Improving Medicaid Fraud Prosecution

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

Due Date: November 1, 2023

Submitted to:

Senate Health and Human Services Committee
Senate Judiciary Committee
House Public & Behavioral Health & Human Services Committee
House Health & Insurance Committee
House Judiciary Committee

Contents

COLORADO
Department of Health Care Policy & Financing

Summary

This report contains information on Health First Colorado (Colorado's Medicaid program) member and provider fraud investigations and identifies fraud trends.

The following amounts were identified for state fiscal year 2022-2023 (SFY 2022-23):

- **$9,954,603** was identified as the total aggregate Health First Colorado savings for members and providers.
- **$2,194,574** of member fraud was identified, as reported by the counties.
- **$261,086** of member non-fraud was identified, as reported by the counties.
- **$27,005** was identified by the Colorado Medicaid Fraud Control Unit (COMFCU or Unit) in provider criminal restitution.
- **$6,341,752** was identified in provider civil settlements by the COMFCU.

The following fraud trends were identified for SFY 2022-23:

- In regard to member fraud, waste, and abuse investigations, the majority of cases continue to be due to inaccurate reporting of household composition, failure to report income, and failure to update residency information.
- In regard to provider fraud, there continues to be fraud involving the provision of in-home services and off-site services, billing Health First Colorado when services were not provided, or overbilling for the services actually rendered.

Background

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, 2022, to June 30, 2023. This section requires the Department of Health Care Policy & Financing (HCPF) to submit a written report by Nov. 1 of each year regarding Medicaid fraud prosecution. HCPF compiles the report from self-reported information from each of Colorado's 64 counties and from the COMFCU report. The reported numbers for SFY 2022-23 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 Health First Colorado 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 HCPF, for determining eligibility for medical assistance programs. Subject to recent policy changes from the Centers for

Medicare and Medicaid Services (CMS), which will be discussed in detail later in this report, persons who are found to be ineligible for Medicaid due to fraud or error on the part of the applicant are required to 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 HCPF provides fraud-related education to all counties. HCPF also provides policy directives and specific guidance upon request from individual counties. When HCPF receives a member fraud referral directly, HCPF staff review and document the referral, retrieve relevant case information from the Colorado Benefits 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 2023-24 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.

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 was established in 1978, is housed within the Department of Law, and has both criminal and civil prosecutorial authority. In 2023, it was administratively transferred to the DOL Consumer Protection Section. It generally pursues three categories of cases:

1. Fraudulent conduct by Medicaid providers and individuals involved with providing Medicaid services;
2. Abuse, neglect, and exploitation of individuals in health care facilities that receive Medicaid funds or are classified as board and care facilities; and
3. Recovery of Medicaid overpayments identified in the investigation of fraud, patient abuse and neglect, and financial exploitation of clients.
4. The COMFCU's jurisdiction does not extend to the investigation of fraud by recipients, 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 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 either through civil or criminal filings.

Definitions

Total member case count – Total number of Health First Colorado members

Cases Investigated by County – Total number of Health First Colorado member fraud cases that were investigated

Criminal Complaints Requested – Total number of criminal complaints concerning Health First Colorado member fraud that were requested

Criminal Complaints Dismissed - Total number of Health First Colorado member fraud criminal cases that were dismissed without conviction

Criminal Complaints Acquitted - Total number of Health First Colorado member fraud criminal cases in which the member was acquitted

Criminal Complaint Convictions - Total number of Health First Colorado member fraud criminal cases that resulted in a criminal conviction

Confessions of Judgment - Total number of Health First Colorado member fraud cases that were resolved by written agreement signed by the Health First Colorado member admitting that fraud occurred

Fraud Recoveries - Recovery amount that Health First Colorado established as an overpayment due to Health First Colorado fraud, whether or not a prosecution occurred

Non-fraud Recoveries - Recovery amount that Health First Colorado 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 Health First Colorado member fraud investigations that led to terminations this fiscal year

