Improving Medicaid Fraud Prosecution

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

Due Date: November 1, 2024

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

COLORADO
Department of Health Care Policy & Financing

Contents

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 2023-2024 (SFY 2023-24):

- **$3,839,046** was identified as the total aggregate Health First Colorado savings for members and providers.
- **$536,541** of member fraud was identified, as reported by the counties.
- **$877** of member non-fraud was identified, as reported by the counties.
- **$65,404** was identified by the Colorado Medicaid Fraud Control Unit (COMFCU or Unit) in provider criminal restitution.
- **$2,253,156** was identified in provider civil settlements by the COMFCU.

The following fraud trends were identified for SFY 2023-24:

- 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, 2023 to June 30, 2024. 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 2023-24 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 policy changed by 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 provides the conditions that must be met in order for individual states to receive federal matching dollars for "State plans for medical assistance" such as Medicaid. Title 42 U.S.C. 1396a(a)(61) requires that a state "must demonstrate that it operates a Medicaid [sic] 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, state programs 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). OIG-HHS reviewed the COMFCU for the time period of April 1, 2023, through March 31, 2024, and determined that the Unit was in compliance with the federal statutory and regulatory requirements for state Medicaid Fraud Control Units. OIG-HHS recertified the COMFCU for an additional one-year period (July 1, 2024, through June 30, 2025).

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, the Unit 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.

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 appropriate circumstances, the COMFCU will refer a matter to a different governmental agency with jurisdiction to address the situation presented. The COMFCU's jurisdiction does not extend to the investigation of fraud by recipients, for example. Complaints involving false statements of income or eligibility for Medicaid are referred by the COMFCU to other applicable state and federal agencies that have jurisdiction.

Matters referred to the COMFCU often require substantial investigation as they may involve hundreds of patients and tens of thousands of pages of documents, and it may take months or years to complete an investigation. Once fully investigated, it is not uncommon for a matter to be closed without the filing of charges. This can occur for a variety of reasons, such as an inability to prove criminal intent, lack of evidence to substantiate a charge, or inconsistencies and vagueness of the applicable rules of the Medicaid program. The Unit endeavors to be as 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 Medicaid members

Cases Investigated by County – Total number of Medicaid member fraud cases that were investigated

Criminal Complaints Requested – Total number of criminal complaints concerning Medicaid member fraud that were requested

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

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

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

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

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

Non-fraud Recoveries - Recovery amount that Medicaid has established as an overpayment due to reasons other than fraud, such as member error or mistake

Fines and Penalties – Monetary amount a court orders to be paid as a penalty

Restitution Ordered – Monetary amount ordered by a court to repay for services

Restitution Collected – Monetary amount actually received to recoup expenses stemming from services

Terminations – Total number of Medicaid member fraud investigations that led to terminations this fiscal year

Overall Totals

Member Fraud – As reported by the counties

- **2,094** investigations of member fraud during the fiscal year. This is an increase of 15% from last fiscal year.
- **64** terminations of services of member Medicaid benefits due to fraud. This is an increase of 156% from last fiscal year.
- Number of District Attorney actions:
  - **21** criminal complaints requested
  - **1** case dismissed
  - **0** cases acquitted
  - **8** convictions
  - **2** confessions of judgment
- **$536,541** of fraud identified, as reported by the counties. This is a decrease of 76% from last fiscal year.
- **$877** of non-fraud identified, as reported by the counties. This is a decrease of 99% from last fiscal year.
- **$15,128** of fines and penalties recovered and retained by counties. This is a decrease of 60% from last fiscal year.
- Amount of Restitution:
  - **$412,804** ordered. This is a decrease of 56% from last fiscal year.
  - **$25,7993** collected. This is a decrease of 43% from last fiscal year.

Analysis of Investigations and Estimated Member Fraud Cost Avoidance

During SFY 2023-24, there was a 76% decrease in member fraud recoveries from last fiscal year, down to **$536,541**, but with a 15% increase in the number of investigations of member fraud. The COVID-19 Public Health Emergency, as declared and extended by the U.S. Department of Health and Human Services (PHE), officially ended on May 11, 2023. However, in accordance with the Families First Coronavirus Response Act, signed into law on March 18, 2020, (FFCRA), which led to corresponding HCPF policy guidance issued, in place for all of SFY 2023-24, no overpayments could be collected for any ineligibility period falling within the previous PHE period.

