



COLORADO

Department of Health Care
Policy & Financing

303 E. 17th Ave. Suite 1100
Denver, CO 80203

March 17, 2026

By E-mail to Committee Staff

Chairman Brett Guthrie
Committee on Energy & Commerce
U.S. House of Representatives
Washington, D.C. 20515

Chairman John Joyce, M.D.
Committee on Energy & Commerce
Subcommittee on Oversight & Investigations
U.S. House of Representatives
Washington, D.C. 20515

Chairman H. Morgan Griffith
Committee on Energy & Commerce
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Guthrie, Chairman Joyce, and Chairman Griffith:

The Department of Health Care Policy and Financing (HCPF) is Colorado's single state agency responsible for the administration of Colorado's Medicaid program, Health First Colorado. HCPF provides comprehensive health benefits and services to about 1.3 million members per year including Medicaid, the Children's Health Insurance Program (CHP+ in Colorado) and through ten Home and Community Based Services Waivers. On behalf of HCPF, I am responding to your March 3, 2026 letter regarding program integrity and fraud, waste, and abuse (FWA) in Colorado's Medicaid program.

We appreciate the Committee's attention to ensuring that Medicaid programs operate with strong safeguards that protect beneficiaries and taxpayers alike. Ensuring the integrity of the Medicaid program and the responsible stewardship of public funds is a core responsibility shared by states and the Centers for Medicare & Medicaid Services (CMS). Colorado remains firmly committed to maintaining rigorous program integrity standards and continuously strengthening oversight mechanisms to prevent, detect, and address fraud, waste, and abuse.



While Colorado remains dedicated to continuously improving upon its safeguards to mitigate FWA, we would point out a number of inaccuracies in the Committee's letter. For example, the Committee's letter asserts that "Colorado broadly defines Medicaid eligibility and administers several Medicaid programs that are considered high risk for FWA," but cites a CMS letter directed at the Governor of Maine, not Colorado, in support. As another example, the letter cites actions Colorado has taken to identify, prosecute, and prevent fraud in the Non-Emergency Medical Transport program (NEMT) as a basis to suggest that fraud is occurring unaddressed. On the contrary, as the enclosed materials show, Colorado's diligence in identifying, prosecuting, and addressing fraud has led to many of the policy changes and prosecutions your letter cites.

We share the Committee's concern that fraud, waste, and abuse undermine the Medicaid program and threaten access to care for vulnerable populations, and welcome the opportunity to work collaboratively with federal partners to address the priorities outlined in your letter. Your requests seek detailed information related to program integrity activities, provider screening processes, fraud investigations, and improper payment recovery efforts across several areas of the Medicaid program. While the Committee's wide-ranging and broad requests pose significant burdens upon the agency, Colorado is nonetheless prepared to serve as a proactive partner in the Committee's efforts, and is committed to providing the information and materials necessary to advance the Committee's legislative interests. As such, Colorado has provided an initial set of responsive information, and intends to supplement its responses on a rolling basis.

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This letter and the enclosed documents (the "Confidential Materials") are submitted solely in response to your March 3, 2026 letter. Colorado respectfully requests that it be provided notification, via the undersigned contact, and an opportunity to review any proposed disclosure of the Confidential Materials, before any such information is shared with a third party. Although not to the exclusion of other grounds, Colorado requests confidential treatment of the Confidential Materials that implicate sensitive operational data, third-party privacy interests, or third-party proprietary interests, disclosure of which may harm Colorado, HCPF, or its health care partners with whom Colorado conducts business.

Moreover, by providing these documents, Colorado does not waive, and does not consent to waiver of the attorney-client privilege or attorney work product protection, or any other applicable privilege, immunity, or protection. To the extent that any privileged materials have been inadvertently produced, please note that it does not reflect a decision to waive privilege. Rather, we ask that standard clawback procedures be respected.

Thank you for your time and careful consideration of our response.

