2018 - 2019 Annual Report

Colorado Medicaid Fraud Control Unit

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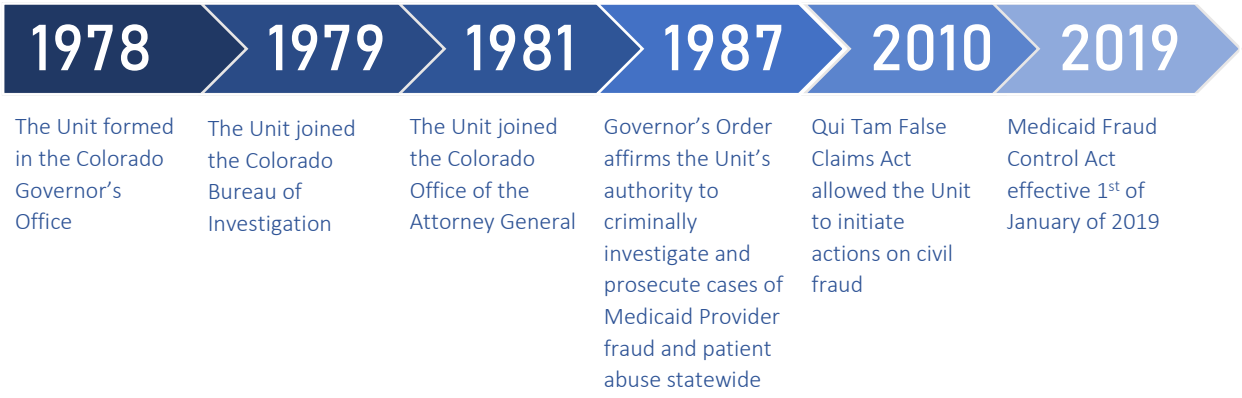
COLORADO MEDICAID FRAUD CONTROL UNIT



Medicaid was created in 1965 to provide healthcare to those without the means to do so based upon their income, assets, or status such as significant medical, physical, or mental disability. The State of Colorado spends approximately $9.3 billion per year on Medicaid, an amount that comprises almost 25 percent of the State's annual budget and permits coverage for approximately one out of every five residents of Colorado.

In 1978, in conformance with 42 USC § 1396a (a)(61) which requires states to operate a Medicaid Fraud Control Unit ("MFCU") to receive federal funds for their Medicaid program, the Colorado Medicaid Fraud Control Unit ("COMFCU" or "the Unit") was formed. Since its inception, the Unit has operated in accordance with Pub. L. 95-142. The goal of that act was to strengthen the capability of the government to detect, prosecute, and punish fraudulent activities under the Medicare and Medicaid programs. To accomplish this goal, federal funding was authorized for state MFCUs to support the investigation and prosecution of fraud in state Medicaid programs administered under Title XIX of the Social Security Act of 1965.

The COMFCU was initially organized within the Governor's Office, but in 1979, it was transferred to the Colorado Bureau of Investigation (CBI). In 1981, CBI's authority to investigate Medicaid fraud matters was terminated, and on the 1st of July of that same year, the COMFCU moved to the Colorado Attorney General's Office. In March of 1987, Governor Roy Romer, exercising the authority granted by C.R.S. § 24-31-101(a), which provides that the Colorado Attorney General

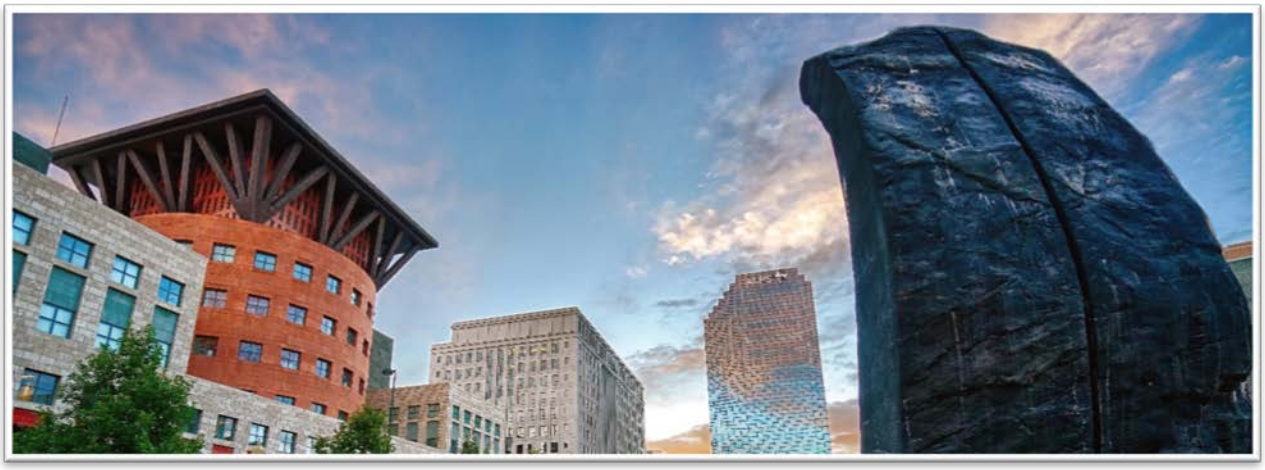
"The Colorado Medicaid Fraud Control Unit is dedicated to the investigation and prosecution of Medicaid provider fraud and to the investigation and prosecution of the abuse and neglect of the most vulnerable Coloradans."

"shall appear for the state and prosecute and defend all actions and proceedings, civil and criminal, in which the state is a party or is interested when required to do so by the governor" issued Executive Order 1787. This executive order approved the continuation of the Colorado Medicaid Fraud Control Unit within Attorney General's Office and "require[d] the Attorney General to investigate and prosecute Medicaid fraud and patient abuse cases as either the Attorney General, or when so designated, as a Special Deputy District Attorney." As a result, the COMFCU was granted both statewide jurisdiction and the ability to partner with District Attorneys across the state in the investigation and prosecution of cases.

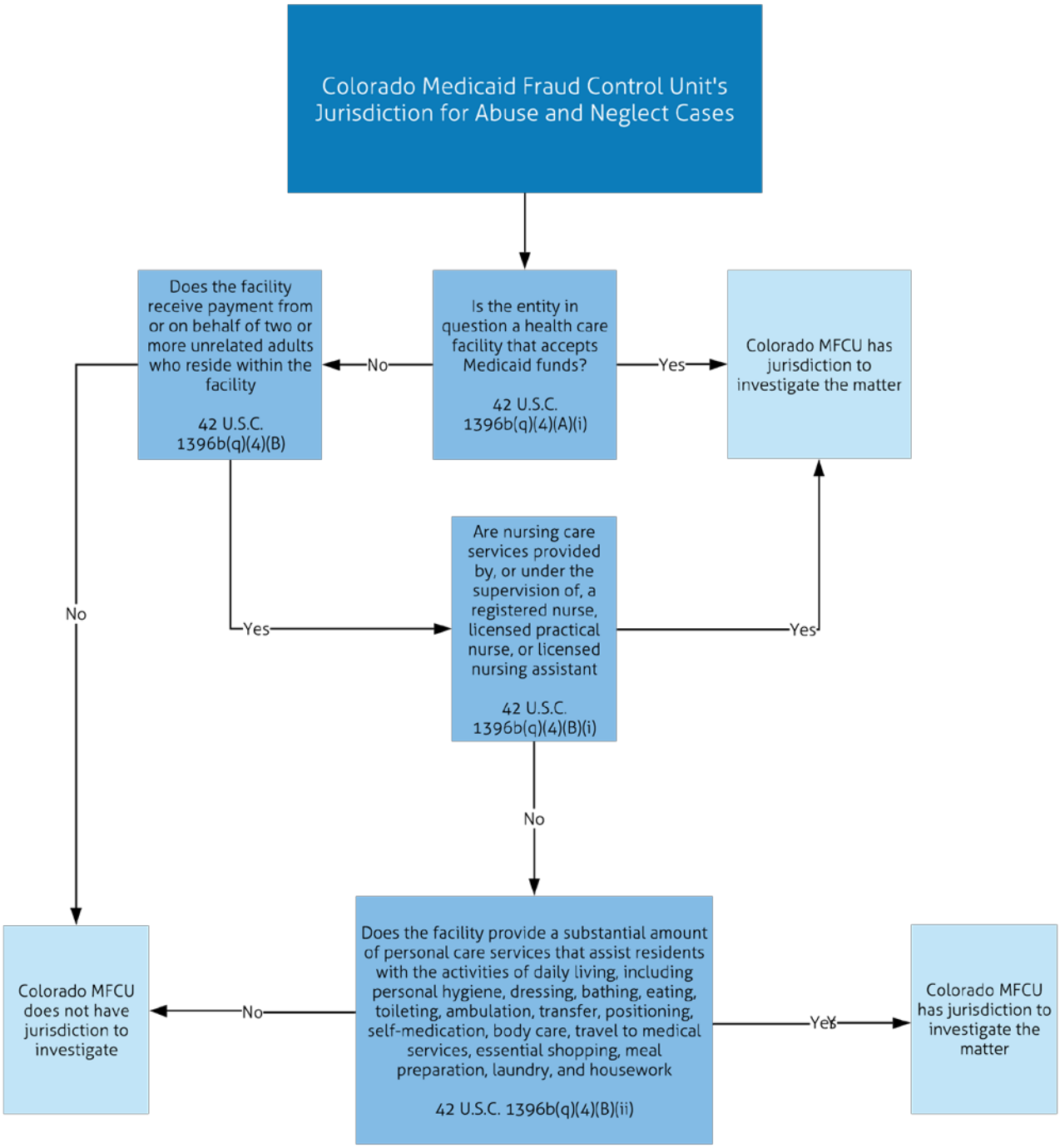
The Unit recovered $23.69 million and collected $3.57 million in civil & criminal actions during this reporting period.

In 2010, with the enactment of C.R.S. § 25.5-4-303.5 et seq., the COMFCU was vested with additional authority that authorizes the Unit to investigate and bring civil actions against parties believed to have filed false claims with the Colorado Medicaid program. The COMFCU continued to operate under Executive Order 1787 until the 1st of January of 2019. Since that time, the Unit has operated under the authority of the Medicaid Fraud Control Act, C.R.S. § 24-31-801 et seq.

Under the Medicaid Fraud Control Act, the COMFCU continues to be part of the Colorado Attorney General's Office and has authority to prosecute individuals for violations of criminal laws with respect to fraud in the provision or administration of medical assistance under the Colorado Medicaid program. Pursuant to the same authority, the COMFCU investigates and prosecutes those who abuse, neglect, or financially exploit patients in any facility that accepts Medicaid funds. The Unit also investigates physical and financial abuse and exploitation in board and care facilities regardless of funding.