Overall Totals

Member Fraud – As reported by the counties

- **1,826** investigations of member fraud during the fiscal year. This is a decrease of 8% from last fiscal year.
- **25** terminations of services of member Health First Colorado benefits due to fraud. This is a decrease of 77% from last fiscal year.
- Number of District Attorney actions:
  - **44** criminal complaints requested
  - **1** case dismissed
  - **0** cases acquitted
  - **25** convictions
  - **9** confessions of judgment
- **$2,194,574** of fraud identified, as reported by the counties. This is a decrease of 7% from last fiscal year.
- **$261,086** of non-fraud identified, as reported by the counties. This is an increase of 4% from last fiscal year.
- **$37,871** of fines and penalties recovered and retained by counties. This is an increase of 187% from last fiscal year.
- Amount of Restitution:
  - **$927,939** ordered. This is an increase of 30% from last fiscal year.
  - **$452,653** collected. This is an increase of 12% from last fiscal year.

Analysis of Investigations and Estimated Member Fraud Cost Avoidance

During SFY 2022-23, there was a 7% decrease in member fraud recoveries from last fiscal year, down to **$2,194,574**, accompanying an 8% decrease in the number of investigations of member fraud. Under the COVID-19 public health emergency (PHE), as declared and extended by the U.S. Department of Health and Human Services, the Families First Coronavirus Response Act, signed into law on March 18, 2020, (FFCRA), and corresponding HCPF policy guidance issued, 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. This multi-year PHE restriction was in place through May 11, 2023, when the PHE officially ended. For the majority of SFY 2022-23, counties were only able to seek fraud recoveries from the limited pool of identified fraudulent member ineligibility that occurred prior to the start of the PHE. This decreased investigation and recovery numbers for SFY 2022-23.

On Oct. 17, 2022, CMS issued a frequently asked questions document (FAQ), entitled, "COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State

Medicaid and CHIP Agencies."[1] FAQ 31 of this document says in part that: "States cannot recover or recoup the cost of services from a beneficiary, even if they have been found after an administrative or criminal proceeding to have committed Medicaid beneficiary fraud or abuse." HCPF, along with representatives from other state Medicaid agencies, had numerous calls and email exchanges with CMS to clarify the meaning of FAQ 31 and this break from long-standing precedent. CMS informed states that FAQ 31 is not limited to the PHE period, and that no administrative overpayment recoveries from Medicaid members are permissible. In FAQ 31, CMS states that the only permissible means to recover from a Medicaid member are through three narrow exceptions appearing in federal regulation, which they cite in the FAQ. However, while FAQ 31 also expressly prohibited criminal recoveries from members, CMS backtracked and confirmed that state criminal court ordered restitution recoveries are still a permissible means of recovery.

CMS states that further written guidance is in progress, and HCPF anticipates that this additional guidance will reinforce and make permanent the prohibition on administrative overpayment recoveries from Medicaid members. In accordance with the CMS FAQ and subsequent CMS clarification, effective as of the end of the PHE period, May 11, 2023, HCPF issued Operational Memo 23-034, entitled "Temporary Prohibition on Administrative Overpayment Recoveries from Medicaid Members."[2] This memo conveyed the CMS guidance to counties, stating that as of May 11, 2023, there could be no overpayment recovery from a current or past Health First Colorado member outside of the criminal court process. Counties were instructed to continue to investigate fraud referrals, and to terminate eligibility for currently ineligible members. HCPF informed counties that they could still refer cases to their local county district attorneys for potential criminal charges and criminal restitution.

Operational Memo 23-034 was only effective for the last month and a half of SFY 2022-23, so any impact on recovery numbers would be minimal in this report. However, as it is expected that the CMS policy change prohibiting administrative recoveries will be made permanent, HCPF anticipates a substantial reduction of fraud and non-fraud recovery numbers for future years. Operational Memo 23-034 may be subsequently revised, removed, or made permanent, pending further written guidance from CMS.

Continuing a downward trend from previous fiscal years, eligibility terminations are down 77% this fiscal year. The ongoing trend of decreasing eligibility terminations is due largely to the PHE period. In compliance with the Federal Medical Percentage (FMAP) made available by the FFCRA, coverage for any beneficiary enrolled in Health First Colorado on or after March 18, 2020, could not be terminated until the end of the month in which the emergency period ended, 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 nearly all of SFY 2022-23, only

[1] See: https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf

[2] Operational Memo 23-034, entitled "Temporary Prohibition on Administrative Overpayment Recoveries from Medicaid Members", and related attachments, can be found here: https://hcpf.colorado.gov/2023-memo-series-communication

ending on May 11, 2023, with continuous enrollment severely restricting the ability of counties to terminate members who would otherwise be ineligible for Health First Colorado.

