Colorado Medicaid Fact Sheet
Protecting Against Fraud, Waste and Abuse

April 2025

The Department of Health Care Policy & Financing (HCPF) oversees the state's Medicaid program and takes program integrity seriously by leveraging several tools and techniques to be sound stewards of taxpayer dollars. **From July 2023 to February 2025, HCPF reduced inappropriate Medicaid spending by more than $300 million through prospective cost avoidance and retrospective recoveries.**

HCPF works to efficiently administer Colorado Medicaid, and to protect member benefits and eligibility and provider reimbursements through thoughtful, time-tested and proven cost control mechanisms, including:

Ensuring proper payments are made to qualified providers

- Preventing overpayment by conducting pre-payment reviews of high cost and high risk claims
- Using technology to identify improper provider billings while rejecting or correcting overbilling before payment is made
- Updating provider eligibility daily to ensure only valid providers are paid
- Reviewing provider claims through a contracted vendor, as required by federal law, to reduce improper payments and recoup overpayments
- Conducting post-payment reviews for Long Term Services and Supports to ensure proper billing. HCPF reviews a minimum of 5,000 claims each year to meet CMS requirements; **in state fiscal year (FY) 2023-24, HCPF recovered $1.36 million through these post payment reviews.**

More detail on each of these efforts is on the following pages.

Ensuring only those who are eligible are enrolled

- Checking member eligibility annually and proactively disenrolling people who move out of state. **Last quarter, we outreached 23,138 members who may have moved and enrolled in another Medicaid program** to terminate cases and prevent overpayments from duplicate coverage.
- Removing deceased members and recouping capitation payments: **HCPF processes have recovered $7.64 million in capitations from 2017 through February 2025**

Recovering improper payments and payments from third parties where appropriate

- Ensuring Medicaid is the payer of last resort: **HCPF achieves approximately $20 million quarterly in cost savings** from the denial of claims for proper coordination with a commercial carrier and **approximately $250 million quarterly in cost savings** from the denial of claims for proper coordination with Medicare
- **HCPF FY 2024-25 Fraud Waste and Abuse and Third Party Liability (TPL) recoveries and cost avoidance efforts currently average about $20 million per month.**

COLORADO
Department of Health Care Policy & Financing

Ensuring Only Those Eligible Are Enrolled

Public Assistance Recipient Information System (PARIS) - PARIS is a tool to identify members who may be enrolled in a Medicaid program in another state. The data from this program allows HCPF to identify, outreach and disenroll as appropriate those who may no longer be eligible because they are enrolled with a Medicaid program in another state. Last quarter, PARIS found 23,138 member matches and performed outreach to terminate member cases and prevent overpayments and duplicate coverage for members who had moved to another state.

PARIS is actively working with other states and federal agencies to enhance the matching process to run monthly rather than quarterly. It is also working to add other important data elements to use in providing proper eligibility, such as death data from the Death Master File (DMF), incarceration data from the Prisoner Update Processing System (PUPS), and information from the List of Excluded Individuals/Entities (LEIE) to identify those banned from participating in Medicare and Medicaid. Third, PARIS is also researching the ability to use Do Not Pay (DNP) data maintained by the U.S. Department of the Treasury to determine proper eligibility. As these three advances are implemented, Colorado Medicaid's eligibility management efficiencies will advance in tandem.

Annual Renewal Process - Federal law requires each Medicaid member's eligibility to be reviewed every 12 months to make sure an individual still qualifies. Many member renewals can be completed automatically using current information on file or from other programs; other members will need to submit a completed renewal packet to verify that they still qualify for coverage. Those no longer eligible are disenrolled and receive contact information for the Connect for Health Colorado health insurance marketplace.

Removing Deceased Members - Some payments, known as "capitation payments," are released monthly to providers and contracted entities to secure access to care or certain administrative services. Capitation payments can be made on people who are deceased because of the delay in time from when a payment is released and when notification is received that a covered individual has passed away. HCPF has processes in place to recover all unallowable payments upon the receipt of verified death information. In 2021, HCPF automated capitation payment recoupments and enhanced verification processes, further reducing the risk of future improper payments. HCPF processes have recovered $7.64 million in capitations from 2017 through February 2025. Processes continue to run daily.

Ensuring Proper Payments are Made to Qualified Providers

Provider Enrollment – Colorado Medicaid updates its provider file nightly to remove disenrolled, terminated or suspended providers. This updated provider file is employed during claims processing and populates the provider locator website. Revalidation of enrolled providers is verified through a federally required process every five years. This makes sure that all providers continue to meet established state and federal standards for billing as well as monitoring and reporting on care quality, member safety, fraud, waste, abuse, outlier utilization, cost trends and more. Approximately 104,000 providers are enrolled in the Colorado Medicaid network to provide care to enrolled members.

