

High-Risk Provider & Services Prepayment Review Initiative - Fiscal Year 2025-26

*Response to a Request from the Colorado General Assembly
Joint Budget Committee*

November 1, 2025

Submitted to: Joint Budget Committee



COLORADO
Department of Health Care
Policy & Financing

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Executive Summary

Promoting financial integrity and operational efficiency are critical responsibilities of the Federal Government and Colorado is committed to rooting out waste, fraud, and abuse in Government programs. State and Federal Governments jointly share the cost burden of Medicaid programs and are therefore required to take appropriate action to reduce waste, fraud, and abuse through the identification and recovery of improper payments, the elimination of silos, etc¹. The Colorado Department of Health Care Policy and Financing (HCPF) received funding for FY 2025-26 to conduct prepayment reviews of high-risk providers to reduce expenditures by preventing improper billing. The Joint Budget Committee (JBC) requested that HCPF submit reports by November 1, 2025 and November 1, 2026, describing how HCPF is using the funding for prepayment claims reviews, including information about the services prioritized for prepayment claims reviews and the associated savings estimated and achieved. This report demonstrates how HCPF is continually strengthening oversight and has already achieved over \$8 million in recommended Non-Emergent Medical Transportation (NEMT) savings and is expecting an additional \$14 million in savings for pre- and post-payment claim review efforts for Pediatric Behavioral Therapy (PBT) services based on billing deficiencies identified in a recent audit by the U.S. Department of Health and Human Services' Office of Inspector General (OIG). Additionally, HCPF has expanded its prepayment efforts to Vision providers and services, specifically improper aspheric lens billing. Cost savings for the Vision prepayment review efforts are estimated at \$1.2 million. HCPF has recovered \$585,000 in improper payments from a single Vision provider in FY 2025-26 after the provider conducted a self-audit of claims related to another Medicaid recovery effort. HCPF also is conducting policy analyses on Durable Medical Equipment (DME), Independent Laboratory (Labs), and Home Health by leveraging advanced analytics, rule reviews, and system evaluations to detect additional areas of focus and prevent further improper payments. These and other efforts for the remainder of FY 2025-26 will include:

- Continuing prepayment review efforts for PBT and Vision providers and services;
- Identifying and addressing policy gaps for other high-risk provider types and services including DME, Labs, and Home Health;
- Strengthening systematic audit protocols and enhancing compliance support;

¹ The White House, Presidential Memoranda, Eliminating Waste, Fraud, and Abuse in Medicaid



- Determining additional cost savings through new advanced analytics; and
- Developing provider education related to specific areas of billing.

HCPF is committed to program integrity and estimates achieving a cost savings of over \$15.9 million in prepayment reviews and overpayment collections, achieving the overall estimated Return on Investment (ROI) required for this initiative in FY 2025-26.

Introduction

The identification and recovery of improper payments continues to be a priority focus for Medicaid programs nationally, which serve more than 70 million Americans and account for approximately one-sixth of U.S. health care spending. The Centers for Medicare & Medicaid Services (CMS) reported \$36.7 billion in improper Medicaid payments in FY 2021-22^{2,3}. While not all improper payments are fraudulent, federal watchdogs estimate that each year billions of dollars are spent as a result of intentional improper payment schemes such as phantom billing, up-coding, kickbacks, eligibility falsification, and more. These activities strain federal and state budgets, limit access to care for vulnerable populations, and divert resources from benefits, services and provider reimbursements.

Specifically, programs nationwide face persistent threats from bad actors targeting high-value provider types. For instance, the OIG recently audited multiple states on PBT benefits, also known as Applied Behavioral Analysis (ABA) services. In Indiana, the OIG found that the state had made at least \$56 million in improper payments for ABA services provided to children with autism.⁴ In Wisconsin, the OIG found that the state had made at least \$18.5 million in improper payments for services provided to children with autism.⁵ OIG is currently auditing Colorado Medicaid for PBT benefits and HCPF is expecting very similar findings to Indiana, including a recommendation for repayment of federal share. Another well-known focus area across the nation has been NEMT services. NEMT was implicated in nearly 200 criminal convictions and civil settlements over five years⁶. Additionally, Vision benefits have been the target of

² Centers for Medicare & Medicaid Services (CMS). (2023). Medicaid & CHIP Enrollment Data Highlights.

