addition to criminal prosecutions, the COMFCU recovered **$1.26 million** in civil matters (with an additional **$5 million** reported just after the closing of SFY 2021-22) and collected almost **$1 million**. No litigation costs were recovered during the review period.

## Total Cost Savings from Members and Providers

In SFY 2021-22, the total aggregate Medicaid savings for members and providers was **$5,599,068**[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 members in order to obtain a yearly amount of Medicaid dollars saved. This fiscal year, there were **111** terminations. The average cost per Medicaid member for this past fiscal year, per month, was $535.32, or $6,423.87[2] per year. Therefore, the estimated cost savings is **$713,050**. This savings is in addition to the **$2,367,645** fraud recovery amount.

The cost savings formula is laid out below:

Average Yearly Cost Per Member x Number of Terminations = Total Cost Avoidance
$6,423.87 x 111 = **$713,050**

During SFY 2021-22, the Department had one position who worked heavily on 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 this position, even with the extensive continuing restrictions of the PHE period, the Department's cost avoidance figure was **$713,050**, as the Department issued guidance and provided investigation assistance. This position helped work on 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 other Department staff, continued to work closely with county representatives throughout the state and helped county

[1] From the member side, this total cost savings figure includes **$2,367,645** in fraud recoveries, **$250,372** in non-fraud recoveries, **$13,185** in fines and penalties, **$711,311** in restitution ordered, and **$713,050** in estimated cost savings from terminating ineligible members. On the provider side, the total cost saving figure reflects **$283,505.05** in criminal restitution, and **$1.26** million in civil recoveries.
[2] Source of data for average monthly cost is based on the Department's Nov. 1, 2022, budget request.

investigators with investigation questions and support. The position also continued to serve 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 important issues involving Medicaid 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. Within the Department, member and provider fraud are both housed within the Fraud, Waste, and Abuse Division (FWA Division). 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 member fraud and promoting cost avoidance. The FWA Division's work is complemented by additional Department and county staff efforts to further improve the accuracy of initial eligibility determinations, limiting ineligible individuals from being approved to receive medical assistance benefits. Once the PHE has ended, the required redetermination of all Medicaid members will further ensure that ineligible members are disenrolled from Medicaid.

**Cost Savings – Providers**

During this review period, the state of Colorado tasked a law enforcement team of up to **20** staff members with the investigation and civil or criminal prosecutions to protect the funds and beneficiaries of Colorado's $14 billion Medicaid program. By any analysis, the COMFCU is one of the most efficient and effective recipients of Colorado funding. COVID-19 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 regard to visits and interviews with Medicaid members 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 member.

Despite the repercussions of COVID-19 related hurdles, the COMFCU was able to recover a total of **$1.6 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.

Between 2010 and 2021, the recoveries from the COMFCU 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 Medicaid program has risen **141.12%** while funding for the COMFCU has risen only **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 20 or 30, 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 unsubstantiated allegations of fraud are made against them. And as noted above, many referrals and complaints remain in the queue to be addressed when personnel become available.

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 four 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 twenty-nine percent (29%) between 2010 and 2015, the third fastest rate in the nation.[4] This is significant, for though Medicare is 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, there may be an opportunity to leverage federal dollars to support the COMFCU's fraud detection and recovery efforts within Colorado's Medicaid program. Funding for the COMFCU is provided 25% from the state budget and 75% from

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

the federal government.[6] 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."[7]

## Trends

In regard to member fraud, waste, and abuse investigations, the majority of cases continue to be due to inaccurate reporting of household composition and failure to report income. These cases stem largely from fraudulent misrepresentations made on applications and intentional failure to report subsequent required changes.

Other cases involve members moving to other states without reporting their change in residency. Often these types of cases are due to confusion by members as to what changes they must report and when they must report them. For this reason, focusing on training and education remains a priority for the Department in combating member fraud, waste, and abuse.

It is clear there are cost benefits to the Department's fraud investigation efforts. Despite the significant limitations of the PHE, the Department has established an increased fraud recovery totaling **$2,367,645**, as well as non-fraud recovery totaling **$250,372**. This was while still avoiding an estimated additional **$713,050** in unnecessary costs by terminating those members whose eligibility was able to be terminated during the PHE.

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 services actually rendered. These schemes are difficult to investigate in many instances, as the potential witnesses are often patients who 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.

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[6] 42 USC 1396b(a)(2)(A).
[7] 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

We hope that the continued use 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 make it easier to both prevent and 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.[8]

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.