Third Party Liability (TPL) Edits - To make sure Medicaid is the payer of last resort, HCPF loads its medical and pharmacy claims systems with Medicare and commercial health insurance coverage information to determine the proper coordination of payers when a member has more than one payer. Every claim submitted to Medicaid for payment is immediately reviewed for other coverage and is denied back to the provider for proper billing when other coverage exists that was not billed first. Providers can resubmit a denied claim once the other coverage has been billed. HCPF achieves approximately $20 million quarterly in cost savings from the denial of claims for proper coordination with a commercial carrier and approximately $250 million quarterly in cost savings from the denial of claims for proper coordination with Medicare. All cost savings are reported to the Centers for Medicare & Medicaid Services (CMS) in required quarterly reporting.

Leveraging Technology to Prevent Overbillings - HCPF leverages intelligence software tools as part of the claim adjudication process that identify improper provider billings, unbundling and upcoding while rejecting or correcting such overbilling practices before payment is made. This technology also determines upfront when billing policies are not being followed by providers to propel improvements in policy and provider training, while also reducing the need to identify and recover payments after the fact. HCPF has been applying and advancing these electronic pre-payment claim reviews since 2020 and is working to adopt additional intelligence software modules that keep pace with and mitigate the impact of industry overbilling and revenue maximization behaviors.

Pre-Payment Reviews – Pre-payment reviews allow HCPF to determine the accuracy of information on provider claims prior to making payment. These reviews are in place for large claims and outlier claims prior to payment. They are also in place on high risk claims to mitigate fraudulent spending before it occurs. For example, pre-payment reviews are in place to mitigate overpayments to Non-Emergency Medical Transportation (NEMT) providers. HCPF has been comprehensively addressing an NEMT fraud scheme by also suspending enrollments, terminating for cause, and making referrals to the Office of the Attorney General's Medicaid Fraud Abuse and Neglect Unit (formerly the Medicaid Fraud Control Unit) and other law enforcement agencies.

Ensuring Proper Payments are Made to Qualified Providers

Post-Payment Review: Long-Term Services and Supports - The Long-Term Services and Supports (LTSS) program integrity follows federal regulations and state statutes when performing post-payment reviews on qualified providers. HCPF conducts ongoing post-payment reviews on approximately 190 nursing facilities. Medicaid is the payer of last resort, meaning if a member has other insurance coverage or is required to pay their share of the cost while in a nursing facility, that funding must be used before Medicaid will pay. These post-payment reviews make sure that qualified providers bill according to HCPF rules and regulations. HCPF recovered over $1.2 million during FY 2023-24 from nursing facility post-payment reviews. Other post-payment reviews with non-monetary recoveries make sure that qualified providers comply with HCPF rules and regulations. Compliance includes making sure nursing facilities maintain fiduciary care of resident personal needs accounts and that home and community-based services (HCBS) waiver direct care workers are paid at least the minimum base wage for rendered services, among other rules and regulations. The Colorado Medicaid claims billing system is utilized to prevent overbillings with well-designed system edits and audits specific to nursing facilities. In addition, nursing facility enrollments are closely monitored, and HCPF approval is required before enrollment applications can be completed and accounts activated. HCPF also conducts annual records reviews of HCBS claims as part of CMS requirements of all HCBS waivers. HCPF reviews a minimum of 5,000 claims each year to meet CMS requirements; in FY 2023-24, HCPF recovered $1.36 million through these post-payment reviews.

Post-Payment Review: Unified Program Integrity Contractor (UPIC) Program - HCPF participates in the UPIC Program, which is implemented and operated by CMS. Vendors are contracted by CMS and assigned to geographic regions to conduct audits and investigations of providers to detect and address fraud, waste and abuse within the Medicare and Medicaid programs. HCPF and the UPIC vendor for the Southwest Region work together under a joint operating agreement to coordinate fraud, waste and abuse reviews and referrals and recover identified overpayments. The UPIC vendor also works with multiple law enforcement agencies to coordinate provider investigations, including the U.S. Office of Inspector General and the Colorado Medicaid Fraud Abuse and Neglect Unit.