Sincerely,

/s/ Ralph Choate

Ralph Choate, Chief Operating Officer



cc: The Honorable Frank Pallone, Jr., Ranking Member, Committee on Energy and Commerce

The Honorable Yvette D. Clarke, Ranking Member, Subcommittee on Oversight and Investigations

The Honorable Diana DeGette, Ranking Member, Subcommittee on Health



Question 1. What actions, if any, are being taken to identify, assess fraud risk, and investigate Medicaid fraud schemes that may be occurring in the state?

a. Please provide all audits related to fraud, waste, and abuse in the state's Medicaid programs including audits completed by third-party contract auditors, from January 1, 2021, to present.

b. Are any audits of the Medicaid program ongoing? If so, please detail the type of audits that are ongoing.

Audits responsive to 1.a. and 1.b. are included with this narrative as Attachment 1. Please find below further information responsive to this request.

FWA Overview

HCPF employs a comprehensive framework to identify risk and achieve compliance involving multiple strategies to prevent, detect, and deter fraud, waste and abuse (FWA) in the Colorado Medical Assistance Program. As part of these efforts, HCPF utilizes a "Detect and Deploy" strategy. This framework includes the following areas.

Identifying Risk

Data Analytics

HCPF uses a layered analytic approach to identify potential FWA risks across providers, members, and claims. Analysts employ a combination of descriptive, predictive, and relational techniques to detect patterns that may indicate FWA. HCPF also verifies existing statistical models from contractors and the federal government to ensure alignment with HCPF and program-specific rules and goals. HCPF currently has 45 analytic models that run monthly to detect irregular Medicaid claims activity in all provider types and services. The models identify patterns of risk in providers, members, groups, and across programs. HCPF uses the results to determine areas for further investigation.

As an example, several methods were used in a recent Non-Emergent Medical Transportation (NEMT) investigation. Descriptive and exploratory analytics were used to detect a large, programmatic billing increase. Similar methods were used to uncover which providers were driving the increase, including outlier detection and spike analysis. Unsupervised machine learning was used to build peer groups of nominally similar providers based on the patient mix they serve. Network analysis was used to uncover non-explicit ties between providers and members, linking problematic providers to other, non-NEMT services.



HCPF has also contracted with an external vendor for a FWA tool and its various FWA models. The FWA tool provides a platform for conducting initial analysis through a large library of statistical models to detect FWA and identify specific providers and services that warrant deeper investigation. The tool analyzes data to identify fraud risks and integrates directly with a case management solution that allows staff to initiate investigations, capture and generate documentation, and refer cases externally to law enforcement agencies.

Environmental Scans

Environmental scans are a way of looking broadly across multiple types of providers and services to identify where there are anomalies, outliers, and trends that are incongruous with what we would expect based on enrollment, populations served, etc. They serve as another mechanism to help target specific issues that need further investigation to determine if there is FWA, if there are policy issues we need to address, or where we have opportunity to get ahead of an emerging problem. Below are examples of some recent environmental scans.

Environmental Scan #1: HCPF contracted with a third party to identify and prioritize high-risk provider types and services, including provider screening of certain behaviors/patterns suggestive of FWA. The initial environmental scan occurred in October 2025. The scan led to a recommended rate reduction for multiple services, as well as risk pools for further investigation in areas like Home and Community Based Services (HCBS), Laboratory, Durable Medical Equipment (DME), and professional services.

Environmental Scan #2: HCPF has contracted with a vendor through an existing partnership to provide a Medicaid Member Analysis to identify and prioritize vulnerable areas of eligibility like incarcerated individuals out-of-state, deceased members, identity inconsistencies, synthetic or fraudulent identities, etc. The results of this scan are expected by June 30, 2026.

Environmental Scan #3: HCPF monitors the cost trend of every benefit for increased utilization or member participation. Anomalous trends are then further investigated by an interdisciplinary team that includes analytic, budget, policy, and clinical staff. This process has identified areas for HCPF intervention including pediatric behavioral therapy/applied behavior analysis (PBT/ABA), long-term services and supports (LTSS), and specialty pharmacy.



External Referrals

HCPF maintains a phone line, email, and webform for people to report information about providers and members suspected of FWA. HCPF reviews any information received to determine if there is a suspected fraud issue and if so, HCPF refers the case to the proper law enforcement agency for full investigation.