On October 17, 2022, CMS issued guidance in the form of a frequently asked questions document (FAQ), entitled, "COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies."[1] In this guidance and through subsequent conversations with HCPF and other states, CMS conveyed a new policy prohibiting all administrative overpayment recoveries from Medicaid members. CMS stated 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, and through state criminal process.

Since the publication of the October 17, 2022, FAQ, CMS has stated numerous times that further formal written guidance is in process, but no such guidance has been received prior to the submission of this report. However, HCPF still anticipates that whenever this additional written guidance is released by CMS, it will likely reinforce and make permanent the prohibition on administrative overpayment recoveries from Medicaid members.

In accordance with the CMS FAQ, subsequent CMS verbal clarification, and a lack of updated formal written guidance from CMS, HCPF's previously issued Operational Memo 23-034, entitled "Temporary Prohibition on Administrative Overpayment Recoveries from Medicaid Members" continued to be in effect for all of SFY 2023-24.[2] Under this Memo, counties could not recover an overpayment from a current or past Medicaid member outside of the criminal court process.

Counties were instructed to continue to investigate fraud referrals, and to terminate eligibility for currently ineligible members. During SFY 2023-24, counties could still refer cases to their local county district attorneys for potential criminal charges and criminal restitution. Dependent upon further written guidance being released by CMS, Operational Memo 23-034 may be subsequently revised, removed, or made permanent.

As expected, the CMS policy change prohibiting administrative recoveries has continued to substantially reduce fraud and non-fraud recovery numbers. Eligibility terminations are up

[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

156% this fiscal year, as following the end of the PHE it again became permissible to terminate eligibility for those members who were found to be ineligible for Medicaid benefits following a fraud investigation.

Cost avoidance increased this year, coinciding directly with the increase in eligibility terminations following the end of the PHE. This fiscal year there was a resulting cost avoidance of approximately **$555,136**, up from **$164,376**, 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 decreased in SFY 2023-24, down to **$15,128**, **$412,804**, and **$257,993**, respectively. While the new CMS policy prohibiting administrative recoveries made criminal court proceedings the only means of recovering from Medicaid members, not all counties are able to effectively build cases for potential criminal prosecutions due to limited county resources and staffing. Additionally, local district attorney offices have differing priorities and case load levels, as well as varying threshold requirements for accepting Medicaid cases.

Provider Fraud - As reported by the COMFCU

Between July 1, 2023, and June 30, 2024, the COMFCU received 435 complaints and referrals, which is generally consistent with the number of recorded complaints and referrals received in prior state fiscal years. Included in that number are fifteen referrals received from HCPF, from which eight new cases were opened by the COMFCU for preliminary review, and two ongoing investigations continue.

In addition to referrals received from HCPF, the COMFCU also received referrals 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, and the Department of Public Health and Environment; federal agencies, such as OIG-HHS and the Federal Bureau of Investigation; and Medicaid clients and their caregivers. After a preliminary review of the 435 referrals that the COMFCU received in SFY 2023-24, the Unit made formal decisions to open 112 cases. The Unit was active across Colorado, having received referrals from many areas of the state.

The COMFCU saw fluctuations in staffing levels during SFY 2023-24, due to the appointment of a new Director, hiring of a nurse analyst, retirement of a senior civil attorney, and the resignations of two criminal investigators. Nevertheless, the Unit implemented new internal procedures that contributed to increased numbers of cases being opened and assigned to investigators and attorneys for investigation. During SFY 2023-24, the COMFCU opened a total of 172 matters for initial investigation overall, including referrals received during prior fiscal years. This number included 148 fraud cases, 24 abuse and neglect cases, and 0 drug diversion cases. Of the fraud cases, 74 were civil cases, and 74 were criminal cases. Additionally, in the last week of the Federal Fiscal Year 2023-2024 (as of September 30,

2024), COMFCU has 295 active investigations, of which 69 are criminal investigations, including 16 abuse/neglect matters, 1 drug diversion matter, and 52 fraud matters.