JURISDICTION FOR ABUSE & NEGLECT CASES



MISSION

Tasked with auditing, investigating, and prosecuting Medicaid provider fraud and patient abuse, the COMFCU operates in accordance with C.R.S. § 24-31-801 et seq., C.R.S. § 25.5-4-303.5 et seq., 42 U.S.C. § 1396b(q), 42 C.F.R. § 1007.1 et seq., and 42 C.F.R. § 455 et seq. As a result, the COMFCU generally pursues three categories of cases:

COLORADO ATTORNEY GENERAL
PHIL WEISER

1. **Fraudulent conduct by Medicaid providers and individuals involved with providing Medicaid services.**

2. **The abuse, neglect, and exploitation of individuals in health care facilities that receive Medicaid funds or in board and care facilities.**

3. **The recovery of Medicaid overpayments identified in the investigation of fraud, patient abuse and neglect, and financial exploitation of clients.**

The COMFCU maintains a strong commitment to ensuring that Coloradans have access to the highest quality care from dedicated providers while continuing to take an aggressive approach to reducing Medicaid fraud and patient abuse across the state.

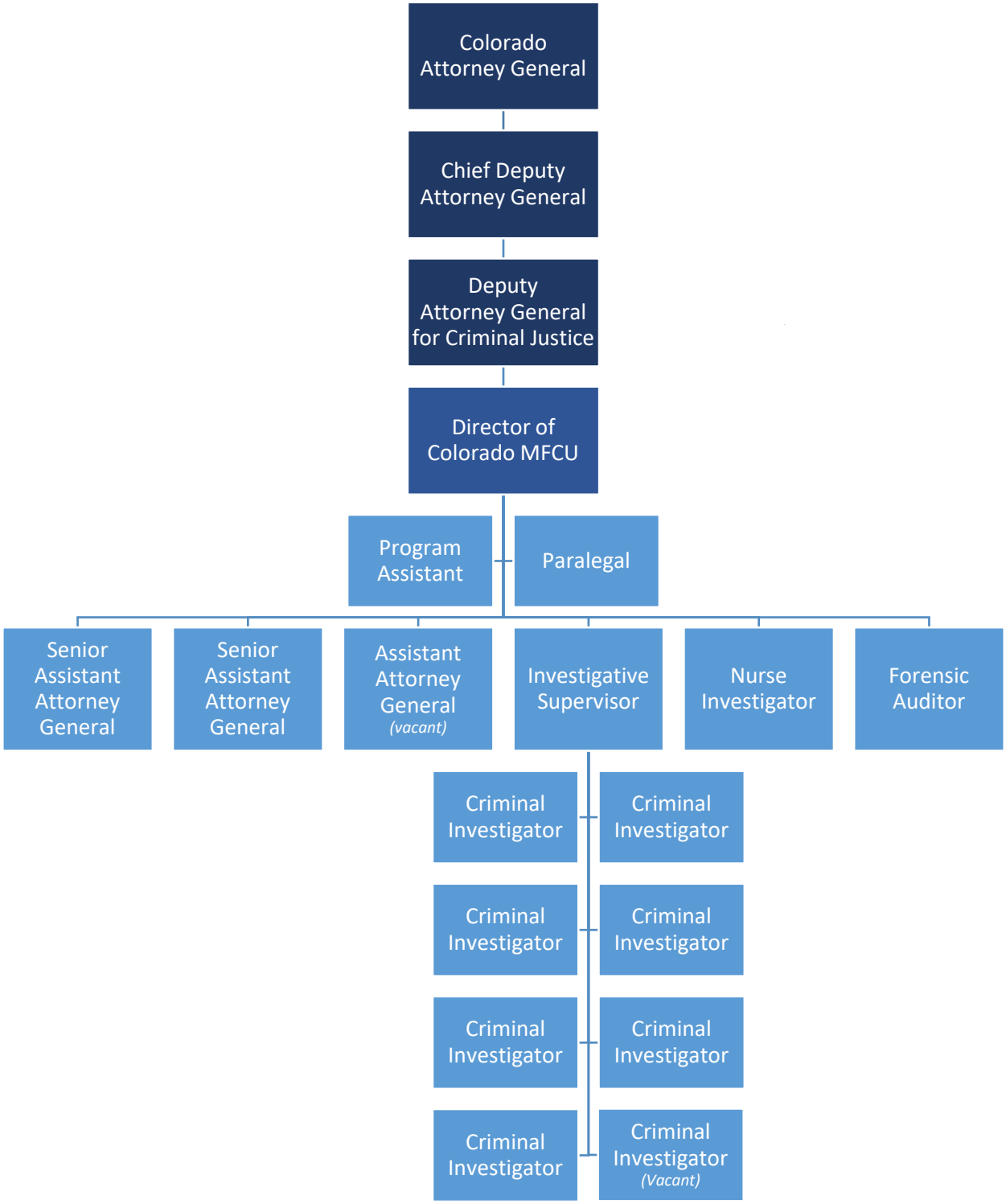
In instances when the COMFCU determines that civil or criminal actions are not possible, the Unit will refer the matters to other agencies, such as the Colorado Department of Health Care Policy and Financing or U.S. Department of Health and Human Services – Office of the Inspector General (HHS-OIG). The COMFCU has procedures in place for referrals and maintains a record of complaints received and actions taken.

STAFFING

Housed within the Criminal Justice Section of the Colorado Attorney General's Office, the COMFCU is staffed with a Director, two Attorneys, an Investigative Supervisor, six Fraud Investigators, an Abuse Investigator, a Nurse Analyst, a Forensic Auditor, a Paralegal, and a Program Assistant.

The Director and Investigative Supervisor have the responsibility for the day-to-day operation of the Medicaid Fraud Control Unit. This includes oversight of all investigations, contacts with other agencies, civil and criminal filing decisions, the management of cases through trial, plea and/or sentencing, grand jury investigations and indictments, and fiscal management of the COMFCU's budget and expenditures.

ORGANIZATIONAL CHART



NOTABLE CASES

The People of the State of Colorado v. Tara Leigh Rose

On the 15th of November 2018, Tara Leigh Rose, a Speech Pathologist and the owner of Beyond Words, LLC pled guilty to one count of Class 3 felony Theft and one count of Class 4 felony Theft. An investigation by the COMFCU determined that $1.28 million or 67% of the $1.9 million in funds that Rose had receive for treating minors over a six-year period was based upon the submission of billing claims that were deceptive and fraudulent. Rose submitted Medicaid billing and received funds for patient treatment sessions that did not occur. Many of those patients had no relationship with Rose and did not know who she was. When Rose did see patients, she submitted billing indicating that she provided more extensive treatments than what was actually provided and that treatment sessions were provided more frequently than they occurred. The parties argued sentencing before the Court and Rose was sentenced to a term of eight (8) years in Colorado Community Corrections on the first charged count and to a ten (10) year term of probation on the second charged count, which will run consecutive to the first. Rose was also ordered to pay $1.28 million in restitution to the Colorado Medicaid program.

The People of the State of Colorado v. Victor Gab-Ojukwu

On the 23rd of January 2019, Victor Gab-Ojukwu, the owner of home health care provider CareProx LLC., pled guilty to one count of Class 3 felony Theft and one count of Class 3 misdemeanor Theft. An investigation by the COMFCU determined that Gab-Ojukwu had billed the Colorado Medicaid program for $44,490 in services that simply were not provided to Medicaid patients. When Medicaid patients did receive services, the frequency and duration of those services were inflated for Medicaid billing purposes. As a result of this fraudulent billing, individuals were not able to obtain Medicaid services as the program initially believed that the patients had used all of their allotted hours for care. Gab-Ojukwu was sentenced to three (3) years of supervised probation, ordered to pay restitution to the Colorado Medicaid program equal to the full amount of fraudulent billing, and ordered to complete 200 hours of useful public service.

The People of the State of Colorado v. Victoria Pletting

On the 12th of March 2018, Victoria Pletting, a former caregiver at Wheat Ridge Regional Center, pled guilty to the Class 5 felony Criminally Negligent Homicide. The victim, a resident of the facility, was diagnosed with developmental disabilities, a severe seizure disorder, and dysphagia which resulted in him receiving all of his nourishment from a G-tube. The patient had a tendency to pull out his G-tube which necessitated medical care. Supervision protocols required staff to maintain line-of-sight supervision of the patient at all times while he was awake. Despite these requirements, Pletting left the patient unattended in a bathtub where his partially submerged lifeless body was later discovered. The Coroner's Office determined that the cause of death was

drowning which may have been precipitated by a seizure. During the investigation of this matter, Pletting admitted that despite being aware of the line-of-sight supervision requirements, she had left the victim unattended in the bathtub eight or nine times previously. On the 4th of June 2018, the parties argued sentencing before the Court and Pletting was sentenced to five (5) years of probation paired with one (1) year of jail time with all but the two days she'd previously spent in jail after her arrest suspended.

The People of the State of Colorado v. Roxanne Ousley

On the 11th of October 2018, Roxanne Ousley, a former caregiver at Ashley Manor, an assisted living facility, pled guilty to the Class 5 felony Negligence Causing Serious Bodily Injury to an At-Risk Individual. The defendant was one of the caregivers on duty on the 15th of June 2016 when a 93 year-old resident was left unattended outside of the facility for three hours. During that time, the resident who was blind in one eye, suffered from severe dementia and had mobility issues, fell into a rock bed. Over a three hour period, security cameras captured the victim's attempts to get out of the rock bed before she finally succumbed to heatstroke and passed away. Ousley faced reduced charges due to the limited amount of time that she was present at the facility during the events of that day. Ousley was sentenced on the 30th of November 2018 to two (2) years of probation and cannot be employed or participate in caring for the elderly or developmental disabled persons. Her co-defendant is discussed in the pending cases portion of this report.

The People of the State of Colorado v. Elizabeth Sharkey

On the 30th of April 2018, Elizabeth Sharkey, a former employee of Comfort Dental, pled guilty to the Class 4 felony Identity Theft and the Class 1 misdemeanor Second Degree Forgery. An investigation by the COMFCU determined that on three different occasions when the Dentist was out of the office, Sharkey wrote Oxycodone prescriptions in her name and her parents' names. Sharkey would then forge the Dentist's signature on the prescriptions and fill those prescriptions at local pharmacies using both her and her parent's Medicaid ID's. Sharkey was sentenced to a four (4) year deferred judgment on the felony, one (1) year of probation on the misdemeanor, and ordered to complete 250 hours of useful public service.

The People of the State of Colorado v. Havana Pharmacy & Medical Supply and George Sackey

On the 30th of January 2019, the Arapahoe County District Court entered judgment in favor of the State of Colorado and against George Sackey and his company, Havana Pharmacy. Sackey, a licensed pharmacist, created a branded pain cream called "Havana Pain Cream" and provided physicians with pre-printed prescription forms to order this cream for their patients. Two of the primary ingredients for the cream were Ketoprofen and Lidocaine. Between the 7th of January 2014 and the 6th of February 2017, Havana Pharmacy billed Medicaid for $2,435,070 in Ketoprofen tablets and $1,967,125 in Lidocaine Ointment. These amounts made Sackey's pharmacy major outliers in Medicaid billing, as larger pharmacy chains were averaging approximately $20,000 -

$50,000 in billing for those pharmaceuticals during the same time period. While Sackey billed Medicaid for Lidocaine ointment and Ketoprofen tablets to make the compounds, he used the bulk powder form of the substances to create the branded pain cream, significantly increasing his profit margin while defrauding the Medicaid program. The judgment of $14,181,349 is the largest recovery in the history of the Colorado MFCU. In addition to the funds taken, the judgment amount includes false claims damages, penalties, and interest.