Post-Payment Review: Recovery Audit Contractor (RAC) Program - Federal law requires states to contract with a vendor to review provider claims. The purpose of the review is to reduce improper payments through efficient detection and recoupment of overpayments. Another important result of the review is the identification and implementation of actions that can prevent future improper payments, including provider billing education opportunities to improve the accuracy of future submitted claims for reimbursement. HCPF has made, and continues to make, changes to the RAC program to increase the span and effectiveness of RAC audits and improve provider education in a way that reduces future overbillings while also reducing provider burden.

Recovering Improper Payments and Payments from Third Parties Where Appropriate

Medicaid is the payer of last resort, meaning if a member has other health insurance coverage, that third party insurance must cover services before Medicaid will pay. About 10% of all Medicaid members have known other coverage. HCPF has several Third Party Liability (TPL) recovery initiatives to make sure Medicaid remains the payer of last resort even after it may have erroneously paid a claim. HCPF FY 2024-25 Fraud, Waste and Abuse and TPL recoveries and cost avoidance efforts currently average about $20 million per month. The methodologies are provided below.

Direct Billing of Carriers - When a claim is paid by Medicaid and HCPF later learns of a member having primary commercial insurance, the claim is redirected to the commercial carrier to repay Medicaid directly. This process can be used for any type of claim, especially for high volume services like professional, pharmacy, home health, etc. HCPF received $52 million in repayments from the direct bill process in FY 2023-24. HCPF successfully passed House Bill 25-1033: Medicaid Third-Party Liability Payments. The bill allows HCPF to recover monies from commercial health plans even when the health plan does not have a pre-authorization for the health care service, and precludes that as a basis to deny HCPF's request for reimbursement. HB 25-1033 will generate an estimated recovery of $5 million annually.

Provider Retractions - HCPF employs another TPL recovery process that allows providers the chance to capture higher reimbursements from Medicare and commercial insurance while making sure that Medicaid remains the payer of last resort. When a claim is paid by Medicaid and HCPF later learns of a member having Medicare or commercial insurance, the claim is redirected to providers to bill the primary coverage. Once the provider bills the primary and receives payment, HCPF retracts the Medicaid payment and allows the provider to submit a new secondary claim to Medicaid. If the claim is denied by the primary coverage, HCPF will not retract any funds. HCPF received $21.1 million in repayments from the TPL provider retraction process in state fiscal year 2023-24.

Tort and Casualty - Federal and state law requires HCPF to identify and recover monies from third parties when they are liable for the medical payments made by Medicaid. These recoveries are related to personal injury actions, accidents, and other tort actions. HCPF recovered $24.5 million in tort recoveries in FY 2023-24.

Credit Balance Reviews - HCPF works directly with providers to make sure they are not holding credit balances that are created by the receipt of a full commercial insurance payment and a full Medicaid payment. Providers allow HCPF to review their financial statements to identify the credit balances and then remit the proper overpayment to Medicaid. This process not only makes sure Medicaid remains the payer of last resort but also assists providers with ensuring their financials remain accurate. HCPF received $1.9 million in repayments from credit balance recoveries in state fiscal year 2023-24.

Recovering Improper Payments and Payments from Third Parties Where Appropriate

Estate Recovery - Under the Federal Omnibus Budget Reconciliation Act of 1993 (OBRA '93), Congress required states to recover the cost of Medicaid benefits from the estates of certain members receiving nursing facility benefits and/or home and community-based services. Under federal guidance, members are allowed to retain a primary residence and a primary vehicle as exempt assets for purposes of Medicaid eligibility. HCPF works to recover assets like this from deceased member estates when the member was permanently institutionalized or was 55 years or older and receiving long term care services and supports (i.e., nursing facility, waiver services, etc.). HCPF recovers the minimum amount required under federal law with regard to member estates. HCPF received $4.6 million in estate recoveries in FY 2023-24.

Trust Recoveries - Under federal and state law, members are allowed to create certain types of exempt trusts with excess resources and still be eligible for Medicaid benefits. Exempt trusts require payback to HCPF when the member dies or is no longer eligible for medical assistance in Colorado. HCPF received $6.1 million in trust recoveries in FY 2023-24.

Collaboration with the Medicaid Fraud Abuse and Neglect Unit - As appropriate, HCPF refers instances of potential provider fraud to the Attorney General's Office (AGO) for investigation in their Medicaid Fraud Abuse and Neglect Unit (formerly the Medicaid Fraud Control Unit). We also work with the AGO's Health Care Unit (which represents HCPF) for assistance with the provider suspension process where appropriate, to facilitate pre-payment review, compliance review, and other monitoring and investigation activities.

For more information about HCPF and the programs we administer visit Colorado.gov/hcpf