During SFY 2023-24, the COMFCU filed three criminal cases and one civil case. Four criminal cases (three fraud cases and one abuse and neglect case) that had been filed in prior fiscal years were resolved, with four defendants sentenced in criminal courts. The criminal matters filed and prosecuted involved a variety of conduct, including a 28-year-old respite patient who choked to death after caretakers did not follow medically necessary line-of-sight feeding protocols; a home caretaker who submitted fraudulent timecards alleging caretaking for a family member that was not provided; a day habilitation provider that billed and received payments for services not provided; and a personal services provider that submitted billing for services provided to an individual who was in fact incarcerated during the billing period. For the four cases sentenced during SFY 2023-24, criminal restitution was ordered in the amount of $704,467.07.

During SFY 2023-24, COMFCU collected $65,403.58 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. In addition to criminal prosecutions, COMFCU recovered $2,253,156.13 in civil matters, and collected $1,285,327.68. Civil recoveries include $513,869.18 in penalties, interest and damages. No litigation costs were recovered during the review period.

Total Cost Savings from Members and Providers

In SFY 2023-24, the total aggregate Medicaid savings for members and providers was **$3,839,046**[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 Medicaid amount of all state Medicaid members in order to obtain a yearly amount of Medicaid dollars saved. This fiscal year, there were 64 terminations. The average cost per Medicaid member for this past fiscal year, per month, was $722.81, or $8,673.76[4] per year. Therefore, the estimated cost savings is **$555,136**. This savings is in addition to the **$536,541** fraud recovery amount.

The cost savings formula is laid out below:

[3] From the member side, this total cost savings figure includes **$536,541** in fraud recoveries, **$877** in non-fraud recoveries, **$15,128** in fines and penalties, **$412,804** in restitution ordered, and **$555,136** in estimated cost savings from terminating ineligible members. On the provider side, the total cost saving figure reflects **$65,404** in criminal restitution, and **$2,253,156** million in civil recoveries
[4] Source of data for average monthly cost is based on HCPF's Nov. 1, 2024, budget request.

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

$8,674 x 64 = **$555,136**

During SFY 2023-24, 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 continued to work closely 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 with policy adherence following the end of the PHE period.

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. For a portion of SFY 2023-24, this position 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. These subgroup meetings continued to be attended by HCPF staff throughout SFY 2023-24. 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. Following the end of the PHE, the now completed required redetermination of all Medicaid members has further ensured that ineligible members are disenrolled from Medicaid.

Cost Savings – Providers

During this review period, the State of Colorado tasked the COMFCU's law enforcement team of up to **24** staff members with investigation authority and civil or criminal prosecution authority to protect the funds and beneficiaries of Colorado's approximately $15 billion Medicaid program. The COMFCU's recoveries for the state Medicaid program resulted in savings to the state, significantly exceeding the cost of the COMFCU. The COMFCU was able to recover a total of **$2,253,156.13 in fraudulent Medicaid billing.** Additionally, it should be noted that if the providers responsible for such billings had not been identified, the

fraudulent activity would likely have continued and the losses to the Medicaid program would likely have been far higher than the amounts that were recovered.

The Unit experienced positive growth during the last reporting period. Recent increases in funding in the past few years allowed for a larger team of investigators, as well as the successful hire of additional attorneys. The addition of a nurse analyst to assist in reviewing and analyzing medical records and bills has been a tremendous asset for the Unit's civil and criminal investigations. The Unit's civil team now includes three attorneys, which has strengthened the Unit's active civil and *qui tam* practice, and which is expected to contribute to increased recoveries in civil matters moving forward. Staffing increases have allowed the COMFCU to make positive gains towards resolving its backlog of incoming referrals. The COMFCU was able to perform investigations effectively in SFY 2023-24, both in person and using videoconferencing solutions such as Zoom or Microsoft Teams as appropriate.