Billing for Deceased Medicaid Clients

The COMFCU is continuing with its investigation of provider claims submitted after the deaths of Medicaid clients. The investigation by the COMFCU has shown that some providers continued to bill the program for services or supplies for deceased clients, which is prohibited by Medicaid rules. This past year, COMFCU has settled such claims with several providers. For the providers that have claimed that the improper billing was due to an error or the failure to terminate continuing rentals, such as for oxygen equipment, the COMFCU has begun to obtain corporate integrity agreements from the offending providers. These agreements require that the providers implement business practices to verify clients and assure communication across departments to prevent improper billing. It is hoped that these settlements and integrity agreements will result in a shift within the provider community and an overall reduction of such billing going forward.

GLOBAL CASES

The United States of America v. Kmart Corporation
Southern District of Illinois

In this global *qui tam* matter, the state and federal investigation revealed that Kmart had an extensive discount program offering cash-paying pharmacy customers low drug prices. Instead of charging Medicaid and other government programs the same prices that is was offering to the "general public," it instead charged multiples of the prices resulting in a substantial number of false claims submitted to the programs.

Total Colorado recovery: $435,624.95

The United States of America v. Walgreens Boots Alliance, Inc. and Walgreens Corporation
Southern District of New York

The COMFCU joined in these settlements following an extensive investigation revealing that Walgreens enrolled millions of people nationwide in a prescription savings card (PSC) program. This enrollment to allowed customers to pay substantially lower prices for certain drugs than Walgreens charged the federal programs. As in the Kmart case, these widespread prices became "usual and customary" and therefore should have been charged to Medicaid and other programs.

The second Walgreens case involved insulin injection pens that contained varying amounts of insulin depending upon the patient's needs and the associated prescription. The pens were packaged and shipped to Walgreens with multiple pens in a box. The process of opening and partially dispensing the contents is commonly referred to as "breaking the box." When a Medicaid patient presented Walgreens with a prescription for insulin pen(s), the quantity needed would not always match the number of pens in a box. When such a situation arose, Walgreens would falsify the dispensing data that they submitted to the Medicaid program. This allowed Walgreens to provide the patient with the entire box of insulin pens and bill the Medicaid program for the entire box of pens, even though the patient may only have needed one or two. Walgreens' practice of not "breaking the box" was not justified as a consumer safety issue and the company conceded that they did dispense partial boxes when billing private insurers.

Total Colorado recovery: $5,858,082.79

The United States of America v. Alere San Diego
District of Maryland

A COMFCU attorney led the national team that negotiated and facilitated the federal *qui tam* settlement with Alere. The company produced and sold various point of care (POC) emergency room triage devices for early detection of cardiac and pulmonary emergencies and for toxicological evaluation, whose accuracy did not comply with the accuracy levels that were required in the FDA approval of the tests. This caused a risk of potential of harm to patients and unnecessary care and expense.

Total Colorado recovery: $143,944.79

The United States of America v. Amerisource Bergen Corporation
Eastern District of New York

In December of 2018, the COMFCU settled three interstate cases against pharmaceutical manufacturer Amerisource Bergen (ASB) resolving claims that ASB pooled vials of various oncology drugs to create prefilled syringes. Packaging the syringes in this manner would allow ASB to sell more of the drugs to providers without reporting the extra sales. Further, these "adulterated" drugs were not approved in the dose and format in which they were distributed and sometimes contained foreign matter and/or biologics after being transferred to the syringes.

Total Colorado recovery: $1,009,527.80

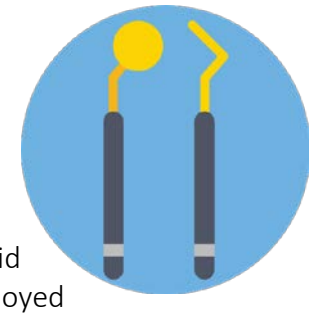
PENDING CRIMINAL CASES

In accordance with rules 3.6 and 3.8 of the Colorado Rules of Professional Ethics, limited information can be shared regarding the below cases. The fact that a defendant has been charged with a crime is merely an accusation and the defendant is presumed innocent until and unless proven guilty.

The People of the State of Colorado v. Deidre Lopez

Deidre Lopez, a former caregiver at Ashley Manor, an assisted living facility, was one of the caregivers on duty on the 15th of June 2016 when a 93 year old resident was left unattended outside of the facility for three hours. During that time, the resident who was blind in one eye, suffered from severe dementia and had mobility issues, fell into a rock bed. Over a three hour period, security cameras captured the victim's attempts to get out of the rock bed before she finally succumbed to heatstroke and passed away. Lopez has been charged with the Class 4 felony Negligent Death of an At-Risk Person, the Class 4 felony Manslaughter, and the Class 4 felony Attempt to Influence a Public Servant. The matter is currently set for trial.

The People of the State of Colorado v. John Trahan



On the 26th of March 2019, John Trahan, the owner of America's Children Dental Clinic (ACDC), was charged with one count of Class 3 felony Theft and two counts of Class 3 felony Computer Crimes. Trahan is accused of fraudulently obtaining over $400,000 in funds from the Colorado Medicaid program between 2013 and 2016. Trahan, who is not a dentist, employed licensed dentists to provide services to Medicaid patients. It is alleged that Trahan routinely billed the Medicaid program for services that ACDC did not provide to patients and submitted billing indicating that work was performed by dentists that at one point worked for ACDC but were no longer employed by the practice.

The People of the State of Colorado v. Daniel Lira

On the 27th of March 2019, Daniel Lira, was charged with two counts of the Class 2 felony Sexual Assault of an At-Risk Person and two counts of the Class 6 felony Unlawful Sexual Contact of an At-Risk Person. Daniel Lira was previously employed as a caregiver in a group home where it is alleged that between January and November of 2018, he repeatedly sexually assaulted a wheelchair bound resident of the facility who suffered from cerebral palsy.

ACTIVITIES AND COMMUNITY OUTREACH

Partnerships

The COMFCU and the Colorado Department of Public Health and Environment (CDPHE), the entity responsible for licensing and monitoring long-term care facilities, clinics, and hospitals in Colorado have a very strong relationship. This resulted in the parties entering into a Memorandum of Understanding (MOU) in August of 2017. Under the terms of the MOU, CDPHE reports all potential mistreatment and findings of mistreatment, suspected fraud and findings of fraud, as well as all complaints regarding potential abuse or fraud to the COMFCU. The MOU also authorizes the Unit receive and review Occurrence Reports from CDPHE. During the reporting period, the COMFCU reviewed 7,784 Occurrence Reports to determine potential patient abuse and neglect that merited additional investigation. These reports in many instances detailed alleged acts of physical abuse, sexual abuse, financial exploitation, threatened abuse, and criminal neglect.

The COMFCU also partners with and reviews disciplinary actions taken by the Colorado Department of Regulatory Agencies (DORA) on a regular basis. The evaluation determines whether the actions taken by a licensed medical provider that resulted in a disciplinary action merit COMFCU investigation. Likewise, when a COMFCU investigation uncovers wrongdoing by a Medicaid provider, those actions are forwarded to DORA for investigation.

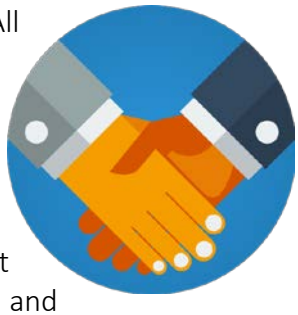
Further, the COMFCU collaborates with officials of the state's Long-Term Care Ombudsman Act program. The Ombudsmen assist patients and residents of nursing homes and other long-term care facilities in asserting their civil, legal, and human rights. With their wealth of information about patient care in these facilities, the COMFCU encourages information sharing and referral of allegations of patient abuse for possible criminal investigation. These collaborative efforts against health care fraud and patient abuse have been an unquestioned success and have had a significant impact on preserving the integrity of the Medicaid program in the State of Colorado.

The COMFCU is a member of the Special Investigations Unit Working Group. The group brings together state and federal healthcare agencies as well as private health insurance entities to discuss health care fraud issues, coordinate investigations, and facilitate information sharing on health care fraud trends.

Additional partnership efforts taken by the COMFCU to further its mission include coordination and meetings with the Department of Health Care Policy and Financing - Program Integrity Section, the U.S. Department of Health and Human Services – Office of the Inspector General, the Colorado Department of Public Health and Environment, the state's Long-Term Care Ombudsman Act program members, as well as local FBI and DEA offices.

Assistance to Other Medicaid Fraud Control Units

The Colorado Medicaid Fraud Control Unit responds to and complies with requests from other state MFCUs and National Association of Medicaid Fraud Control Units (NAMFCU) teams concerning substantive or procedural business in the State of Colorado. All members of the COMFCU place a high priority on immediately responding to and fulfilling all requests for assistance made around the country.



COMMUNITY OUTREACH

Members of the Medicaid Fraud Control Unit have been invited to present to government agencies, local law enforcement, health care groups, and community groups regarding the mission of COMFCU. The Unit also provides law enforcement and civilians with the tools to assist them in identifying possible incidents of Medicaid fraud and incidents of abuse, neglect, and exploitation of Colorado's most vulnerable citizens. The COMFCU continues to engage in substantial efforts to provide public and provider education about the Colorado Medicaid program, elder abuse issues, national health care fraud issues, and specific provider-oriented education efforts.

During the past year, the COMFCU presented trainings for several organizations across the state, including the Victim Advocate Academies in Boulder and Broomfield counties, National Association of Medicaid Fraud Control Units, Colorado Adult Protection Services, Colorado Commission on Aging, Jefferson County TRIAD, Colorado Coroner's Association, Colorado Coalition for Elder Rights and Abuse Prevention, and the Colorado Homicide Investigator's Association. The following chart reflects some of the outreach activities, in which the COMFCU's staff presented.

