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CRIMINAL JUSTICE SECTION
MEDICAID FRAUD

STATE OF COLORADO
DEPARTMENT OF LAW

ATTORNEY GENERAL'S REPORT TO THE LEGISLATURE REGARDING THE COLORADO MEDICAID FALSE CLAIMS ACT (C.R.S. 25.5-4-310)

The Attorney General is required by C.R.S. § 25.5-4-310 to submit an annual report to the Joint Budget Committee and to the Health and Human Services Committees of the House and Senate concerning claims under Colorado Medicaid False Claims Act. In accordance with that requirement, the Attorney General tenders this report for the State Fiscal Year that began on the 1st of July 2019 and ended on the 30th of June 2020 (SFY 2020).

First established in 1978, the Colorado Medicaid Fraud Control Unit (COMFCU) has been housed within the Attorney General's Office since 1979. COMFCU is vested with statewide jurisdiction to investigate and prosecute waste, fraud, and financial abuse committed by Colorado Medicaid providers and to investigate and prosecute the abuse, neglect, and exploitation of patients.

While there are exceptions, fraud in the Medicaid program generally falls into one of three categories: billing for services that are not provided, overbilling for services that are provided, and billing for providing services for which there is no medical necessity. The types of practitioners that commit such fraud and the schemes that they devise differ significantly. Some examples of matters investigated and prosecuted by the COMFCU include a speech therapist that billed for services over and above those actually provided to patients, a nurse practitioner that billed

Medicaid for office visits used to dispense opioids when there was no medical necessity for the drugs, and a home health corporation that billed for providing in-home services to patients when this was not occurring.

In some instances, fraudulent actions taken by Medicaid providers do not fit within the Colorado criminal statutes and absent another remedy, Colorado would not be able to recover dollars unlawfully taken from the Medicaid program. The Colorado False Claims Act, C.R.S. § 25.5-4-305, is a powerful tool that allows the COMFCU to pursue fraud and overpayments in the civil arena.

As a result of an impaired funding model and the resulting staffing levels, while the COMFCU received 312 new case referrals during this review period, 70 of those matters remained queued for a preliminary investigation to determine whether a formal investigation should be opened by the Unit. After a preliminary investigation, the Unit opened 166 new cases for formal investigation, of which 80 were criminal and 86 were civil cases. During SFY 2020, the COMFCU filed 16 criminal cases, prosecuted 13 defendants that were sentenced in criminal court and settled 24 civil cases.

As a result of its work, the COMFCU recovered $4.63 million for the State of Colorado, with $1.05 million of the total the direct result of criminal prosecutions and the remaining $3.58 million a result of work under the Colorado False Claims Act. Of that figure, $3.08 million was recovered in multi-state civil matters, while $494,326.07 was recovered in local civil matters. During SFY 2020, the COMFCU was able to collect $1.65 million of that sum and while no litigation costs were recovered, it should be noted that $1.67 million of the $3.58 million recovered under the Colorado False Claims Act consisted entirely of penalties that were assessed against providers. The State of Colorado did not incur extraordinary expenses for investigation or litigation of any matters during SFY 2020. The time spent by salaried investigators and attorneys to investigate civil cases would be difficult to determine

because cases often begin as criminal investigations before being reclassified as a civil inquiry, while others may be shared between criminal and civil groups.

Using the Colorado False Claims Act, the COMFCU continues its active work in both Colorado cases and interstate federal court cases. It should be noted that of the 24 settled civil cases, 8 of them involved Colorado based Medicaid providers. As a result of those settlements, the Colorado Attorney General's Office did not file any civil actions under the False Claims Act during the reporting period, though COMFCU is currently preparing several civil matters for filing.

Additionally, Colorado is currently seeking recovery under 58 new federal court cases that were served on the state by *qui tam* relators, in which Colorado was named as a plaintiff. During SFY 2020, Colorado also participated in the settlement of 16 *qui tam* cases in federal courts with other states. These cases likely would not have been pursued in the absence of the False Claims Act. These settlements produced the appropriate result without the need for initiating civil litigation.

Summary

During SFY 2020, the COMFCU opened 80 new criminal investigations, 86 new civil investigations, filed 16 criminal cases, settled 24 civil cases, and obtained 16 criminal convictions of providers related to Medicaid fraud and patient abuse. Though there were COVID-19 related hurdles in place for last quarter of SFY 2020, COMFCU recovered over $4.63 million for the State of Colorado, an amount that again this year is many multiples higher than Colorado's spending to fund the Unit. This clearly demonstrates the cost effectiveness of the Unit.

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.[1]

It is reasonable to believe that if Medicaid providers responsible for improper billings had not been identified, then the fraudulent activity would have continued and the losses to the Medicaid program would have been far higher than the amounts that were recovered. The Legislature's appropriation has been used effectively as measured by the monetary value returned to the State and a reduction in fraud within the Medicaid program. The COMFCU and the Attorney General's Office continue to diligently pursue providers who commit fraud and financial abuse against the State's Medicaid program.

FOR THE ATTORNEY GENERAL,

Robert James Booth II
Assistant Deputy Attorney General
Director, Medicaid Fraud Control Unit

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[1] The statistical data listed in the paragraph is from the HHS-OIG's Federal Fiscal Year reporting period that occurs from October 1st to September 30th of each year. 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 Years 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.

COMFCU Investigations During SFY 2020

Reporting Period of July 1, 2019 to June 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**

Criminal Actions

Complaints Filed	Criminal Convictions	Restitution Ordered	Restitution Collected
16	13	$1,054,476.73	$44,407.11 [2]

Civil Actions

Complaints Filed	Judgments & Settlements	Multi-State Settlements	Civil Recoveries	Recoveries Collected
0	8	16	$3,583,907.43	$1,608,870.19

[2] It should be noted that in criminal matters, the Court generally establishes repayment guidelines for the defendant after their conviction. As a result, all COMFCU collection activities over and above those guidelines held in abeyance until such time as the defendant has completed repayment or there has been a violation of the guidelines.