Despite recent additions, however, the pace of incoming referrals continues to exceed existing staffing. Over time, funding for the Medicaid program has continued to rise faster than funding for the COMFCU, resulting in a backlog of cases and the inability to pursue certain leads and complaints. The Unit has historically needed to "triage" investigative cases, turning down matters involving lower monetary losses and at times limiting the scope of ongoing investigations. For example, if interviews with 200 individual patients are required to determine the true dollar loss to the Medicaid program as a result of a provider's fraudulent conduct, the number of interviews conducted may be capped at twenty or thirty, simply to allow a case to be filed and a partial recovery obtained, allowing the investigator to work on other matters. The COMFCU continues to experience a need to triage referrals and investigations. Since December 2023, the COMFCU's investigator caseloads have tripled, and attorney caseloads have increased five-fold. Nevertheless, the Unit received 62 referrals in SFY 2023-24 that have been preliminarily approved for initial investigation, but which have not yet been assigned to investigators for follow-up due to continuing staffing limitations. This number has continued to increase, and the Unit anticipates that the need to triage investigations will continue through the next reporting period. The Unit will need to confirm state funding for existing FTEs,[5] and fund staffing for additional investigators and attorneys, to continue adequately fulfilling its mission and objectives.

In addition, the number of high priority abuse and neglect referrals and investigations is expected to increase moving forward. 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. Colorado's 65-and-over population has grown much faster than most other states.[6] From 2010 to 2020, Colorado had the second fastest-growing population over the age of 65 in the nation, and this trend is

[5] The Unit has been allocated three investigator positions that cannot currently be filled as state funding has not been confirmed.
[6] Colorado Department of Local Affairs. (2016, Sept. 20). *Aging in Colorado Part 1: Why is Colorado Aging So Quickly?* Retrieved from: https://gis.dola.colorado.gov/crosstabs/aging-part-1/#:~:text=Why%20is%20CO%20aging%20so%20fast%3F%20To%20put,18%25%20in%20Florida%2C%20to%20put%20it%20in%20perspective%29

expected to continue into the next decade.[7] By 2050, the number of older adults in Colorado is expected to double to 1.7 million.[8] 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 covered by Medicaid.[9]

The COMFCU has recently conducted targeted outreach to managed care organizations (MCOs), Long Term Care Ombudsmen, and the Colorado Department of Public Health and Environment (CDPHE) and anticipates that it will receive increased referrals of patient abuse and neglect in the next reporting period as a result. The COMFCU is also in the process of designing an outreach program that will specifically focus on increasing awareness of Medicaid fraud among nursing home facilities, patients, and family members, which is also likely to generate increased referrals. Due to these factors, the Unit anticipates that abuse and neglect referrals, and therefore investigator and attorney caseloads, will continue to increase.

The Unit hopes to add additional investigator and attorney positions in future fiscal years to allow it to adequately handle anticipated increased patient abuse and neglect referrals and to more effectively pursue criminal and civil fraud allegations. Increased staffing for the COMFCU is reasonable in light of the staffing of other state Medicaid Fraud Control Units. Statistics published by the OIG-HHS for Federal Fiscal Year 2023 compared staffing and funding for Medicaid Fraud Control Units (MFCUs) across the nation. In Federal Fiscal Year 2023, the COMFCU had 384 total open investigations, a Medicaid Budget of $13.6 billion, and 22 staff.[10] Statistics reflect that some Medicaid fraud control units in other states with Medicaid program budgets and caseloads comparable to those of the COMFCU had proportionately higher staffing funded.[11]

For these reasons, additional consideration should be given to better leverage federal dollars to support the fraud detection and recovery efforts within Colorado's Medicaid program. The benefit to the State of Colorado is significant. 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. Funding for the COMFCU is provided in a 25% to 75% match