³ Centers for Medicare & Medicaid Services (CMS). (2022). Payment Error Rate Measurement (PERM) 2022 Medicaid and CHIP Improper Payment Rates.

⁴ U.S. Department of Health & Human Services, Office of Inspector General (OIG). Indiana Made at Least \$56 Million in Improper Fee for Service Medicaid Payments

⁵ U.S. Department of Health & Human Services, Office of Inspector General (OIG), Wisconsin Made at Least \$18.5 Million in Improper Fee for Service Medicaid

⁶ U.S. Department of Health & Human Services, Office of Inspector General (OIG). Medicaid Non-Emergency Medical Transportation: Overview and Fraud Investigations



improper billing in Colorado. In 2022, Colorado Medicaid received over \$1 million in a settlement with an optical lens company that paid providers kickbacks to refer patients and subsequently submitted false claims for payment⁷. The billing complexities and high costs associated with Medicaid benefits create an environment more susceptible to higher volumes of inappropriate and improper spending, therefore requiring Medicaid Programs to expend increasing resources to maintain program integrity.

Background to FY 26 Prepayment Initiative

A concerning shift emerged in the summer of 2023 when numerous newly enrolled NEMT providers began exhibiting unusual billing patterns. HCPF received funding in FYs 2023-24 and 2024-25 to address this outlier concern. The investigation into the suspected improper billing revealed sophisticated billing schemes involving multiple bad actors exploiting the NEMT benefit system here in Colorado and across the nation. In February 2024, HCPF partnered with a contractor, Deloitte, to conduct prepayment reviews of NEMT claims, automate investigation and review processes, and make policy change recommendations to reduce fraudulent and improper billing activities. HCPF realized \$8.8 million in total savings during FYs 2023-24 and 2024-25 from this prepayment effort. Based on the success of prepayment reviews for NEMT services, HCPF requested additional funds for FY 2025-26 to conduct investigations and launch additional prepayment efforts for other high-risk provider types and services. The Joint Budget Committee recommended and the General Assembly appropriated \$3.5 million in FY 2025-26 to generate an overall ROI for the year of \$15.9 million. HCPF is required to submit a Legislative Request for Information (LRFI) of the initial efforts of the funding by November 1, 2025 (this report). A final LRFI of the FY 2025-26 findings must be submitted by November 1, 2026.

Analysis & Assessment Approach

Building on the successes of prepayment review for NEMT services, HCPF has launched expanded efforts to review PBT and Vision benefits where improper billing of services has been identified. For instance, HCPF determined that there was a 300% increase in PBT claims between FY 2018-19 and FY 2023-24. HCPF is expanding immediate claim

⁷ U.S. Department of Health & Human Services, Office of Inspector General, Colorado To Receive Over \$1 Million In Medicaid Fraud Settlement With Optical Lens Company

denials for PBT and Vision services submitted through HCPF's Medicaid Management Information System (MMIS). The claims are vetted against HCPF regulations, provider billing requirements and manuals, and system edits. The prepayment process helps in the standardization of required documentation to ensure providers submit clean and accurate claims. The process also highlights areas for provider education on rules, regulations, and required documentation to enable ongoing compliance with Colorado policy. The prepayment process immediately provides the HCPF program with oversight and compliance, as well as immediately streamlines improper payment detection. The diagram below demonstrates the workflow elements of the prepayment review process.