Outreach Topic	Staff	Date(s)
DEA DI Academy #50 - Intro to MFCU/Deconfliction	Senior Assistant Attorney General and Investigator	4/2/2018
Homicide Investigations in Facilities	Abuse Investigator	4/4/2018
Elder Abuse and Domestic Violence	Abuse Investigator	4/10/2018
MFCU History and Abuse & Neglect Cases	Abuse Investigator	4/12/2018

Outreach Topic	Staff	Date(s)
Homicides in Plain Sight	Abuse Investigator	6/8/2018
Indicators of Elder Abuse and the MFCU	Abuse Investigator	6/11/2018
Indicators of Elder Abuse and the MFCU	Abuse Investigator	6/12/2018
Indicators of Elder Abuse and the MFCU	Abuse Investigator	6/13/2018
Indicators of Elder Abuse and the MFCU	Abuse Investigator	6/19/2018
Indicators of Elder Abuse and the MFCU	Abuse Investigator	6/20/2018
Indicators of Elder Abuse and the MFCU	Abuse Investigator	6/21/2018
MFCU History and Abuse & Neglect Cases	Abuse Investigator and Director	6/27/2018
MFCU History, Mission, and Updates	Senior Assistant Attorney General	8/2/2018
Interviewing People with Disabilities	Abuse Investigator	8/8/2018
Investigating Abuse and Homicides in Facilities	Abuse Investigator	8/14/2018
MFCU History and Abuse & Neglect Cases	Abuse Investigator	10/22/2018
MFCU History and Mission	Abuse Investigator and Director	11/8/2018
Interviewing People with Disabilities	Abuse Investigator	11/13/2018
Deconstructing At-Risk Abuse and Neglect	Abuse Investigator	12/5/2018
MFCU History and Abuse & Neglect Cases	Abuse Investigator	1/8/2019
MFCU History and Abuse & Neglect Cases	Abuse Investigator	1/16/2019
MFCU History and Abuse & Neglect Cases	Abuse Investigator and Director	1/24/2019
Deconstructing At-Risk Abuse and Neglect	Abuse Investigator	2/19/2019

INVESTIGATIVE STATISTICS

The Colorado Medicaid Fraud Control Unit is dedicated to the investigation of Medicaid fraud and any allegations of patient abuse & neglect of at-risk individuals.

Case Type	Open Cases (as of 3/31/2018)	New Cases	Closed Cases	Open Cases (as of 4/1/2019)
Fraud	362	156	78	356
Abuse	28	22	5	38
Total	**390**	**178**	**83**	**394**

Case Type	Criminal Actions Filed	Criminal Convictions	Civil Actions	Investigated but Not Prosecuted due to Insufficient Evidence
Fraud	11	8	35	60
Abuse	1	2	0	6
Total	**12**	**10**	**35**	**66**

FRAUD: Facility Based – Inpatient and/or Residential	Opened	Closed	Currently Open
1.01 Assisted Living Facility	4	2	3
1.02 Developmental Disability Residential Facility	0	0	0
1.03 Hospice	0	2	1
1.04 Hospital	7	2	12
1.05 Inpatient Psychiatric Services for Individuals < 21 Age	0	1	1
1.06 Nursing Facility	2	2	11
1.07 Other Inpatient Mental Health Facility	0	0	0
1.08 Other Long-Term Care Facility	0	0	1
TOTAL	13	9	29

FRAUD: Facility Based – Outpatient and/or Day Services	Opened	Closed	Currently Open
2.01 Adult Day Center	0	0	1
2.02 Ambulatory Surgical Center	1	0	1
2.03 Developmental Disability Facility (Non-Residential)	0	0	0
2.04 Dialysis Center	0	0	5
2.05 Mental Health Facility (Non-Residential)	0	0	0
2.06 Substance Abuse Treatment Center	2	0	2
2.07 Other Facility (Non-Residential)	0	1	1
TOTAL	3	1	10

FRAUD: Physician (MD/DO) By Medical Specialty	Opened	Closed	Currently Open
3.01 Allergist / Immunologist	0	0	0
3.02 Cardiologist	0	0	0
3.03 Emergency Medicine	1	0	1
3.04 Family Practice	0	0	1
3.05 Geriatrician	0	0	0
3.06 Internal Medicine	0	0	0
3.07 Neurologist	0	0	0
3.08 Obstetrician/Gynecologist	0	2	0
3.09 Ophthalmologist	0	0	0
3.10 Pediatrician	0	0	2
3.11 Physical Medicine and Rehabilitation	0	0	0
3.12 Psychiatrist	0	0	0
3.13 Radiologist	0	0	0
3.14 Surgeon	1	0	2
3.15 Urologist	0	0	0
3.16 Other MD / DO	1	3	10
TOTAL	3	5	16

FRAUD: Licensed Practitioners	Opened	Closed	Currently Open
4.01 Audiologist	0	0	0
4.02 Chiropractor	0	0	0
4.03 Clinical Social Worker	0	0	0
4.04 Dental Hygienist	0	0	0
4.05 Dentist	8	0	15
4.06 Nurse (LPN, RN, or Other Licensed)	6	0	6
4.07 Nurse Practitioner	0	0	1
4.08 Optometrist	0	0	1
4.09 Pharmacist	0	0	0
4.10 Physician Assistant	0	0	1
4.11 Podiatrist	0	0	1
4.12 Psychologist	4	0	4
4.13 Therapist (Non-Mental Health) PT, Speech, OT, RT	9	2	15
4.14 Other Practitioner	4	0	4
TOTAL	31	2	48

FRAUD: Other Individual Providers	Opened	Closed	Currently Open
5.01 EMT / Paramedic	0	0	0
5.02 Nurse's Aide (CNA or Other)	2	1	2
5.03 Optician	0	0	0
5.04 Personal Care Services Attendant	9	3	13
5.05 Pharmacy Technician	0	0	0
5.06 Unlicensed Counselor (Mental Health)	0	0	1
5.07 Unlicensed Therapist (Non-Mental Health)	0	0	0
5.08 Other Individual Providers	7	6	12
TOTAL	18	10	28

FRAUD: Medical Services	Opened	Closed	Currently Open
6.01 Ambulance	0	0	0
6.02 Billing Services	2	0	3
6.03 Durable Medical Equipment (DME)	19	20	44
6.04 Home Health Agency	4	3	4
6.05 Lab (Clinical)	2	1	11
6.06 Lab (Radiology and Physiology)	0	0	1
6.07 Lab (Other)	2	0	2
6.08 Medical Device Manufacturer	5	1	21
6.09 Pain Management Clinic	0	0	1
6.10 Personal Care Services Agency	1	2	3
6.11 Pharmaceutical Manufacturer	34	17	94
6.12 Pharmacy (Hospital)	0	0	0
6.13 Pharmacy (Institutional Wholesale)	3	3	8
6.14 Pharmacy (Retail)	10	3	26
6.15 Transportation (Non-Emergency)	0	0	0
6.16 Other Medical Services	3	0	5
TOTAL	85	50	223

FRAUD: Program Related	Opened	Closed	Currently Open
7.01 Managed Care Organization (MCO)	0	1	1
7.02 Medicaid Program Administration	0	0	0
7.03 Other Program Fraud	1	0	1
TOTAL	1	1	2

ABUSE AND NEGLECT (Including Patient Needs Funds)	Opened	Closed	Currently Open
8.01 Assisted Living Facility	5	2	9
8.02 Developmental Disability Facility Setting (Residential)	3	2	4
8.03 Hospice	0	0	0
8.04 Non-Direct Care	0	0	0
8.05 Nurse's Aide (CNA or Other)	0	0	0
8.06 Nursing Facility	15	1	22
8.07 Personal Care Aide or Other Home Care Aide	0	0	0
8.08 Licensed Nurse (RN, LPN, PA, NP)	0	0	0
8.09 Other Abuse and Neglect	1	0	3
TOTAL	24	5	38

Abuse and Neglect Complaints Received	Abuse and Neglect Complaints Investigated	Abuse and Neglect Complaints Referred
22	28	5

RECOVERIES AND COLLECTIONS

CRIMINAL

Case Type	Criminal Actions	Restitution Ordered	Other Monetary Payments	Total Days (Jail)	Total Months (Probation)	Total Hours (UPS)
Fraud	8	$1,396,449.91	$19,736.50	3,130	372	750
Abuse	2	$0	$5,144	365	84	60
Total	**10**	**$1,396,449.91**	**$24,880.50**	**3,495**	**456**	**810**

CIVIL

Case Type	Civil Actions	Recoveries to the Medicaid Program	Other Recoveries	Total Civil Recoveries
Global	13	$3,887,398.78	$3,705,334.18	$7,592,732.96
Non-Global	22	$4,478,713.64	$10,227,689.73	$14,706,403.37
Total	**35**	**$8,366,112.42**	**$13,933,023.91**	**$22,299,136.33**

COLLECTIONS

Criminal Overpayments Collected	Civil Overpayments Collected	Total Civil and Criminal Collections
$89,113.02	$3,482,906.35	$3,572,019.37

The Unit refers actions to the State Medicaid Agency but does not track recoveries or overpayments by the agency.

PROJECTIONS FOR APRIL 1, 2019 TO MARCH 31, 2020

Projected Number of Cases Prosecuted or Referred for Prosecution	Projected Number of Cases Resolved in Settlement or Conviction	Projected Number of Cases Investigated but Not Prosecuted Due to Insufficient Evidence
10	50	100

Projected Number of Recovery Actions Initiated by Unit	Projected Number of Recovery Actions Referred to Another Agency	Projected Total Amount of Overpayments Identified	Projected Total Amount of Overpayments Collected
55	0	$1,000,000	$650,000

FRAUD: Facility Based – Inpatient and/or Residential	Projected Opened	Projected Closed	Projected End
1.01 Assisted Living Facility	4	2	7
1.02 Developmental Disability Residential Facility	0	0	0
1.03 Hospice	0	1	0
1.04 Hospital	4	2	16
1.05 Inpatient Psychiatric Services for Individuals < 21 Age	0	1	0
1.06 Nursing Facility	4	2	13
1.07 Other Inpatient Mental Health Facility	0	0	0
1.08 Other Long-Term Care Facility	0	1	0
TOTAL	12	9	36

FRAUD: Facility Based – Outpatient and/or Day Services	Projected Opened	Projected Closed	Projected End
2.01 Adult Day Center	1	1	1
2.02 Ambulatory Surgical Center	0	1	0
2.03 Developmental Disability Facility (Non-Residential)	0	0	0
2.04 Dialysis Center	1	2	4
2.05 Mental Health Facility (Non-Residential)	0	0	0
2.06 Substance Abuse Treatment Center	0	1	1
2.07 Other Facility (Non-Residential)	0	0	1
TOTAL	2	5	7

FRAUD: Physician (MD/DO) By Medical Specialty	Projected Opened	Projected Closed	Projected End
3.01 Allergist / Immunologist	0	0	0
3.02 Cardiologist	0	0	0
3.03 Emergency Medicine	0	0	1
3.04 Family Practice	1	0	2
3.05 Geriatrician	0	0	0
3.06 Internal Medicine	0	0	0
3.07 Neurologist	0	0	0
3.08 Obstetrician/Gynecologist	0	0	0
3.09 Ophthalmologist	0	0	0
3.10 Pediatrician	0	1	1
3.11 Physical Medicine and Rehabilitation	0	0	0
3.12 Psychiatrist	0	0	0
3.13 Radiologist	0	0	0
3.14 Surgeon	1	1	2
3.15 Urologist	0	0	0
3.16 Other MD / DO	3	1	12
TOTAL	5	3	18