Now that the PHE has ended, the required redetermination of all Health First Colorado members will ultimately terminate coverage of those members who are no longer eligible to receive medical assistance benefits. However, this extensive redetermination process will take place over a twelve-month period (14 months including noticing). Redetermination noticing began in March of 2023 for the first renewals that were due in May of 2023.

Cost avoidance decreased this year, coinciding directly with the continuing 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 **$164,376**, down from **$713,050**, identified last fiscal year. This cost avoidance calculation is explained further in the Member Fraud Cost Savings Section of this report.

Court-imposed fines and penalties, restitution ordered, and restitution collected all increased in SFY 2022-23, up to **$37,871**, **$927,939**, and **$452,653**, respectively. Criminal fraud actions, convictions, and restitution may all be expected to increase in future years, given that the new CMS policy prohibiting administrative recoveries has now made criminal court proceedings the only means of recovering from Medicaid members.

Provider Fraud – As reported by the COMFCU

Between July 1, 2022, and June 30, 2023, the COMFCU received **503** complaints and referrals, which represents a significant increase in recorded complaints and referrals from the prior state fiscal year. Of that number, **9** were received from HCPF, of which **5** resulted in new cases opened at the MFCU. 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 and Environment; and Health First Colorado members and their caregivers. The Unit was active across Colorado, having received referrals from many areas of the state.

While the COMFCU saw a dramatic increase in staffing levels during SFY 2022-23 and implemented a new referral system and case management software, by the end of the reporting period these improvements had only begun to address the increased number of referrals and complaints received. Accordingly, **322** of the matters received remain in preliminary investigation status, without a formal decision as to whether an investigative case will be opened. After a preliminary investigation, based on these referrals, the Unit opened **71** new cases for formal investigation, of which **47** were criminal matters and **24** were civil matters. The cases opened during the reporting period consisted of **59** fraud cases, **12** abuse and neglect cases, and **2** drug related cases (included within the fraud cases; not believed on first impression to be within the definition of drug diversion). Additionally, in the last week of the Federal Fiscal Year 2022-2023 (as of Sept. 29, 2023),

the COMFCU has **394** active investigations with **92** criminal cases, of which **23** are abuse/neglect matters, **13** are drug diversion matters, and **69** are fraud matters.

During SFY 2022-23, the COMFCU filed **9** criminal cases. **9** cases, mostly ones that had been filed in earlier fiscal years, were resolved and **9** defendants were sentenced in criminal court, **3** of whom were sentenced on abuse/neglect charges. The criminal matters filed and litigated involved conduct as varied as three defendants who engaged in an extensive false billings scheme to claim money for care ostensibly provided by an individual who was in state prison during the dates of care; a facility employee who threw a developmentally disabled patient to the ground, causing extensive permanent leg injuries; and a provider company whose principals billed for at least **$693,000** of care that was not provided.

During SFY 2022-23, the COMFCU collected **$27,005.06** in criminal restitution, both directly through checks sent to the Unit, and indirectly through checks sent to HCPF from the courts based on COMFCU cases. Of this amount, **$13,727.14** represents restitution collected from criminal convictions during SFY 2022-23.

In addition to criminal prosecutions, the COMFCU recovered **$6,341,752.11** in civil matters, and collected over **$905,000**. No litigation costs were recovered during the review period.

Total Cost Savings from Members and Providers

In SFY 2022-23, the total aggregate Health First Colorado savings for members and providers was **$9,954,603**[3]. 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, HCPF calculated the average yearly amount spent on all state Health First Colorado members in order to obtain a yearly amount of Health First Colorado dollars saved. This fiscal year, there were 25 terminations. The average cost per member for this past fiscal year, per month, was $547.92, or $6,575.05[4] per year. Therefore, the estimated cost savings is **$164,376**. This savings is in addition to the **$2,194,574** fraud recovery amount.