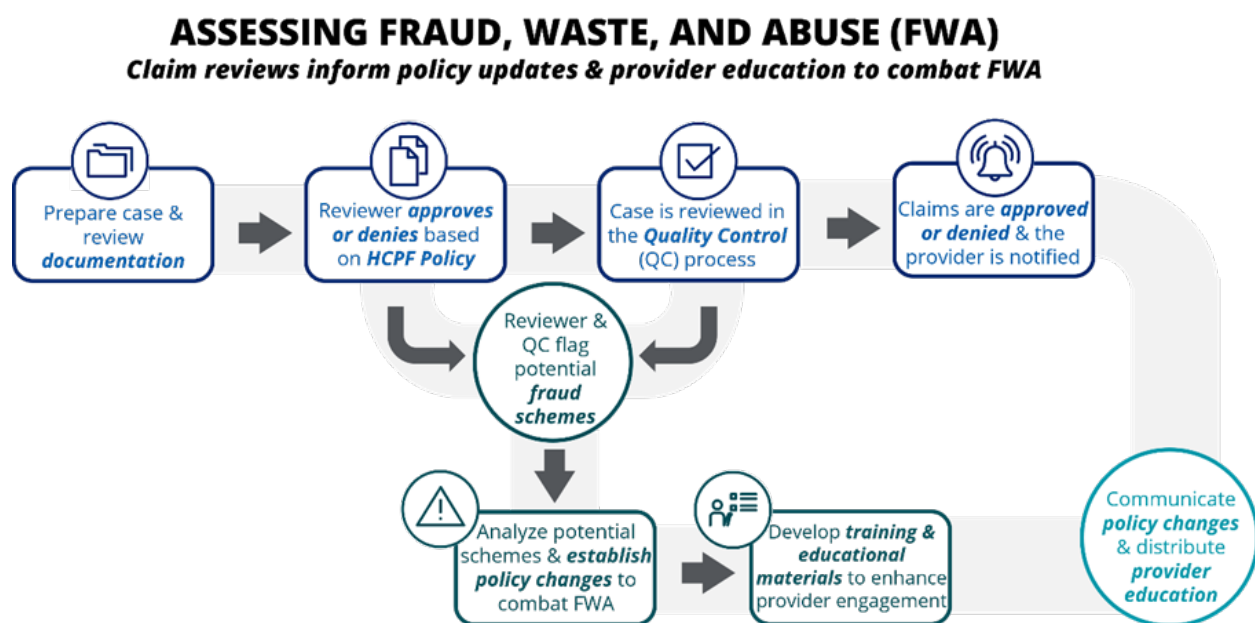


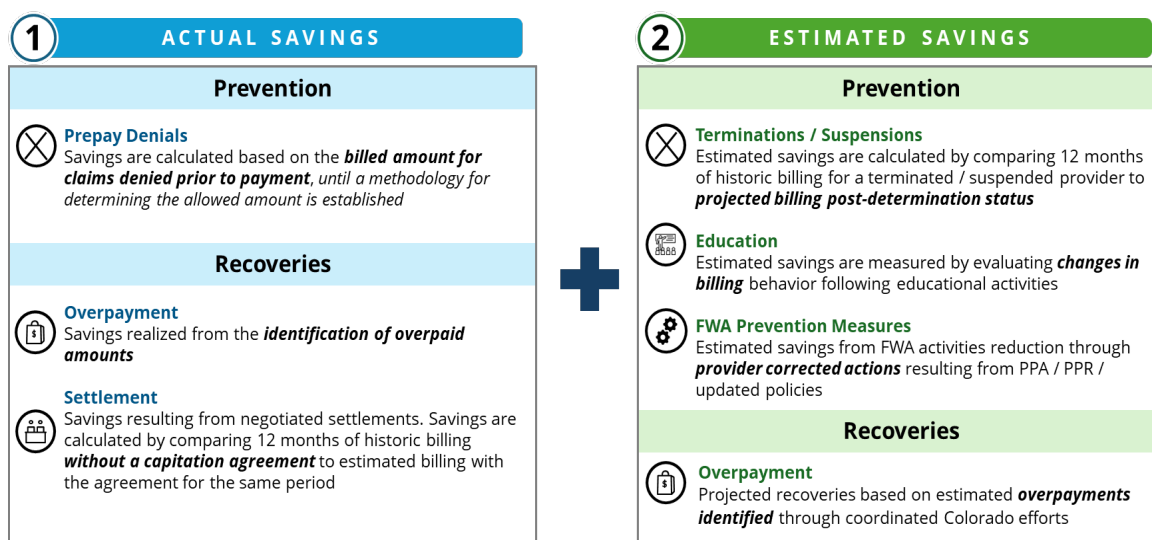
Figure - Combatting FWA Workflow

Additional reviews of other provider types such as DME, Labs and Home Health will be prioritized through a specific policy assessment process which involves analyzing Colorado Medicaid claims data using a broad spectrum of risk indicators. The assessment will identify high-risk providers and behaviors, as well as potential gaps and loopholes in rules and system policies. Identification of the gaps and loopholes will help guide future investigations, audits, and necessary changes. The most prevalent risk areas will be consolidated into a Policy and Provider Analysis List (PAPAL), enabling HCPF to continue targeting efforts in the highest-risk areas. The PAPAL will be available for review by stakeholders and will be included in the final LRFI, which is due November 1, 2026.

Furthermore, HCPF has expanded internal resource capacity and expertise in conjunction with its vendor relationships to aid in analytical efforts and data modeling. In particular, HCPF implemented two new program integrity system modules to assist in identifying and recovering funds, as well as to streamline efforts with overall case management and law enforcement referrals⁸. These measures coupled with ongoing prepayment review and cost savings measures deepen HCPF's capacity to identify and prevent improper payments, reinforce cost discipline, and sustain long-term program integrity and efficiency.

Financial Methodology

For the purpose of reporting on savings under this initiative, HCPF follows a similar methodology to CMS standards⁹, which defines actual savings as *the measurable financial benefit gained*. Estimated savings definitions vary by program but generally refer to *the reduction in expenditures compared to a baseline*. ROI is measured as a combination of actual funds recovered through overpayment recoupments and/or claim denials and estimated cost avoidance from policy and/or process changes.



Combining actual and estimated savings enables stakeholders to see the ROI calculation methodology to date and the pipeline of the value expected from ongoing improper payment identification, prevention, education, and recovery efforts. These