National Participation and State Partnerships to Improve FWA Efforts

Staff at HCPF participate in a variety of national associations and groups to collaborate with other state and federal partners to identify different schemes and issues that could lead to FWA in Colorado. This includes:

- Healthcare Fraud Prevention Partnership (HFPP): HCPF reviews data provided to identify improper payments and potential fraud schemes.
- Medicaid Integrity Institute (MII): HCPF has attended and presented at training courses covering topics such as audits, managed care oversight, provider enrollment, and data analytics.
- The National Association for Medicaid Program Integrity (NAMPI): HCPF staff attend the annual conference and have presented on topics relevant to FWA investigations.
- FWA Technical Assistance Group: Department staff participate in the monthly discussion of issues states face in their FWA programs.
- Unified Program Integrity Contract (UPIC) Southwest Region: UPICs are CMS-contracted entities that detect and investigate FWA in Medicare and Medicaid. They conduct data-driven, pre- and post-payment audits, often triggered by billing anomalies, high-volume claims, or complaints. Non-compliance can lead to severe penalties, including payment suspensions, revocation of billing privileges, or legal prosecution.
- FWA CMS Regional Meetings: Monthly meetings held between CMS and all State Medicaid Agencies to identify national trends and issues of concern and determine comprehensive solutions between state and federal partners.
- Third Party Liability (TPL) CMS Regional Meetings: Monthly meetings held between CMS and all State Medicaid Agencies to identify national trends and issues of concern and determine comprehensive solutions between state and federal partners.

Establishing Provider Expectations

Statutes, Rules, Guidance

HCPF establishes and provides notice of the requirements of the program through state statutes, state regulations, and HCPF-issued guidance. Colorado's Medicaid Provider Participation Agreement (PPA), which all providers sign to participate in the program, requires that all providers follow all applicable federal and state statutes, rules and guidance. These documents set expectations for compliance.



The PPA sets forth the requirements related to provider legal compliance and the consequences of noncompliance. Specifically, section 3.1.2 of the PPA states:

If HCPF determines that the Provider failed to comply with any of the Laws or terms of this agreement, including the claims submission requirements described below in section 3.2, HCPF has the discretion to impose any sanction authorized by law, including suspension of payments to the Provider when there is a credible allegation of fraud, suspending the Provider's use of the Portal, placing the Provider on prospective review and/or inactivating the Provider's use of the Portal, initiating administrative, state, or federal legal proceedings against the Provider, or terminating the Provider for cause in accordance with section 7 of this agreement. The Provider acknowledges that failure to comply may also result in administrative action, criminal investigation, prosecution, and all other actions authorized by the Laws.

Colorado's recovery statute authorizes HCPF to recover Medicaid payments to providers equal to the amount of any overpayment. In cases where overpayments are made as a result of a provider's false representation, HCPF can collect the amount of the overpayment plus a civil monetary penalty equal to one-half the amount of the overpayment, plus interest. See C.R.S. § 25.5-4-301(2). Colorado's Medicaid False Claims Act imposes civil monetary liability for false claims submitted to HCPF for payment. See C.R.S. § 25.5-4-305. Civil monetary penalties under the state False Claims Act are equal to the civil penalties imposed under the federal False Claims Act, plus three times the amount of damages sustained by the state because of such false claims. These statutes further strengthen Colorado's robust legal compliance framework to prevent and address FWA.

Provider Education

When provider claims reviews identify a discrepancy that does not result in an overpayment but reflects other forms of noncompliance or an area requiring corrective action, provider education is issued and documented in the case summary. The case summary:

- Cites the applicable federal and/or state rules and regulations;
- Describes the specific discrepancy identified; and
- Clarifies the compliance expectations moving forward.

Provider education is intended to promote prospective compliance and mitigate future risk. Although financial recovery action typically is not required in these instances, documentation of the discrepancy and corresponding regulatory citation establishes a clear compliance standard and supports program integrity oversight requirements.



Recovery Audit Contractor (RAC) Provider Advisory Engagement

The RAC Provider Advisory Board's purpose is to educate providers on RAC audit content, processes, and trends driving overpayment findings, as well as create a venue for providers to give feedback to HCPF regarding the RAC audit process and content. Topics include educating providers on proposed future RAC audits scenarios, professional society guidelines that will be applied in audits, and educating providers on overpayment findings commonly seen in audit scenarios. The PAB also educates providers on topics such as current CMS and OIG areas of payment integrity concerns. HCPF additionally conducts a RAC Provider Stakeholder Engagement meeting each quarter to offer an overview of upcoming program enhancements, discuss audits and reviews, identify common billing errors, and engage in provider feedback and education.