The cost savings formula is laid out below:

Average Yearly Cost Per Member x Number of Terminations = Total Cost Avoidance

$6,575.05 x 25 = **$164,376**

[3] From the member side, this total cost savings figure includes **$2,194,574** in fraud recoveries, **$261,086** in non-fraud recoveries, **$37,871** in fines and penalties, **$927,939** in restitution ordered, and **$164,376** in estimated cost savings from terminating ineligible members. On the provider side, the total cost saving figure reflects **$27,005** in criminal restitution, and **$6,341,752** in civil recoveries.

[4] Source of data for average monthly cost is based on HCPF's Nov. 1, 2023, budget request.

During SFY 2022-23, HCPF 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. This position worked extensively with CMS and other HCPF staff regarding the CMS policy change prohibiting administrative recoveries from Medicaid members. This position also helped work on member fraud cases by assisting county investigators and ensuring compliance with the FFCRA and related HCPF PHE and post-PHE policy.

During this time period, this position, along with other HCPF staff, continued to work closely with county representatives throughout the state and helped county investigators with investigation and policy questions and support. The position also continued to serve as the chair of the nationwide 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 HCPF, member and provider fraud are both housed within the Fraud, Waste, and Abuse Division (FWA Division). HCPF 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 and policy are consistent across the state.

HCPF 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 HCPF and county staff efforts to further improve the accuracy of initial eligibility determinations, limiting ineligible individuals from being approved to receive medical assistance benefits. Now that the PHE has ended, the required redetermination of all Health First Colorado members will further ensure that ineligible members are disenrolled.

Cost Savings - Providers

During this review period, the state of Colorado tasked a law enforcement team of up to **21** staff members with investigation authority and civil or criminal prosecution authority to protect the funds and beneficiaries of Colorado's over $10 billion Medicaid program. The COMFCU's recoveries for the state Medicaid program resulted in significant savings to the state, exceeding the cost of the COMFCU. The COMFCU was able to perform investigations effectively in person following earlier limitations that were encountered due to the COVID-19 pandemic. Video conferencing solutions such as Zoom or Microsoft Teams have continued to be used effectively in appropriate circumstances.

Despite the repercussions of COVID-19 related hurdles, the COMFCU was able to recover a total of **$6.3 million in fraudulent Health First Colorado 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 Health First Colorado would likely have been far higher than the amounts that were recovered.

As reported in earlier reports, between 2010 and 2021, the average annual recovery by the COMFCU was **23.1** times the level of funding it received from the state. Over time, funding for the Medicaid program rose faster than funding for the COMFCU, resulting in a backlog of cases and the inability to pursue certain leads and complaints. However, recent increases in funding allowed for a larger team of investigators, as well as the successful hire of additional attorneys.

With a high investigative case load, triage decisions must continually be made in order to push cases forward. For example, if interviews with 200 individual patients are required to determine the true dollar loss to the Health First Colorado program as a result of a provider's fraudulent conduct, the number of interviews conducted may be capped at twenty or thirty, simply to allow a case to be filed and a partial recovery obtained, allowing the investigator to work on other matters. 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. The number of such investigations is only going to increase going forward. Colorado's 65-and-over population has grown much faster than most other states.[5]

This is significant, for though Medicare is considered an insurance program for older Americans, Medicare does not cover long-term nursing home care, and as of 2019, three in five nursing home patients in Colorado were Health First Colorado members.[6]

For these reasons, there may be an opportunity to better leverage federal dollars to support the fraud detection and recovery efforts within Health First Colorado. Funding for the COMFCU is provided in a 25% to 75% match arrangement. 42 USC 1396b(a)(2)(A). For every $25 in Colorado spending used to fund the COMFCU operations, the federal government provides $75 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

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[5] Colorado State Demography Office. *Aging in Colorado Part 1: Why is Colorado Aging So Quickly?* (October 2016).

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

[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.

they must report and when they must report them. For this reason, focusing on training and education remains a priority for HCPF in combating member fraud, waste, and abuse.

It is clear there are cost benefits to HCPF's fraud investigation efforts. Despite the significant limitations of the PHE and new CMS policy prohibiting administrative recoveries, HCPF has established a fraud recovery totaling **$2,194,574**, as well as a non-fraud recovery totaling **$261,086**. This was while still avoiding an estimated additional **$164,376** in unnecessary costs by terminating those members whose eligibility was able to be terminated during the PHE. SFY 2022-23 also showed increased criminal proceedings, with **$927,939** ordered in restitution.