[8] 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 | 185,008 | 260 | 0 | 0 | 0 | 0 | 0 | $84,256.00 | 0 | 0 | 0 | 0 | 37 |
| Alamosa | 8,323 | 27 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Arapahoe | 184,264 | 12 | 0 | 0 | 0 | 2 | 0 | $368,045.81 | 0 | 0 | $145,851.13 | $110,015.28 | 0 |
| Archuleta | 4,522 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Baca | 1,622 | 8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Bent | 2,113 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Boulder | 64,585 | 196 | 1 | 0 | 0 | 0 | 0 | $180.00 | $7,473.00 | 0 | 0 | 0 | 0 |
| Broomfield | 10,054 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Chaffee | 5,030 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Cheyenne | 576 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Clear Creek | 1,877 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Conejos | 3,810 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Costilla | 2,458 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Crowley | 1,653 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Custer | 1,295 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Delta | 12,004 | 14 | 0 | 0 | 0 | 0 | 0 | $107,192.83 | 0 | 0 | 0 | 0 | 6 |
| Denver | 241,827 | 663 | 6 | 0 | 0 | 1 | 0 | $222,015.98 | $28,718.58 | $40.00 | $17,350.21 | 0 | 1 |
| Dolores | 817 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Douglas | 38,771 | 166 | 0 | 0 | 0 | 0 | 3 | $229,790.58 | 0 | 0 | $204,451.82 | 0 | 0 |
| Eagle | 9,213 | 11 | 6 | 0 | 0 | 6 | 0 | $129,061.11 | 0 | 0 | $118,988.66 | $44,617.26 | 7 |
| Elbert | 4,101 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| El Paso | 221,299 | 15 | 1 | 0 | 0 | 1 | 0 | $533,113.59 | 0 | $8,392.06 | $73,410.95 | $73,410.95 | 15 |
| Fremont | 16,516 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Garfield | 17,385 | 78 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gilpin | 1,388 | 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 › Budget Reports and Documents › Premiums, Presumptive Eligibility Expenditures and Caseload Reports. The Document is entitled Member Caseload by County – Colorado Department of Health Care Policy and Financing Medicaid Caseload Without Retroactivity by County Reporting Month Ending on 6/30/2022.

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Grand | 2,626 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gunnison | 3,898 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Hinsdale | 182 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Huerfano | 3,365 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Jackson | 332 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Jefferson | 117,333 | 157 | 2 | 2 | 0 | 3 | 3 | $137,600.73 | 0 | $4,752.50 | $19,473.06 | $74,822.18 | 0 |
| Kiowa | 530 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Kit Carson | 2,537 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| La Plata | 15,510 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Lake | 2,086 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Larimer | 82,871 | 236 | 0 | 0 | 0 | 0 | 0 | $175,719.76 | 0 | 0 | 0 | 0 | 0 |
| Las Animas | 6,911 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Lincoln | 1,804 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Logan | 6,401 | 37 | 5 | 0 | 0 | 0 | 1 | $283,688.85 | $202,891.93 | 0 | $121,963.57 | $24,892.95 | 13 |
| Mesa | 53,587 | 2 | 2 | 0 | 0 | 1 | 1 | $5,817.84 | 0 | 0 | 0 | 0 | 2 |
| Mineral | 233 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Moffat | 4,660 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Montezuma | 11,352 | 40 | 2 | 0 | 0 | 2 | 2 | $6,929.76 | $11,288.51 | 0 | $9,821.41 | $773.80 | 23 |
| Montrose | 15,478 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Morgan | 10,999 | 4 | 0 | 0 | 0 | 0 | 0 | $21,638.05 | 0 | 0 | 0 | 0 | 2 |
| Otero | 9,252 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Ouray | 889 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Park | 4,044 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Phillips | 1,280 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Pitkin | 2,054 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Prowers | 5,855 | 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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| 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 | 80,350 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Rio Blanco | 1,790 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Rio Grande | 5,170 | 1 | 0 | 0 | 0 | 0 | 0 | $1,544.07 | 0 | 0 | 0 | 0 | 1 |
| Routt | 4,058 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Saguache | 3,098 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| San Juan | 241 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| San Miguel | 1,472 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Sedgwick | 853 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Summit | 5,147 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Teller | 6,917 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Washington | 1,543 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Weld | 96,710 | 45 | 0 | 0 | 0 | 0 | 0 | $61,050.44 | $29, 691.58 | 0 | 0 | $73,893.88 | 0 |
| Yuma | 3,449 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Totals** | **1,617,378** | **1,992** | **28** | **2** | **0** | **16** | **10** | **$2,367,645.40** | **$250,372.02** | **$13,184.56** | **$711,310.80** | **$402,426.30** | **111** |

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 (7/1/2021 TO 6/30/2022)

| Type of Investigation | # of Closed Investigations | # of New Investigations |
|---|---|---|
| Fraud | 79 | 51 |
| Drug Diversion | 0 | 0 |
| Abuse, Neglect, & Financial Exploitation | 58 | 35 |
| **TOTAL** | **137** | **86*** |

* This number does not include the 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 FILED, CASES DISMISSED, CASES ACQUITTED, AND CONVICTIONS

| Criminal Complaints | Cases Dismissed | Cases Acquitted | Criminal Convictions |
|---|---|---|---|
| 8 | 0 | 0 | 15 |

### CIVIL COMPLAINTS FILED, CASES DISMISSED, AND CONFESSIONS OF JUDGMENT

| Civil Complaints | Cases Dismissed | Confessions of Judgment |
|---|---|---|
| 2 | 0 | 0 |

### CRIMINAL RECOVERIES, RESTITUTION ORDERED, AND RESTITUTION COLLECTED

| Total Criminal Recoveries | Restitution Ordered | Fines and Penalties | Restitution Collected |
|---|---|---|---|
| $383,969.17 | $383,969.17 | $750.00 | $251,039.17 |

### CIVIL RECOVERIES AND CIVIL COLLECTIONS

| Total Civil Recoveries | Principal State Recovery | Fines, Penalties, and Interest | Recoveries Collected |
|---|---|---|---|
| $1,265,801.50 | $669,527.74 | $384,395.66 | $984,854.72 |