FRAUD: Licensed Practitioners	Projected Opened	Projected Closed	Projected End
4.01 Audiologist	0	0	0
4.02 Chiropractor	0	0	0
4.03 Clinical Social Worker	0	0	0
4.04 Dental Hygienist	0	0	0
4.05 Dentist	6	3	18
4.06 Nurse (LPN, RN, or Other Licensed)	3	2	7
4.07 Nurse Practitioner	2	1	2
4.08 Optometrist	0	1	0
4.09 Pharmacist	0	0	0
4.10 Physician Assistant	1	1	1
4.11 Podiatrist	0	1	0
4.12 Psychologist	1	3	2
4.13 Therapist (Non-Mental Health) PT, Speech, OT, RT	8	5	18
4.14 Other Practitioner	1	2	3
TOTAL	22	19	51

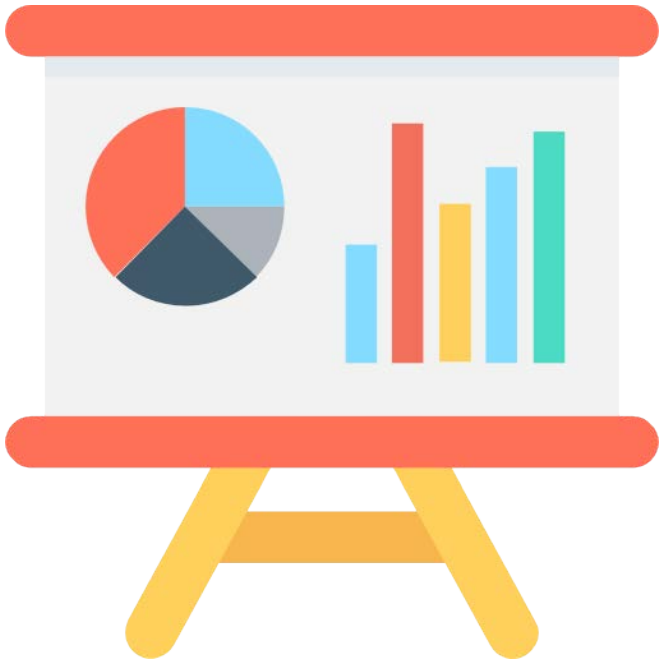
FRAUD: Other Individual Providers	Projected Opened	Projected Closed	Projected End
5.01 EMT / Paramedic	0	0	0
5.02 Nurse's Aide (CNA or Other)	4	2	4
5.03 Optician	0	0	0
5.04 Personal Care Services Attendant	10	7	17
5.05 Pharmacy Technician	0	0	0
5.06 Unlicensed Counselor (Mental Health)	0	1	0
5.07 Unlicensed Therapist (Non-Mental Health)	0	0	0
5.08 Other Individual Providers	8	6	15
TOTAL	22	16	36

FRAUD: Medical Services	Projected Opened	Projected Closed	Projected End
6.01 Ambulance	0	0	0
6.02 Billing Services	1	1	3
6.03 Durable Medical Equipment (DME)	12	20	40
6.04 Home Health Agency	5	2	7
6.05 Lab (Clinical)	15	5	21
6.06 Lab (Radiology and Physiology)	1	1	1
6.07 Lab (Other)	0	1	1
6.08 Medical Device Manufacturer	5	3	23
6.09 Pain Management Clinic	0	1	0
6.10 Personal Care Services Agency	3	3	4
6.11 Pharmaceutical Manufacturer	27	21	100
6.12 Pharmacy (Hospital)	0	0	0
6.13 Pharmacy (Institutional Wholesale)	4	4	9
6.14 Pharmacy (Retail)	10	10	26
6.15 Transportation (Non-Emergency)	2	0	2
6.16 Other Medical Services	3	3	5
TOTAL	88	75	242

FRAUD: Program Related	Projected Opened	Projected Closed	Projected End
7.01 Managed Care Organization (MCO)	0	0	1
7.02 Medicaid Program Administration	0	0	0
7.03 Other Program Fraud	0	1	0
TOTAL	0	1	1

ABUSE AND NEGLECT (Including Patient Needs Funds)	Projected Opened	Projected Closed	Projected End
8.01 Assisted Living Facility	7	5	11
8.02 Developmental Disability Facility Setting (Residential)	2	3	3
8.03 Hospice	1	0	1
8.04 Non-Direct Care	0	0	0
8.05 Nurse's Aide (CNA or Other)	2	1	1
8.06 Nursing Facility	15	10	27
8.07 Personal Care Aide or Other Home Care Aide	2	1	1
8.08 Licensed Nurse (RN, LPN, PA, NP)	2	0	2
8.09 Other Abuse and Neglect	0	2	1
TOTAL	31	22	47

Projected Number of Abuse and Neglect Complaints Received	Projected Number of Abuse and Neglect Complaints Investigated	Projected Number of Abuse and Neglect Complaints Referred
25	30	0



TRAININGS

Individual staff members of the COMFCU pursue training opportunities both within Colorado and outside of the state to enhance their ability to detect and investigate fraudulent schemes, as well as the abuse, neglect, and exploitation of vulnerable individuals. The trainings attended by members of the COMFCU cover subject areas such as financial crime, computer crime, white-collar fraud, enhanced criminal investigative techniques, conducting audits for the purpose of detecting fraudulent activity, and training on software used by the Colorado Department of Health Care Policy and Financing, which houses the Colorado Medicaid program.

Training Topic	Staff	Date(s)
Mandatory Records and Information Management I (RIM)	Investigator	4/2/2018
Advanced Clan Lab Site Safety Officer	Investigator	4/4/2018
Financial Crimes Police 1 Academy Online	Investigator	4/6/2018
Interactions between MFCUs and PI Units	Investigative Supervisor	4/10/2018 - 4/11/2018
DEA Qualifications Training	Investigator	4/10/2018
Lean Office: Maximizing Efficiency by Minimizing Waste	Program Assistant	4/12/2018
Financial Crimes Symposium (CBI)	Investigator	4/16/2018
Annual Cyber Security Training	Investigator	4/16/2018
Information and Security Systems Training	Investigator	4/17/2018
Report Writing for Justice Professionals	Investigator	4/17/2018
Cyber Security Training	Senior Assistant Attorney General	4/23/2018
Cyber Security Training	Investigative Supervisor Investigator	4/24/2018
Boot Camp for the Health Care Fraud Investigator	Investigator	5/1/2018
Defensive Tactics and Firearms Training	2 Investigators	5/4/2018
CAPET Spring Training Conference	Investigator	5/15/2018
Cyber Security Training	2 Investigators	5/15/2018

Training Topic	Staff	Date(s)
Defensive Tactics, Arrest Control, and Firearms Training	4 Investigators	5/18/2018
Cyber Security Training	Investigator	5/21/2018
Excel II	Program Assistant	5/24/2018
Adobe Acrobat DC: Level 1	Investigator	5/30/2018
Defensive Tactics and Firearms Training	Investigative Supervisor Abuse Investigator Investigator	6/1/2018
Relativity Software	Program Assistant	6/1/2018
Physical Surveillance	Investigator	6/4/2018 - 6/8/2018
Persuasive Writing	Investigator	6/14/2018 - 6/25/2018
Excelling as a Manager or Supervisor	Director Investigative Supervisor Senior Assistant Attorney General Investigator	6/15/2018
Information Security in the Workplace	Investigator	6/20/2018
Effective Communication	Investigative Supervisor Investigator	6/25/2018
Forgotten Victims - Elder Homicides	Abuse Investigator	7/13/2018
Advanced Interviewing for Law Enforcement Investigators	Investigator	7/16/2018 - 7/20/2018
Responding to Elder Abuse Victims With Alzheimer's Disease or Other Dementias	Abuse Investigator	7/19/2018
Opioid Abuse: Consumer Protection and Enforcement	Investigator	7/24/2018 - 7/25/2018
NADDI Annual Conference	2 Investigators	8/2/2018
Advanced Microsoft Excel	Investigator	8/6/2018 - 8/7/2018
Information Security Awareness in the Workplace	Investigative Supervisor 2 Investigators	8/13/2018
IAPE Managing Property and Evidence in Law Enforcement	Investigator	8/13/2018 - 8/14/2018

Training Topic	Staff	Date(s)
Colorado District Attorneys' Council Conference	Director Abuse Investigator	9/24/2018 - 9/26/2018
Colorado State Investigators' Association Conference	2 Investigators	9/25/2018 - 9/26/2018
NAGTRI Investigations: Conducting Financial Investigations in Consumer Protection Cases	2 Investigators	9/25/2018
Information Security Awareness in the Workplace	Investigator	9/28/2018
DEA Range - Qualifications	Investigator	9/28/2018
Strangulation: The Last Warning Shot	Abuse Investigator	10/3/2018
Cyber Security Module 4	Investigative Supervisor	10/10/2018
Cyber Security Module 4	2 Investigators	10/12/2018
De-escalation Training	Investigative Supervisor	10/15/2018
Cyber Security Training	Investigative Supervisor Investigator	10/16/2018
De-escalation Training	Investigator	10/16/2018
Cyber Security Module 4	Investigator	10/18/2018
Defensive Tactics and Firearms Training	Investigative Supervisor	10/19/2018
Defensive Tactics and Firearms Training	Abuse Investigator Investigator	10/19/2018
De-Escalation and Minimizing Use of Force Training	2 Investigators	10/22/2018
Simunition® Range Program Training	Investigator	10/23/2018
Open Source Intelligence Training	Investigative Supervisor Abuse Investigator 4 Investigators	10/26/2018
Communicating Across Generational Divide	Investigative Supervisor Investigator	11/1/2018
CCIC Security Training	Investigator	11/2/2018
Interviewing People with Disabilities	Investigator	11/2/2018

Training Topic	Staff	Date(s)
NAMFCU's Abuse and Neglect Conference	Abuse Investigator	11/13/2018 - 11/15/2018
Firearms Training	Investigator	11/30/2018
Medicaid 102A	Investigator	12/3/2018 - 12/7/2018
COGNOS Novice Training	Investigator	12/11/2018
EVOC Driving Training	Investigator	12/17/2018
Information Security Awareness in the Workplace	Investigator	12/26/2018
COGNOS Training	Investigator	12/26/2018
1040 Tax Return Workshop TY 2018	Forensic Auditor	1/1/2019 – 1/25/2019
What We Learned - Strangulation Prevention Institute	Abuse Investigator	1/11/2019
NAGTRI's Diagnosing Performance and Conduct Issues in the Workplace	Investigative Supervisor	1/15/2019
Firearms Training	Investigator	1/25/2019
Tactical Diversion Training	Investigator	2/4/2019 - 2/7/2019
Fundamental Principals of Leadership	Investigative Supervisor	2/28/2019
Supervisory Institute's Law Enforcement Leadership	Investigative Supervisor	3/4/2019 - 3/15/2019
Defensive Tactics and Firearms Training	Investigator	3/8/2019

EXPENDITURES

Personnel Expenses	
Salaries	$1,363,171
Benefits	$467,171

Operational Expenses	
Litigation, Professional and Consulting Fees	$3,937
Information Technology Support Services	$41,575
Automobile Expenses	$8,645
Building Rent	$118,566
Telephone Services	$5,203
Membership Dues	$13,874
Book Subscriptions	$9,083
Registration Fees	$13,711
Non-Capital Furniture and Equipment	$2,194
Travel Expenses	$15,561
Insurance Expenses	$14,179
Miscellaneous Other	$7,016
Total Operational Expenses	**$253,544**

Indirect Costs	
$2,083,886 (Personnel Expenses) x .105	$218,808
Total Indirect Costs	**$218,808**

Grand Total of Expenditures for Colorado MFCU	**$2,302,694**

Indirect Costs	Total	Direct Costs	Total
State Share (25%)	$54,702	State Share (25%)	$520,971
Federal Share (75%)	$164,106	Federal Share (75%)	$1,562,915
Total	**$218,808**	**Total**	**$2,083,886**

Pursuant to 42 U.S.C. § 1396b(a)(6), seventy-five percent of the operating costs of the Colorado Medicaid Fraud Control Unit are provided by the Federal Government.