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

It is hoped that the impending rollout of electronic visit verification will reduce fraud in this area, but a requirement that all in-home care providers receive some form of provider ID or registration number to provide such services would also both prevent fraud and make it easier to uncover 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 a substantial increase in complaints regarding billings for non-emergency medical transportation (NEMT). HCPF has referred the matter to the FBI for pursuit as part of a multi-state fraud investigation currently underway and is instituting internal controls to constrict these attacks by refusing payment to suspected providers and constricting the application flow which HCPF reports is many times historic levels. The COMFCU is working closely with HCPF on NEMT cases, including two currently active referred investigations. The COMFCU is available to support the work of HCPF, as well as our federal partners, in their multi-state fraud investigation.

[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	193,058	1	0	0	0	0	0	$5,957.22	$18,966.5	0	0	0	0
Alamosa	8,406	0	0	0	0	0	0	0	0	0	0	0	0
Arapahoe	195,133	4	0	0	0	0	0	$153,368.00	0	0	0	$1,684.47	0
Archuleta	4,507	0	0	0	0	0	0	0	0	0	0	0	0
Baca	1,583	0	0	0	0	0	0	0	0	0	0	0	0
Bent	2,220	0	0	0	0	0	0	0	0	0	0	0	0
Boulder	65,763	231	1	0	0	1	0	$3,321.29	$4,076.28	0	$95,532.67	$1,603.79	0
Broomfield	10,957	0	0	0	0	0	0	0	0	0	0	0	0
Chaffee	5,130	0	0	0	0	0	0	0	0	0	0	0	0
Cheyenne	615	0	0	0	0	0	0	0	0	0	0	0	0
Clear Creek	1,938	0	0	0	0	0	0	0	0	0	0	0	0
Conejos	3,863	0	0	0	0	0	0	0	0	0	0	0	0
Costilla	2,416	0	0	0	0	0	0	0	0	0	0	0	0
Crowley	1,675	0	0	0	0	0	0	0	0	0	0	0	0
Custer	1,402	0	0	0	0	0	0	0	0	0	0	0	0
Delta	12,209	25	0	0	0	0	0	0	0	0	0	0	6
Denver	250,089	621	5	0	0	4	0	$413,973.83	0	$2,643.00	$68,151.35	0	0
Dolores	843	0	0	0	0	0	0	0	0	0	0	0	0
Douglas	41,271	185	4	0	0	2	2	$181,477.34	0	0	$222,781.36	$25,562.38	0
Eagle	9,484	12	12	0	0	7	0	$347,892.07	0	0	$345,375.92	$221,556.44	7
Elbert	4,303	0	0	0	0	0	0	0	0	0	0	0	0
El Paso	225,282	8	3	0	0	3	0	$210,361.77	$6,527.80	$29,662.87	0	$28,467.28	8
Fremont	16,865	1	0	0	0	0	0	0	0	0	0	0	0
Garfield	17,663	114	0	0	0	0	0	$138,932.52	0	0	0	0	0
Gilpin	1,365	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 › Premiums, Expenditures, and Caseload › Health First Colorado Member Caseload by County. The Document is entitled Health First Colorado Member Caseload by County Reports for Stakeholders using the Medicaid Member Caseload by County, June 2023.