Technical Assistance

HCPF provides Technical Assistance (TA) to ensure providers understand applicable billing standards, documentation requirements, and program expectations. TA is a component of HCPF's oversight and program integrity activities and is intended to promote compliance and improve the accuracy and completeness of claims submission and record maintenance.

TA may include review of submitted documentation, identification of discrepancies or areas requiring clarification, discussion of process deficiencies, and direction regarding necessary corrective action. Representatives from applicable program areas, including Policy and Program Integrity/FWA, may participate in TA activities, as appropriate.

TA also constitutes formal communication of identified concerns. Any records reviewed during the TA process are considered accurate only as of the date TA is provided. Receiving TA does not relieve the provider of responsibility for ongoing compliance. The provider remains solely responsible for maintaining adherence to current and future billing standards, documentation requirements, and program expectations.

Prevention and Controls

Provider Screening

HCPF follows provider screening requirements outlined in 42 CFR Part 455 Subpart E and state regulation at 10 CCR 2505-10, Section 8.125, to ensure that only eligible providers are able to enroll and bill Colorado's Medicaid program. This includes reviewing any information related to license restrictions, exclusions under the System for Award Management (SAM), OIG exclusions, Medicare revocations, other state Medicaid program terminations, prohibited affiliations, and criminal convictions.



CO Public Assistance Reporting Information System (PARIS)

HCPF follows several protocols for identifying and correcting FWA in member eligibility. Colorado out-of-state member matching increases the accuracy of Colorado's Medicaid enrollment, and will play a large role in Colorado's future H.R. 1 compliance. Beginning in 2023, HCPF reduced its out-of-state match totals by over 75% through advanced system automation. These activities led to a sharp decline in the number of capitation payments being paid for individuals who had moved out of Colorado. PARIS has also helped HCPF to identify potential improper payments for federal food assistance (SNAP) and financial assistance (TANF) benefits for our sister agency, the Colorado Department of Human Services.

Federal and Veterans Administration (VA) Files

HCPF utilizes the Federal and VA files when available. The Federal file data has allowed us to identify thousands of instances of third-party coverage - typically private health insurance, Medicare primary, personal injury liability, and workers compensation coverages - which is used to cost-avoid claims for HCPF based on Medicaid's status as the payer of last resort in almost all cases. The VA file has allowed us to identify thousands of individuals who are eligible for VA services and VA service enhancements that reduce member reliance on Medicaid services.

Deceased Members

For several decades HCPF has utilized Social Security Administration (SSA) file feeds and Colorado Vital Statistics data to capture deceased members and close eligibility cases. CO PARIS and CMS have partnered to improve operations through system enhancements associated with changes contained in HR 1. The state and federal partnership is working to implement the new (PARIS) Eligibility Response File. This new file will provide HCPF with SSA Death Master File dates, work requirements, prisoner identification, excluded individuals, and address verification, along with other elements. Colorado has already implemented the project to receive the new file and automate use of the data to properly close beneficiary cases. The data will flow into our Medicaid Management Information System (MMIS) claims system to trigger automatic recovery of capitation payments from managed care entities.

Prior Authorization

HCPF utilizes prior authorizations for many services to ensure that these services are only payable if they have already been determined to be medically necessary for a member prior to the services being rendered.



ClaimsXten Software

HCPF uses a system edit software, ClaimsXten, connected to the MMIS to reduce improper claims payments based on state and federal rules and regulations and previous audit findings. ClaimsXten software helps to ensure that HCPF is only paying for proper claims and services based on specific rules that are part of the tool's library, which are then customized for Colorado Medicaid.

Automated Pre-payment Review (APR) Program

HCPF works with program staff and the MMIS fiscal agent to create customized system edits directly within the MMIS that are not available in the automated tools library for ClaimsXten. These customized billing rules and edits in the system assist with the oversight of claims processing and payments for specific Medicaid programs and benefits. HCPF prioritizes system edits in conjunction with the library of ClaimsXten tools to ensure funding is properly used on permanent solutions that generate cost savings and avoid improper payments.