CONCLUSION

By any measure, this past year was the most successful in the forty-one (41) year history of the Colorado Medicaid Fraud Control Unit. Through the work of the COMFCU's Civil Division, $22 million was recovered for the citizens of Colorado. This amount includes a $14.4 million civil recovery in The People of the State of Colorado v. Havana Pharmacy and George Sackey, a record judgment for the COMFCU. The 3,495 days of incarceration ordered and the $1.4 million in fraudulently obtained Medicaid program funds recovered are also records for the COMFCU's Criminal Division.

The Unit will continue to work with the Colorado Department of Health Care Policy and Financing to create policies, procedures and safeguards to reduce and prevent the few unscrupulous Medicaid providers from fraudulently diverting funds from the Medicaid program and the most in need. The training and outreach activities of the Unit have created new partnerships and reinvigorated existing ones across the state. These partnerships with other agencies, providers and the public aid in the detection Medicaid fraud and the abuse and neglect of patients throughout Colorado. Strengthened by the tools provided in the Medicaid Fraud Control Act, the COMFCU will continue in its mission to protect the integrity of the Colorado Medicaid program and to investigate and prosecute the abuse and neglect of the most vulnerable citizens of Colorado.

HOUSE BILL 18-1211

BY REPRESENTATIVE(S) Wist and Foote, Arndt, Becker K., Beckman, Bridges, Buckner, Catlin, Coleman, Covarrubias, Danielson, Esgar, Exum, Garnett, Ginal, Gray, Hamner, Herod, Hooton, Jackson, Kennedy, Kraft-Tharp, Lawrence, Lee, Liston, Lontine, Lundeen, McKean, McLachlan, Melton, Michaelson Jenet, Pabon, Pettersen, Rankin, Reyher, Roberts, Rosenthal, Saine, Salazar, Sandridge, Sias, Singer, Valdez, Van Winkle, Weissman, Willett, Williams D., Wilson, Winter, Young, Duran;
also SENATOR(S) Smallwood and Aguilar, Court, Crowder, Fields, Gardner, Jones, Kagan, Kefalas, Lambert, Lundberg, Martinez Humenik, Priola, Sonnenberg, Tate, Todd, Williams A., Zenzinger, Grantham.

CONCERNING CONTROLLING MEDICAID FRAUD.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly hereby finds and declares that:

(a) The Colorado attorney general's office continues to prosecute medicaid provider fraud and waste, as well as patient abuse, neglect, and exploitation cases, both criminal and civil, pursuant to executive order D1787 signed by Governor Roy Romer in March 1987 and 42 U.S.C. sec.

_____
Capital letters or bold & italic numbers indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

1396b (q); and

(b) The functions of the medicaid fraud control unit are important to protect the integrity of Colorado's medicaid program, including federal funding for that program, as well as to protect some of Colorado's most vulnerable citizens from abuse, neglect, and exploitation.

(2) The general assembly finds, therefore, that the medicaid fraud control unit should be recognized in statute and its authority to prosecute medicaid provider fraud and waste, as well as patient abuse, neglect, and exploitation cases, should be codified in order to provide clarity to providers and others regarding what constitutes medicaid fraud and waste under Colorado law, including that convictions for medicaid fraud and waste are limited to providers who knowingly and willfully violate the law.

SECTION 2. In Colorado Revised Statutes, **add** part 8 to article 31 of title 24 as follows:

PART 8
MEDICAID FRAUD CONTROL

24-31-801. Definitions. AS USED IN THIS PART 8, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "ABUSE" MEANS WILLFUL INFLICTION OF INJURY, UNREASONABLE CONFINEMENT, INTIMIDATION, OR PUNISHMENT WITH RESULTING PHYSICAL OR FINANCIAL HARM OR PAIN OR MENTAL ANGUISH, INCLUDING ANY ACTS OR OMISSIONS THAT CONSTITUTE A CRIMINAL VIOLATION UNDER STATE LAW.

(2) "BENEFICIARY" MEANS ANY INDIVIDUAL WHO RECEIVES GOODS OR SERVICES FROM A PROVIDER UNDER THE MEDICAID PROGRAM.

(3) "BENEFIT" MEANS ANY BENEFIT AUTHORIZED UNDER THE "COLORADO MEDICAL ASSISTANCE ACT".

(4) "CLAIM" MEANS ANY COMMUNICATION SUBMITTED TO THE MEDICAID PROGRAM OR TO A PERSON THAT HAS CONTRACTED WITH THE MEDICAID PROGRAM, WHETHER ORAL, WRITTEN, ELECTRONIC, OR MAGNETIC, THAT IDENTIFIES A GOOD, ITEM, OR SERVICE AS REIMBURSABLE UNDER THE MEDICAID PROGRAM; IS USED TO AUTHORIZE THE PROVISION OF SERVICES

UNDER THE MEDICAID PROGRAM; SERVES AS AN INVOICE FOR SERVICES PROVIDED UNDER CONTRACT WITH THE MEDICAID PROGRAM; OR STATES INCOME OR EXPENSE AND IS OR MAY BE USED TO DETERMINE A RATE OF PAYMENT UNDER THE MEDICAID PROGRAM.

(5) "COLORADO MEDICAL ASSISTANCE ACT" MEANS ARTICLES 4 TO 6 OF TITLE 25.5.

(6) "EXPLOITATION" MEANS THE WRONGFUL TAKING OR USE OF FUNDS OR PROPERTY OF A PATIENT RESIDING IN A HEALTH CARE FACILITY OR BOARD AND CARE FACILITY THAT CONSTITUTES A CRIMINAL VIOLATION UNDER STATE LAW.

(7) "KNOWINGLY" AND "WILLFULLY" HAVE THE SAME MEANING AS SET FORTH IN SECTION 18-1-501 (6).

(8) "MATERIAL INFORMATION" MEANS AN ASSERTION OR INFORMATION DIRECTLY PERTAINING TO A CLAIM, RECORD, STATEMENT, OR REPRESENTATION THAT A REASONABLE PERSON KNOWS OR SHOULD KNOW WILL AFFECT THE ACTION, CONDUCT, OR DECISION OF THE PERSON WHO RECEIVES OR IS INTENDED TO RECEIVE THE ASSERTED INFORMATION IN A MANNER THAT WOULD DIRECTLY OR INDIRECTLY BENEFIT THE PERSON MAKING THE ASSERTION.

(9) "MEDICAID FRAUD AND WASTE" MEANS ANY ACT, BY COMMISSION OR OMISSION, AS DESCRIBED IN SECTION 24-31-808.

(10) "MEDICAID PROGRAM" MEANS THE MEDICAL ASSISTANCE PROGRAM AUTHORIZED BY TITLE XIX OF THE FEDERAL "SOCIAL SECURITY ACT" AND IMPLEMENTED BY THE "COLORADO MEDICAL ASSISTANCE ACT".

(11) "NEGLECT" MEANS WILLFUL FAILURE TO PROVIDE GOODS AND SERVICES NECESSARY TO AVOID PHYSICAL HARM, MENTAL ANGUISH, OR MENTAL ILLNESS, INCLUDING ANY NEGLECT THAT CONSTITUTES A CRIMINAL VIOLATION UNDER STATE LAW.

(12) "PERSON" MEANS AN INDIVIDUAL, PUBLIC OR PRIVATE INSTITUTION, CORPORATION, PARTNERSHIP, ASSOCIATION, OR MANAGED CARE ENTITY.

(13) "PROVIDER" MEANS ANY PERSON, EMPLOYEE, AGENT, REPRESENTATIVE, CONTRACTOR, OR SUBCONTRACTOR OF A PERSON:

(a) WHO HAS ENTERED INTO A PROVIDER AGREEMENT WITH THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING TO PROVIDE GOODS OR SERVICES PURSUANT TO THE MEDICAID PROGRAM;

(b) WHO HAS ENTERED INTO AN AGREEMENT WITH A PARTY TO SUCH A PROVIDER AGREEMENT UNDER WHICH THE PERSON AGREES TO PROVIDE GOODS OR SERVICES THAT ARE REIMBURSABLE UNDER THE MEDICAID PROGRAM;

(c) WHO IS REIMBURSED OR RECEIVES COMPENSATION FOR DELIVERING, PURPORTING TO DELIVER, OR ARRANGING FOR THE DELIVERY OF HEALTH CARE GOODS OR SERVICES FROM THE MEDICAID PROGRAM;

(d) WHO IS DEFINED AS SUCH IN SECTION 25.5-4-103 (19); OR

(e) WHO IS DEFINED AS SUCH IN SECTION 25.5-4-416 (1).

(14) "RECORDS" MEANS ANY MEDICAL, PROFESSIONAL, OR BUSINESS RECORDS RELATING TO THE TREATMENT OR CARE OF ANY BENEFICIARY, TO GOODS OR SERVICES PROVIDED TO ANY BENEFICIARY, OR TO RATES PAID FOR GOODS OR SERVICES PROVIDED TO ANY BENEFICIARY AND ANY RECORDS THAT ARE REQUIRED TO BE KEPT BY THE RULES OF THE MEDICAID PROGRAM.

(15) "STATEMENT OR REPRESENTATION" MEANS ANY ORAL, WRITTEN, OR ELECTRONIC COMMUNICATION THAT IS USED TO IDENTIFY AN ITEM OF GOODS OR A SERVICE FOR WHICH REIMBURSEMENT MAY BE MADE UNDER THE MEDICAID PROGRAM OR THAT STATES INCOME AND EXPENSE AND IS OR MAY BE USED TO DETERMINE A RATE OF REIMBURSEMENT UNDER THE MEDICAID PROGRAM, THAT MAY SERVE AS THE BASIS FOR THE CALCULATION OF A PAYMENT TO A PROVIDER, OR THAT MAY SERVE AS A BASIS FOR RECEIVING PAYMENT.