⁸ HCPF has partnered with Alivia Analytics to launch the FWA Finder analytics tool and the Recoveries Electronic Database (RED) Case Management Solution.

⁹ National Health Care Anti-Fraud Association. (2021). FY2022 Medicare and Medicaid PI Report to Congress (RTC).

insights support more informed budgeting, priority setting, and accountability to align with federal methodologies and requirements.

FY 2025-26 Initial Findings

In FY 2025-26, prepayment reviews will initially bolster real-time oversight of NEMT, PBT, and Vision providers and services with additional areas of focus to follow. Here are the current findings as of November 1, 2025:

Actual Savings: A total of \$8 million in denials of improperly billed NEMT claims has been realized with over 105 providers and 11,000 claims reviewed since July 1, 2025. In addition, the prepayment reviews have resulted in strategically negotiated provider settlements and corrective-action plans, developed in collaboration with the Office of the Attorney General (AGO). The efforts have led to improved provider compliance with Colorado Medicaid policies or provider termination from Medicaid altogether¹⁰.

Additionally, HCPF has received over \$585,000 in improper payments from a single provider that conducted a post-payment self-audit of Vision claims. These funds were returned after a recent public settlement with an optical provider that improperly billed over 3,000 claims for lenses, demonstrating the effectiveness of audits and provider education overall.¹¹

Estimated Savings:

Prepayment reviews of the top five (5) PBT providers is estimated to generate \$14 million in savings. The efforts are based on a conservative error rate of 25% and for a review period of only three (3) months. The estimated error rate of 25% is conservatively derived from the OIG audit of Indiana that found roughly 95% of PBT claims lacked sufficient documentation and included other billing issues¹². HCPF is expecting a similar claim error rate from OIG once the final findings report is published for Colorado. As we see the results of this initial effort for PBT claims, HCPF will initiate additional reviews of more providers and for extended time periods.