[7] London, N. (2024, April 8). Colorado's Population is Getting Older. It Will Impact Everyone. *CPR*. Retrieved from https://www.cpr.org/2024/04/08/colorado-aging-population/
[8] Gomez A. (2019, May 30). *Aging in Communities in Colorado*. Colorado Health Institute. Retrieved from https://www.coloradohealthinstitute.org/blog/aging-communities-colorado#:~:text=One%20in%20seven%20Coloradans%20(13.8,population%20is%20white%20non%2DHispanic
[9] Henry J. Kaiser Family Foundation. *Colorado Medicaid Fact Sheet*. Retrieved from: http://files.kff.org/attachment/fact-sheet-medicaid-state-CO
[10] U.S. Dep't of Human Services Office of Inspector General. (2023, Feb. 24). *Medicaid Fraud Control Units: Statistical Data for Fiscal Year 2023*. Retrieved from: https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2023-statistical-chart.pdf
[11] The Tennessee MFCU had a Medicaid program budget of $13.4 billion in 2023, and had significantly fewer investigations (209), but twice as many funded personnel (57). The Georgia MFCU had a Medicaid program budget of $16.6 billion, 398 open investigations, and 44 personnel. The Kentucky MFCU had a Medicaid program budget of $16.6 billion, 239 open investigations, and 32 funded positions. The Louisiana MFCU had a Medicaid program budget of $16.6 billion, 472 open investigations, and 61 funded positions. The District of Columbia had the same staffing as in Colorado, but had a much smaller total Medicaid program budget of $4.3 billion, and significantly fewer (66) o pen investigations.

arrangement.[12] For every $25 in Colorado spending used to fund the COMFCU operations, the federal government provides $75 in funding to the Unit. Increased funding for the COMFCU for staffing, although only 25% of the cost of additional investigator and attorney positions, is expected to result in increased recoveries to the Medicaid program and to the State. Given that Medicaid program expenditures are increasing and recently exceeded HCPF's budget by over $100 million General Fund,[13] there is also a need for additional COMFCU resources. 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."[14]

Stevens Amendment Notice[15]: The Colorado Medicaid Fraud Control Unit received 75 percent of its funding from the U.S. Department of Health and Human Services under a grant award totaling $3,795,668.00 for Federal Fiscal Year 2023. The remaining 25 percent, totaling $1,265,218.00 for Federal Fiscal Year 2023, was funded by the State of Colorado.

Trends

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

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

It is clear there are cost benefits to HCPF's fraud investigation efforts. With the significant limitations of the PHE and the CMS policy prohibiting administrative recoveries, HCPF still established fraud recovery totaling **$536,541** and non-fraud recovery totaling **$877**. This was while also avoiding an estimated additional **$555,136** in unnecessary costs by terminating the eligibility of members due to fraud. SFY 2023-24 also showed decreases in criminal restitution, down to **$412,804** ordered and **$257,993** collected.

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[12] 42 USC 1396b(a)(2)(A).

[13] Eason, B. (2024, Sept. 25). Rising spending. Falling enrollment. Nervous health providers. Why Colorado's Medicaid program has the Capitol on edge. *Colorado Sun*. Retrieved from: https://coloradosun.com/2024/09/25/colorado-medicaid-enrollment-budget-overrun/

[14] 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.

[15] The Stevens Amendment, as contained in the Further Consolidated Appropriations Act of 2020, Pub. L. No. 116-94 (Division A, Title V, Section 505), provides: "When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds included in this Act, including but not limited to State and local governments and recipients of Federal research grants, shall clearly state (1) the percentage of the total costs of the program or project which will be financed with Federal money; (2) the dollar amount of Federal funds for the project or program; and (3) percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources."

Trends in provider fraud continue to involve the provision of in-home services and off-site services, including billing the Medicaid program for services that were not provided and overbilling for services rendered. Several of these schemes were observed involving providers of in-home nursing care, providers of day habilitation services for developmentally disabled Medicaid clients, and adult daycare providers.

The COMFCU has received multiple complaints from various sources involving licensed adult daycare facilities. These cases can be challenging, as it can be difficult to ascertain if adult daycare facilities are actually providing covered services, or if they are billing for services not rendered while providing kickbacks to patients who are co-conspirators. In addition, adult daycare and in-home care provider schemes may be difficult to investigate as potential witnesses are often patients who have mental or physical limitations, are unable to provide information, or are unwilling to provide information because the provider is a friend or family member. New procedures and regulations for electronic visit verification requiring that all in-home care providers receive some form of provider ID or registration number to provide services will hopefully help prevent caretaker fraud and make it easier to uncover fraud in the provision of such services.

Genetic testing referrals have declined, although the COMFCU still has several civil cases that are ongoing. Recent fraud trends observed by other states include fraud in the provision of telehealth services, including related to genetic testing. It is anticipated that the COMFCU may see an increase in such referrals in upcoming fiscal years.