Manual Pre-payment Reviews

In accordance with state regulation at 10 CCR 2505-10, Section 8.076.2 Compliance Monitoring, HCPF staff and contractors also manually conduct prepayment reviews. These reviews identify a provider or code that HCPF believes is at high risk for being improperly billed and require providers to include supporting documentation at the time the claim is submitted, so that the claim can be reviewed for compliance prior to payment. HCPF can use prepayment claim reviews for any provider paid within the MMIS and for any subset of CPT codes based on identified need or risk.

Deficit Reduction Act of 2005 (DRA) Compliance

In accordance with Section 6032 of the Deficit Reduction Act of 2005 (DRA), HCPF requires providers that meet the definition of "entity" and that make or receive annual Medicaid payments of \$5 million or more to establish and disseminate certain written policies for preventing and detecting FWA. The entities must also provide information to employees and contractors about the Federal False Claims Act and other applicable federal and state false claims laws, the administrative remedies for false claims and statements, and the whistleblower protections afforded under such laws. Each year HCPF requires providers who are subject to Section 6032 to submit certain documentation to show compliance with these requirements.

Intermediary Actions

Cease and Desist Notices

HCPF sends Notices to providers when it is identified that they are not complying with federal or state statutes, rules, or guidance. These letters serve to put providers on notice that they are not in compliance, and that failure to correct the issue will result in further action by HCPF or its partners.



Request for Written Response

In accordance with C.R.S. § 25.5-4-301(15) and 10 CCR 2505-10, Section 8.076.6, HCPF sends Requests for Written Response to providers who are not in compliance with state and/or federal statute, regulation, or guidance. Providers must then send the requested information to HCPF and explain why they failed to comply and provide documentation describing how they will come into compliance. During the period HCPF has sent the request, but not received an acceptable response, HCPF may restrict new referrals and/or put the provider on prepayment review.

Suspension of Enrollment

Under C.R.S. § 25.5-4-301(16), HCPF may suspend the enrollment of a provider who it believes is participating in an alleged and ongoing organized crime or organized fraud scheme. This prohibits the provider from rendering services while HCPF investigates the scheme. This suspension is temporary, for six (6) months, unless HCPF provides written notice to the provider that the suspension is being extended to complete its investigation.

Federal Programs

Recovery Audit Contractor (RAC)

The RAC program was established under the Affordable Care Act (ACA) in 2010. Its primary purpose is to reduce improper Medicaid payments by auditing provider claims to identify overpayments and underpayments. States are required to implement Medicaid RAC programs to ensure compliance with federal regulations and to improve the financial integrity of their Medicaid programs. The Colorado RAC program has continuously existed since 2018 and conducts post-payment reviews on programs across HCPF to ensure compliance and proper billing. Colorado was one of the first states to implement a RAC program under the Affordable Care Act.

Uniform Program Integrity Contract (UPIIC)

As noted above, CMS contracts with a vendor and partners with state regional areas that detect and investigate FWA across Medicare and Medicaid programs. HCPF works with the UPIIC to conduct reviews for potential FWA in a variety of provider types and services and participates in the Major Case Coordination (MCC) efforts to prioritize law enforcement referrals.

Internal Audits, Investigations, Terminations

Internal Post-payment Reviews

Post-payment audits are conducted after claims have been paid and involve a detailed review of provider documentation to verify that services were delivered as authorized, for medically necessary services, and compliant with applicable federal



and state requirements. These reviews can be completed on all provider types and are done on a rolling basis.

HCBS post-payment reviews specifically examine waiver service documentation to ensure services were provided in accordance with the approved service plan, properly documented, and billed within authorized units and waiver guidelines.

Self-disclosures

In accordance with Section 1128J(d) of the Social Security Act, HCPF provides information to providers about how to report and return overpayments through self-disclosure. This process allows HCPF and providers to avoid the disruption and administrative burden of a HCPF-directed audit, when a provider identifies that they have billed improperly.

Self-audits

Under federal and state guidance, providers are expected to conduct self-audits and to disclose their findings, both within areas that HCPF has identified as at high risk of improper payments and in providers' regular course of business. This process allows providers to identify that they have billed improperly in these areas and return funds without a formal audit.