(16) "UNIT" MEANS THE MEDICAID FRAUD CONTROL UNIT CREATED IN SECTION 24-31-802.

24-31-802. Medicaid fraud control unit - creation - duties. THERE IS CREATED WITHIN THE DEPARTMENT OF LAW AND UNDER THE CONTROL OF

THE OFFICE OF THE ATTORNEY GENERAL THE MEDICAID FRAUD CONTROL UNIT. THE UNIT SHALL INVESTIGATE AND PROSECUTE FRAUD, MISUSE, WASTE, AND ABUSE COMMITTED BY MEDICAID PROVIDERS AND INVESTIGATE AND PROSECUTE CASES OF PATIENT ABUSE, NEGLECT, AND EXPLOITATION.

24-31-803. Medicaid fraud reporting. THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING; THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT; MANAGED CARE ENTITIES; AND THEIR FISCAL AGENTS, CONTRACTORS, OR SUBCONTRACTORS, SHALL REFER ALL CASES WHERE THE AGENCY OR ENTITY HAS REASONABLE CAUSE TO BELIEVE THAT THERE IS SUSPECTED MEDICAID FRAUD AND WASTE AS WELL AS PATIENT ABUSE, NEGLECT, AND EXPLOITATION TO THE UNIT FOR THE PURPOSE OF INVESTIGATION, CIVIL ACTION, OR CRIMINAL ACTION. NOTHING CONTAINED IN THIS PART 8 PROHIBITS THE ATTORNEY GENERAL FROM PURSUING CASES OF SUSPECTED MEDICAID FRAUD AND WASTE OR PATIENT ABUSE, NEGLECT, AND EXPLOITATION CASES ABSENT SUCH A REFERRAL.

24-31-804. Medicaid fraud control unit - displayed information. THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING MAY REQUIRE THAT A NOTIFICATION BE INCLUDED IN ANY EXPLANATION OF BENEFITS PROVIDED TO A BENEFICIARY THAT EXPLAINS THE PROCESS AND CONTACT INFORMATION FOR REPORTING TO THE UNIT SUSPECTED MEDICAID FRAUD AND WASTE AS WELL AS PATIENT ABUSE, NEGLECT, AND EXPLOITATION. ANY NOTIFICATION REQUIRED PURSUANT TO THIS SECTION MUST BE PLACED IN A CONSPICUOUS LOCATION WITHIN THE EXPLANATION OF BENEFITS AND MUST INCLUDE A STATEMENT THAT ALL REPORTS TO THE UNIT MAY BE FILED ANONYMOUSLY BY PERSONS SUSPECTING FRAUDULENT ACTIVITY.

24-31-805. Medicaid fraud control unit authority and responsibilities. (1) IN CARRYING OUT THE RESPONSIBILITIES OF THIS SECTION, THE UNIT HAS THE AUTHORITY TO:

(a) INVESTIGATE AND PROSECUTE CIVIL ACTIONS AND PROCEEDINGS, PURSUANT TO SECTION 25.5-4-301 (2) OR SECTIONS 25.5-4-303.5 TO 25.5-4-310;

(b) INVESTIGATE AND PROSECUTE CRIMINAL MEDICAID FRAUD AND WASTE PURSUANT TO THIS PART 8 AND TITLE 18;

(c) INVESTIGATE AND PROSECUTE PATIENT ABUSE, NEGLECT, OR

EXPLOITATION PROVIDED THAT PRIOR TO THE FILING OF ANY CRIMINAL CHARGES INVOLVING PATIENT ABUSE, NEGLECT, OR EXPLOITATION BY EITHER COMPLAINT OR GRAND JURY INDICTMENT THE UNIT SHALL FIRST CONSULT WITH THE DISTRICT ATTORNEY OF THE JUDICIAL DISTRICT WHERE THE PROSECUTION WOULD BE INITIATED. IF AFTER SUCH CONSULTATION THE DISTRICT ATTORNEY AGREES WITH THE FILING OF CHARGES, THE UNIT SHALL CROSS-DESIGNATE THE DISTRICT ATTORNEY OR HIS OR HER DESIGNATED ASSISTANT OR DEPUTY DISTRICT ATTORNEY AS A SPECIAL ASSISTANT ATTORNEY GENERAL ON THE CASE. IF AFTER SUCH CONSULTATION THE DISTRICT ATTORNEY DOES NOT AGREE WITH THE FILING OF CHARGES, THE UNIT MAY FILE THE CASE INDEPENDENTLY.

(d) ISSUE OR CAUSE TO BE ISSUED CIVIL INVESTIGATIVE DEMANDS AND SUBPOENAS OR OTHER PROCESS IN AID OF INVESTIGATIONS AND PROSECUTIONS;

(e) ADMINISTER OATHS AND TAKE SWORN STATEMENTS UNDER PENALTY OF PERJURY; AND

(f) SERVE AND EXECUTE, IN ANY COUNTY, SEARCH WARRANTS THAT RELATE TO INVESTIGATIONS.

24-31-806. Civil investigative demands and subpoenas. (1) CIVIL INVESTIGATIVE DEMANDS ISSUED PURSUANT TO THIS PART 8 ARE SUBJECT TO THE REQUIREMENTS OF SECTION 25.5-4-309.

(2) SUBPOENAS ISSUED PURSUANT TO THIS PART 8 MUST COMPLY WITH THE PROVISIONS OF ARTICLE 90 OF TITLE 13 AND ANY COURT RULE.

(3) ANY TESTIMONY OBTAINED PURSUANT TO A CIVIL INVESTIGATIVE DEMAND ISSUED PURSUANT TO THIS SECTION IS NOT ADMISSIBLE IN EVIDENCE IN ANY CRIMINAL PROSECUTION AGAINST THE PERSON COMPELLED TO TESTIFY PURSUANT TO THE CIVIL INVESTIGATIVE DEMAND. THE PROVISIONS OF THIS SUBSECTION (3) DO NOT PREVENT THE ATTORNEY GENERAL FROM INDEPENDENTLY PRODUCING OR OBTAINING THE SAME OR SIMILAR FACTS, INFORMATION, OR EVIDENCE FOR USE IN ANY CRIMINAL PROSECUTION.

24-31-807. Provider applications - false statements - penalties. (1) EACH APPLICATION TO PARTICIPATE AS A PROVIDER IN THE MEDICAID

PROGRAM, INCLUDING AMENDMENTS, UPDATES, RENEWALS, OR REVALIDATIONS THEREOF; EACH REPORT STATING INCOME OR EXPENSE UPON WHICH RATES OF PAYMENT ARE OR MAY BE BASED; AND EACH INVOICE FOR PAYMENT FOR A GOOD OR SERVICE PROVIDED TO A BENEFICIARY MUST CONTAIN A STATEMENT THAT ALL MATTERS STATED THEREIN ARE TRUE AND ACCURATE, AND THE STATEMENT MUST BE SIGNED BY THE INDIVIDUAL AUTHORIZED BY THE PROVIDER.

(2) AN APPLICATION UNDER SUBSECTION (1) OF THIS SECTION IS A PUBLIC RECORD OR INSTRUMENT AS DESCRIBED IN SECTION 18-5-102 (1)(d).

24-31-808. Medicaid fraud and waste - penalties - definition. (1) A PERSON COMMITS MEDICAID FRAUD AND WASTE WHEN THAT PERSON KNOWINGLY AND WILLFULLY:

(a) WITH INTENT TO DEFRAUD, MAKES A CLAIM, OR CAUSES A CLAIM TO BE MADE, KNOWING THE CLAIM CONTAINS MATERIAL INFORMATION THAT IS FALSE, IN WHOLE OR IN PART, BY COMMISSION OR OMISSION;

(b) WITH INTENT TO DEFRAUD, MAKES A STATEMENT OR REPRESENTATION, OR CAUSES A STATEMENT OR REPRESENTATION TO BE MADE, FOR USE IN OBTAINING OR SEEKING TO OBTAIN AUTHORIZATION TO PROVIDE A GOOD OR A SERVICE, KNOWING THE STATEMENT OR REPRESENTATION CONTAINS MATERIAL INFORMATION THAT IS FALSE, IN WHOLE OR IN PART, BY COMMISSION OR OMISSION;

(c) WITH INTENT TO DEFRAUD, MAKES A STATEMENT OR REPRESENTATION, OR CAUSES A STATEMENT OR REPRESENTATION TO BE MADE, FOR USE BY ANOTHER IN OBTAINING A GOOD OR A SERVICE UNDER THE MEDICAID PROGRAM, KNOWING THE STATEMENT OR REPRESENTATION CONTAINS MATERIAL INFORMATION THAT IS FALSE, IN WHOLE OR IN PART, BY COMMISSION OR OMISSION;

(d) WITH INTENT TO DEFRAUD, MAKES A STATEMENT OR REPRESENTATION, OR CAUSES A STATEMENT OR REPRESENTATION TO BE MADE, FOR USE IN QUALIFYING AS A PROVIDER OF A GOOD OR SERVICE UNDER THE MEDICAID PROGRAM, KNOWING THE STATEMENT OR REPRESENTATION CONTAINS MATERIAL INFORMATION THAT IS FALSE, IN WHOLE OR IN PART, BY COMMISSION OR OMISSION;

(e) WITH INTENT TO DEFRAUD, SIGNS OR SUBMITS, OR CAUSES TO BE SIGNED OR SUBMITTED, A STATEMENT DESCRIBED IN SECTION 24-31-807 WITH THE KNOWLEDGE THAT THE APPLICATION, REPORT, CLAIM, OR INVOICE FOR SERVICES PROVIDED UNDER CONTRACT CONTAINS MATERIAL INFORMATION THAT IS FALSE, IN WHOLE OR IN PART, BY COMMISSION OR OMISSION;

(f) EXCEPT AS AUTHORIZED BY LAW, AND WITHOUT CONSENT OF THE BENEFICIARY, CHARGES ANY BENEFICIARY MONEY OR OTHER CONSIDERATION IN ADDITION TO OR IN EXCESS OF RATES OF REMUNERATION ESTABLISHED UNDER THE MEDICAID PROGRAM FOR THE SERVICES PROVIDED TO THE BENEFICIARY;

(g) HAVING SUBMITTED A CLAIM FOR OR RECEIVED PAYMENT FOR A GOOD OR A SERVICE UNDER THE MEDICAID PROGRAM:

(I) WITH THE INTENT TO PREVENT THEIR DISCLOSURE AND REVIEW BY REPRESENTATIVES OF THE STATE OR THEIR DESIGNEES, ALTERS, FALSIFIES, OR CONCEALS ANY RECORDS THAT ARE NECESSARY TO FULLY DISCLOSE THE NATURE OF ALL GOODS OR SERVICES FOR WHICH THE CLAIM WAS SUBMITTED, OR FOR WHICH REIMBURSEMENT WAS RECEIVED; DESTROYS OR REMOVES SUCH RECORDS; OR FAILS TO MAINTAIN SUCH RECORDS AS REQUIRED BY LAW OR THE RULES OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FOR A PERIOD OF AT LEAST SIX YEARS FOLLOWING THE DATE ON WHICH PAYMENT WAS RECEIVED; OR