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Grand	2,666	0	0	0	0	0	0	0	0	0	0	0	0
Gunnison	3,969	0	0	0	0	0	0	0	0	0	0	0	0
Hinsdale	169	0	0	0	0	0	0	0	0	0	0	0	0
Huerfano	3,398	0	0	0	0	0	0	0	0	0	0	0	0
Jackson	317	0	0	0	0	0	0	0	0	0	0	0	0
Jefferson	119,551	145	6	1	0	4	4	$157,980.30	0	$5,565.50	$56,490.38	$100,289.65	0
Kiowa	570	0	0	0	0	0	0	0	0	0	0	0	0
Kit Carson	2,543	0	0	0	0	0	0	0	0	0	0	0	0
La Plata	15,784	0	0	0	0	0	0	0	0	0	0	0	0
Lake	2,158	0	0	0	0	0	0	0	0	0	0	0	0
Larimer	85,305	336	0	0	0	0	0	$86,936.10	0	0	0	0	0
Las Animas	6,875	2	0	0	0	0	0	0	0	0	0	0	0
Lincoln	1,873	0	0	0	0	0	0	0	0	0	0	0	0
Logan	6,494	29	5	0	0	1	0	$314,525.55	$202,308.68	0	$135,565.08	$19,051.77	0
Mesa	55,032	137	2	0	0	2	2	$5,817.84	0	0	0	0	0
Mineral	227	0	0	0	0	0	0	0	0	0	0	0	0
Moffat	4,645	4	0	0	0	0	0	0	0	0	0	0	0
Montezuma	11,671	37	1	0	0	1	1	$7,223.10	$2,727.35	0	$4,042.00	0	3
Montrose	15,774	0	0	0	0	0	0	0	0	0	0	0	0
Morgan	11,502	7	0	0	0	0	0	$61,030.18	0	0	0	0	1
Otero	9,502	0	0	0	0	0	0	0	0	0	0	0	0
Ouray	851	0	0	0	0	0	0	0	0	0	0	0	0
Park	4,012	0	0	0	0	0	0	0	0	0	0	0	0
Phillips	1,337	0	0	0	0	0	0	0	0	0	0	0	0
Pitkin	1,996	0	0	0	0	0	0	0	0	0	0	0	0
Prowers	5,990	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 › Premiums, Expenditures, and Caseload › Health First Colorado Member Caseload by County. The Document is entitled Health First Colorado Member Caseload by County Reports for Stakeholders using the Medicaid Member Caseload by County, June 2023.

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
Pueblo	81,470	0	5	0	0	0	0	0	0	0	0	0	0
Rio Blanco	1,841	0	0	0	0	0	0	0	0	0	0	0	0
Rio Grande	5,208	0	0	0	0	0	0	0	0	0	0	0	0
Routt	4,009	0	0	0	0	0	0	0	0	0	0	0	0
Saguache	3,068	0	0	0	0	0	0	0	0	0	0	0	0
San Juan	237	0	0	0	0	0	0	0	0	0	0	0	0
San Miguel	1,475	0	0	0	0	0	0	0	0	0	0	0	0
Sedgwick	893	0	0	0	0	0	0	0	0	0	0	0	0
Summit	5,261	2	0	0	0	0	0	0	0	0	0	0	0
Teller	6,825	0	0	0	0	0	0	0	0	0	0	0	0
Washington	1,593	0	0	0	0	0	0	0	0	0	0	0	0
Weld	103,036	62	0	0	0	0	0	$105,777.19	$26,478.99	0	0	$54,437.47	0
Yuma	3,536	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**1,670,703**	**1,826**	**44**	**1**	**0**	**25**	**9**	**$2,194,574.30**	**$261,085.60**	**$37,871.37**	**$927,938.76**	**$452,653.25**	**25**

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 › Premiums, Expenditures, and Caseload › Health First Colorado Member Caseload by County. The Document is entitled Health First Colorado Member Caseload by County Reports for Stakeholders using the Medicaid Member Caseload by County, June 2023.

APPENDIX B: INVESTIGATIONS OF PROVIDER FRAUD (7/1/2022 TO 6/30/2023)

Type of Investigation	# of Closed Investigations	# of New Investigations
Fraud	33	59
Drug Diversion	0	0
Abuse, Neglect, & Financial Exploitation	16	12
TOTAL	**49**	**71***

* 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
9	0	1	9

CIVIL COMPLAINTS FILED, CASES DISMISSED, AND CONFESSIONS OF JUDGMENT

Civil Complaints	Cases Dismissed	Confessions of Judgment
0	0	0

CRIMINAL RECOVERIES, RESTITUTION ORDERED, AND RESTITUTION COLLECTED

Total Criminal Recoveries	Restitution Ordered	Fines and Penalties	Restitution Collected
$913,676.54	$912,676.54	$1,000.00	$27,005.06

CIVIL RECOVERIES AND CIVIL COLLECTIONS

Total Civil Recoveries	Principal State Recovery	Fines, Penalties, and Interest	Recoveries Collected
$6,341,752.11	$5,579,852.27	$705,715.62	$905,017.04