Managed Care Oversight

HCPF uses Managed Care Entities (MCE) to deliver behavioral health services, and in some limited cases, physical health services. In accordance with 42 CFR § 438.600, et seq., HCPF oversees the FWA programs established by these MCEs. Further information about FWA requirements in MCE contracts is contained in the response to Question 8, below. HCPF holds routine accountability meetings with MCEs to discuss policy issues and address high risk areas in these programs. Additionally, HCPF requires monthly and semi-annual reporting on the audits conducted, overpayments identified and recovered, and fraud referrals made to Colorado's Medicaid Fraud, Abuse, and Neglect Unit (MFANU) within the Colorado Attorney General's Office.

Fraud Referrals

HCPF utilizes a fraud hotline, fraud email, and webform to receive allegations of suspected fraud from the community. Further, HCPF uses data analytics and participates in national conferences and meetings to identify high risk areas to investigate for FWA. These tips are reviewed and sent to the MFANU, and/or to the FBI, US Attorney's Office, or OIG, to complete a full investigation. HCPF partners with these law enforcement agencies in their investigation to provide data, policy, and litigation support. These efforts have resulted in both criminal and civil investigations and prosecutions, where HCPF has recovered money and the



resulting headlines have a deterrent effect on other providers. Further, these cases result in strategy recommendations for additional controls and policies that can be implemented to prevent future FWA.

Termination for Cause

HCPF routinely conducts reviews to ensure that providers meet all requirements to remain enrolled in the Medicaid program. This includes reviewing licensing actions, OIG and the federal System for Award Management (SAM) exclusion lists, other states' terminations, Medicare revocations, compliance issues, fraud convictions, and other issues with providers to determine if they should be terminated for cause, removing them from the program, and reported to the OIG, Medicare, and/or to other states.

Nursing Facility (NF) and Intermediate Care (ICF) Post-payment Reviews

The HCPF Office of Community Living (OCL) follows federal regulations and state statutes when performing post-payment reviews of Nursing Facilities (NF) and Intermediate Care Facilities (ICF).

OCL conducts ongoing post-payment reviews on approximately 190 NFs and ICFs. 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 enrolled providers bill according to HCPF rules and regulations. Compliance includes making sure nursing facilities maintain fiduciary care of Medicaid members' personal needs accounts consistent with state and federal law.

Post-payment reviews are specific to paid room and board/accommodation billings for eligible Long-Term Care (LTC) Medicaid members residing in a facility. Overpayment recoveries are possible from this review if the facility billed HCPF for more days than the member was in the facility or if the facility applied an incorrect member share of cost amount to a claim. Facilities are subject to this post-payment review and potential recovery about every five years. Facility changes in ownership require a post-payment review to be performed near the change of ownership effective date. Each review requires paid claim data from the billing system, patient liability (share of cost) amount for each member from the county or nursing facility, nightly census reports, and accounts receivable reports from the facility.



Pre-Admission Screening Resident Review (PASRR) compliance reviews are specific to the first billing date allowed for a NF stay versus the first billed date for room and board/accommodation. Overpayment recoveries are possible from this review if room and board/accommodation billings occurred before a member's admission approval date. These reviews are performed on all nursing facilities on a three- to four-year rotation. They require paid claims data and member eligibility dates located within the billing system. The PASRR Level I and PASRR Level II documentation are utilized to confirm the admission approval date.

Denial of Payment on New Admissions (DPNA) reviews are performed if CMS has imposed a DPNA and substantial compliance has not been achieved by the NF before the DPNA effective date set by CMS. Overpayment recoveries are possible from this review if new admissions to the NF occurred during the specified imposition period. These reviews are performed quarterly, if needed. The review requires paid claim data and the member's admission date located within the billing system. The NF provides any supporting documentation if upon request.

Personal Needs Account reviews are specific to a Medicaid members' personal needs accounts established by the NF. Overpayment recoveries are not expected from personal needs account reviews. However, NFs have a fiduciary responsibility to manage these accounts and maintain supporting documentation for all activity related to these accounts. NFs are subject to this review at most every five years. NF changes in ownership require a review to be performed near the change of ownership effective date. The review requires paid claim data from the billing system, patient liability (share of cost) amount for each member from the county or NF, bank reconciliations, surety bond, and various accounting reports from the NF. NFs that fail to meet these requirements can be subject to state and federal civil money penalties.