HCPF is also reviewing aspherical and other lens claims billed by Vision providers. Initial data and policy reviews have identified this as another high-risk benefit for improper payments due to dramatic increases in billing from certain providers in October 2024. HCPF made rule changes in April 2025 that resulted in corresponding

¹⁰ HCPF estimates \$13.7 million in cost savings through the termination of certain NEMT providers who are no longer billing for services.

¹¹ The Denver Post, Eye Clinic to Pay \$250,000 for Billing Colorado Medicaid

¹² HCPF expects to receive a similar error rate in the final findings of the Colorado audit by OIG.

billing behavior changes for some vision providers. The rule changes are estimated to have resulted in \$1.2 million less in lens paid totals between April and July 2025, or \$323,834.50 monthly. Analysis suggests there are still some vision providers potentially overbilling aspheric lenses and additional cost savings might be achieved if further process changes are applied. HCPF estimates that an additional approximate \$100,000 per month or \$1.2 million annually could be saved through compliance efforts like prepayment claim review.

HCPF has realized over \$8.5 million in actual savings from prepayment reviews of NEMT claims and provider self-audits of Vision services, with an estimated additional cost savings totaling at least \$14 million from PBT and \$1.2 million in Vision prepayment reviews. Further estimated savings for other provider types and services like Home Health, DME, and lab will be derived from the PAPAL analysis, ultimately achieving more than the JCB recommendation of a \$15.9 million ROI for this initiative.

Recommendations

Based on the ongoing efforts described above for FY 2025-26, and given the significant fiscal challenges facing Colorado, HCPF recommends the following actions to maintain and enhance efforts:

- HCPF has included the estimated savings related to pre and post review of PBT services in the November 1, 2025 budget submission. The savings associated with other high-risk provider types and services will be further refined in the second LRFI to JBC due November 1, 2026. The savings associated with these efforts will be addressed in a future budget submission.
- Enhanced technology exploration of options that aid in more expeditious reviews of medical records, case notes, assessments, and more. The enhanced use of machine learning technology will more easily and efficiently identify deficiencies in documentation and increase the volume of claims that can be reviewed for accuracy. HCPF will seek funding through the CMS Health Information Technology for Economic and Clinical Health (HITECH)/Health Information Exchange (HIE) Federal Financial Participation (FFP) program.
- General Assembly consider a statutory change that would enable HCPF to use extrapolation in recovery efforts to more effectively combat improper payments without expending significant resources for claim-by-claim reviews.

Conclusion

Promoting financial integrity and operational efficiency are critical responsibilities and HCPF is committed to rooting out waste, fraud, and abuse in Medicaid through this initiative.

Expanding on the demonstrated success of program integrity efforts for NEMT, HCPF continues to leverage effective strategies and policy assessments to extend oversight into other high-cost, high-risk benefits and provider types to reach the recommended \$15.9 million ROI from this initiative. As the focus of efforts is broadened, ROI will continue to increase. HCPF's proactive, data-driven program integrity initiatives sets a strong foundation for further improvements and increased savings, while also enhancing the ability to educate providers on proper billing.

For the remainder of FY 2025-26, HCPF will continue:

- Expanding prepayment review efforts into additional high-risk provider types and services, particularly Pediatric Behavioral Therapy (PBT) and Vision, as well as DME, Labs and Home Health.
- Identifying and addressing policy gaps for all high-risk provider types and services to further strengthen billing practices.
- Strengthening systematic audit protocols to enhance compliance support.
- Determining additional cost savings through advanced analytics of fraud, waste & abuse.
- Developing provider education related to specific areas of billing questions and concerns, e.g., Sepsis coding and billing.

HCPF will maintain ongoing reporting and documentation of the efforts and successes of this initiative throughout the fiscal year. These materials will be used to draft a final LRFI highlighting the cost savings and policies for delivery on November 1, 2026.