(II) ALTERS, FALSIFIES, OR CONCEALS ANY RECORDS THAT ARE NECESSARY TO DISCLOSE FULLY ALL INCOME AND EXPENDITURES UPON WHICH RATES OF REIMBURSEMENTS WERE BASED, OR DESTROYS OR REMOVES SUCH RECORDS WITH THE INTENT TO PREVENT THEIR REVIEW BY REPRESENTATIVES OF THE STATE OR THEIR DESIGNEES;

(h) MAKES OR CAUSES TO BE MADE A STATEMENT OR REPRESENTATION FOR USE IN QUALIFYING AS A PROVIDER OF A GOOD OR SERVICE UNDER THE MEDICAID PROGRAM STATING THAT HE OR SHE IS IN COMPLIANCE WITH ALL PROVISIONS OF SECTION 25.5-4-416, KNOWING THAT THE STATEMENT OR REPRESENTATION CONTAINS MATERIAL INFORMATION THAT IS FALSE, IN WHOLE OR IN PART, THROUGH COMMISSION OR OMISSION; OR

(i) EXCEPT AS AUTHORIZED BY LAW, AND WITHOUT CONSENT OF THE BENEFICIARY, RECOVERS OR ATTEMPTS TO RECOVER PAYMENT FROM A BENEFICIARY UNDER THE MEDICAID PROGRAM OR FROM THE BENEFICIARY'S FAMILY OR FAILS TO CREDIT THE STATE FOR PAYMENTS RECEIVED FROM OTHER SOURCES.

(2) ABSENT KNOWING OR WILLFUL CONDUCT, A PROVIDER IS NOT LIABLE FOR MEDICAID FRAUD AND WASTE COMMITTED BY A THIRD PARTY. A PROVIDER DOES NOT KNOWINGLY AND WILLFULLY VIOLATE A REQUIREMENT, STANDARD, OR DIRECTIVE CONTAINED IN WRITTEN MATERIALS ISSUED BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING THAT WAS NOT PROMULGATED IN ACCORDANCE WITH THE "STATE ADMINISTRATIVE PROCEDURE ACT", ARTICLE 4 OF TITLE 24, UNLESS THE PROVIDER HAS ACTUAL KNOWLEDGE OF SUCH REQUIREMENT, STANDARD, OR DIRECTIVE AT THE TIME OF THE VIOLATION.

(3) MEDICAID FRAUD IN VIOLATION OF SUBSECTIONS (1)(a) TO (1)(c) OR (1)(f) OF THIS SECTION IS:

(a) A CLASS 1 PETTY OFFENSE WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS LESS THAN FIFTY DOLLARS;

(b) A CLASS 3 MISDEMEANOR WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS FIFTY DOLLARS OR MORE BUT LESS THAN THREE HUNDRED DOLLARS;

(c) A CLASS 2 MISDEMEANOR WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS THREE HUNDRED DOLLARS OR MORE BUT LESS THAN SEVEN HUNDRED FIFTY DOLLARS;

(d) A CLASS 1 MISDEMEANOR WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS SEVEN HUNDRED FIFTY DOLLARS OR MORE BUT LESS THAN TWO THOUSAND DOLLARS;

(e) A CLASS 6 FELONY WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS TWO THOUSAND DOLLARS OR MORE BUT LESS THAN FIVE THOUSAND DOLLARS;

(f) A CLASS 5 FELONY WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS FIVE THOUSAND DOLLARS

OR MORE BUT LESS THAN TWENTY THOUSAND DOLLARS;

(g) A CLASS 4 FELONY WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS TWENTY THOUSAND DOLLARS OR MORE BUT LESS THAN ONE HUNDRED THOUSAND DOLLARS;

(h) A CLASS 3 FELONY WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS ONE HUNDRED THOUSAND DOLLARS OR MORE BUT LESS THAN ONE MILLION DOLLARS; AND

(i) A CLASS 2 FELONY WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS ONE MILLION DOLLARS OR MORE.

(4) MEDICAID FRAUD AS A VIOLATION OF SUBSECTION (1)(d), (1)(e), (1)(g), (1)(h), OR (1)(i) OF THIS SECTION IS A CLASS 5 FELONY AND SHALL BE PUNISHED AS PROVIDED IN SECTION 18-1.3-401.

(5) A PERSON MAY NOT BE CONVICTED OF MEDICAID FRAUD AND WASTE IN ADDITION TO THEFT OR FORGERY WITH RESPECT TO THE SAME TRANSACTION.

24-31-809. Unlawful remuneration - penalties. (1) EXCEPT AS PROVIDED IN SUBSECTION (2) OF THIS SECTION, IT IS UNLAWFUL FOR ANY PERSON TO KNOWINGLY OFFER, PAY, SOLICIT, OR RECEIVE ANY REMUNERATION INCLUDING, BUT NOT LIMITED TO, ANY KICKBACK, BRIBE, OR REBATE, DIRECTLY OR INDIRECTLY, OVERTLY OR COVERTLY, IN CASH OR IN KIND:

(a) IN RETURN FOR THE REFERRAL OF AN INDIVIDUAL TO A PERSON FOR THE FURNISHING OR ARRANGING OF ANY GOOD OR SERVICE FOR WHICH PAYMENT MAY BE MADE IN WHOLE OR IN PART PURSUANT TO THE "COLORADO MEDICAL ASSISTANCE ACT"; OR

(b) IN RETURN FOR PURCHASING, LEASING, ORDERING, OR ARRANGING FOR OR RECOMMENDING THE PURCHASE, LEASE, OR ORDERING OF ANY GOOD, FACILITY, SERVICE, OR ITEM FOR WHICH PAYMENT MAY BE MADE IN WHOLE OR IN PART PURSUANT TO THE "COLORADO MEDICAL ASSISTANCE ACT".

(2) IT SHALL NOT BE UNLAWFUL UNDER SUBSECTION (1) OF THIS SECTION IF THE REMUNERATION OBTAINED BY THE PROVIDER OR OTHER ENTITY IS:

(a) PERMITTED PURSUANT TO SECTION 25.5-4-414 OR ANY STATUTORY EXCEPTIONS OR SAFE HARBOR REGULATIONS UNDER THE FEDERAL "ANTI-KICKBACK STATUTE", 42 U.S.C. SEC. 1320a-7b (b), AS AMENDED;

(b) PROPERLY DISCLOSED AND APPROPRIATELY REFLECTED IN THE CLAIMS OR COST DOCUMENTS SUBMITTED UNDER THE "COLORADO MEDICAL ASSISTANCE ACT";

(c) PAID BY AN EMPLOYER TO AN EMPLOYEE WHO HAS A BONA FIDE EMPLOYMENT RELATIONSHIP WITH SUCH EMPLOYER FOR EMPLOYMENT IN PROVIDING THE SERVICE; OR

(d) PAID BY A VENDOR OF GOODS OR SERVICES TO A PERSON AUTHORIZED TO ACT AS A PURCHASING AGENT FOR A GROUP OF PROVIDERS, AND:

(I) THE PERSON HAS A WRITTEN CONTRACT WITH THE PROVIDERS THAT SPECIFIES THE AMOUNT TO BE PAID TO THE PERSON, WHICH AMOUNT MAY BE A FIXED AMOUNT OR A FIXED PERCENTAGE OF THE VALUE OF THE PURCHASE MADE BY THE PERSON; OR

(II) IN THE CASE OF A PROVIDER OF SERVICES, THE PERSON DISCLOSES, IN SUCH FORM AND MANNER AS THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING REQUIRES, TO THE PROVIDER AND, UPON REQUEST, TO THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING THE AMOUNT RECEIVED FROM EACH SUCH VENDOR WITH RESPECT TO PURCHASES MADE BY OR ON BEHALF OF THE PROVIDER.

(3) A VIOLATION OF THIS SECTION IS A CLASS 1 MISDEMEANOR AND SHALL BE PUNISHED AS PROVIDED IN SECTION 18-1.3-501.

24-31-810. Other remedies available. (1) THE PROVISIONS OF THIS PART 8 ARE NOT INTENDED TO BE EXCLUSIVE REMEDIES AND DO NOT PRECLUDE THE USE OF ANY OTHER CRIMINAL PROSECUTION DIRECTLY RELATED TO CRIMINAL MEDICAID FRAUD AND WASTE, AS WELL AS CRIMINAL

PATIENT ABUSE, NEGLECT, AND EXPLOITATION, OR ANY OTHER CIVIL REMEDY FOR ANY ACT THAT IS IN VIOLATION OF THIS PART 8.

(2) IN ADDITION TO ANY PENALTIES PROVIDED FOR IN THIS PART 8, A CLAIM UNDER THE "COLORADO MEDICAL ASSISTANCE ACT" THAT INCLUDES ITEMS OR SERVICES RESULTING FROM A VIOLATION OF THIS PART 8 OR THE FEDERAL "ANTI-KICKBACK STATUTE", 42 U.S.C. 1320a-7b (b), AS AMENDED, CONSTITUTES A FALSE CLAIM FOR PURPOSES OF THE "COLORADO MEDICAID FALSE CLAIMS ACT", SECTIONS 25.5-4-303.5 TO 25.5-4-310.

24-31-811. Limitation of action - three years. AN ACTION BROUGHT UNDER THIS PART 8 MUST BE COMMENCED WITHIN THREE YEARS AFTER THE DATE OF DISCOVERY OF THE COMMISSION OF THE OFFENSE, BUT NO LATER THAN SIX YEARS AFTER THE DATE OF THE COMMISSION OF THE OFFENSE. WHEN A VIOLATION OF THIS SECTION IS BASED ON A SERIES OF ACTS PERFORMED AT DIFFERENT TIMES, THE LIMITATION PERIOD STARTS AT THE TIME THE LAST ACT IN THE SERIES IS DISCOVERED.

SECTION 3. Act subject to petition - effective date. This act takes effect January 1, 2019; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within the ninety-day period after final adjournment of the general assembly, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2018 and, in such case, will take effect on January 1,

2019, or on the date of the official declaration of the vote thereon by the governor, whichever is later.

Crisanta Duran
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Kevin J. Grantham
PRESIDENT OF
THE SENATE

Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Effie Ameen
SECRETARY OF
THE SENATE

APPROVED 3:10 P m 4/25/18

John W. Hickenlooper
GOVERNOR OF THE STATE OF COLORADO

To report fraud, waste, or abuse

Every dollar lost to the misuse of Medicaid resources becomes one less dollar available to fund programs providing essential health services for Coloradans. You can help your fellow citizens by reporting any possible Medicaid fraud, waste, and abuse to our office.

Phone	(720) 508-6696
Fax	(720) 508-6034
Email	mfcu.investigations@coag.gov
Website	https://coag.gov/Report_Medicaid_Fraud