Third Party Liability & Recovery

Direct Billing of Carriers

HCPF directly bills commercial insurance carriers for repayment when a claim is paid by Medicaid and HCPF later learns the member has primary commercial insurance or other coverage. This process is used for all types of claims, but particularly for high volume services like professional, pharmacy, home health, etc. HCPF recently passed House Bill 25-1033 that allows HCPF to recover monies from commercial health plans even when the health plan does not have a pre-authorization for the service, and precludes "no authorization" being used as a basis to deny HCPF's request for reimbursement.



Provider Retractions

HCPF utilizes a provider retraction process to allow providers 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 and the Medicaid payment is retracted.

Credit Balance Reviews

HCPF conducts post-payment reviews of provider financials to identify overpayments caused by credit balances from excess payments, improper billing or processing errors and lack of medical necessity. The credit balance recoveries reduce improper Medicaid payments through the detection and collection of overpayments.

Tort and Casualty Subrogation

Under C.R.S. § 25.5-4.301, HCPF recovers money from a legally responsible third party when claims have been paid on behalf of a member involved in an auto, homeowners, malpractice or other tort action where an insurance carrier or other third party is responsible for payment.

Member Estate Recovery

The Colorado Medical Assistance Estate Recovery Program is a federally mandated program that requires HCPF to recover expenditures paid for medical expenses from the estates of deceased members. State and federal law require a member's estate assets to be used to repay HCPF for long-term care services and supports (LTSS) and other related medical expenses.

Member Trust Recovery

Federal and state law allow certain trusts to be created on behalf of Medicaid members to enable applicants and members to qualify for Medicaid when they would otherwise be over resource limits. Each member trust is monitored at least annually to ensure proper distributions are made on behalf of the member, that funds are not being divested or diverted, and to ensure the member is not falling victim to any fraudulent behavior associated with their trust moneys. Any issues identified within a trust are directed to the attention of the member and their trustee to immediately address. Significant problems with a trust are escalated to the Colorado Attorney General's Office. HCPF requires repayment from certain trusts upon the death of the member or when the trust is no longer required for Medical Assistance eligibility.



Question 2. What program integrity measures are currently in place to prevent FWA in your state’s Medicaid programs?

MMIS Pre-payment Measures

In addition to the efforts explained above in response to Question 1, which are also applicable here, HCPF uses system edits within the MMIS to reduce improper payments based on federal rules and regulations, state rules and regulations, and previous audit findings. Program and benefit staff across HCPF review benefit utilization to identify whether the MMIS requires edits to ensure we are appropriately paying medical claims for services. The Automated Pre-payment Review (APR) Program within the FWA Division works directly with its fiscal agent responsible for running the MMIS, and with the vendor responsible for ClaimsXten to find the most efficient use of money, time, and oversight of claims processing and payments. Pre-payment solutions ensure billing accuracy by detecting errors based on industry-standard coding, National Correct Coding Initiative (NCCI), and CMS clinical policies. This ensures there is continuous monitoring of any issues we find as well as a permanent fix to curb provider billing behavior that results in improper payments.

The list below provides the type of pre-payment edits that have been implemented in the software solution to prevent FWA at the source and the savings identified in CY 2025. Approximately \$23M of potential savings were identified, related to FWA.

High Level Rule category	Savings Identified in CY 2025
Add on without base Code	\$3,055,813
E&M Billed on Same Day as Surgery	\$3,859,454
Procedure Validation - incorrect use of Modifier	\$1,693,663
Frequency issues	\$3,254,402
Add on code billed without base code	\$3,055,813
Unbundled Code Pairs	\$794,010
Frequency validation and same day visit	\$3,254,402
New Patient issues	\$1,809,756

In addition to robust system edits, HCPF also has several cost savings measures in place to ensure that only proper claims are paid. The table below provides the cost



saving initiatives and the total amount of cost savings that have been achieved and reported on the CMS 64 between January 1, 2021, and December 31, 2025.

Program	01/01/2021 - 12/31/2021	01/01/2022 - 12/31/2021	01/01/2023 - 12/31/2023	01/01/2024 - 12/31/2024	01/01/2025 - 12/31/2025
Health Insurance Buy-In	\$3,153,406.54	\$2,790,478.09	\$2,987,697.29	\$2,849,042.00	\$2,783,294.59
Commercial Insurance Verification	\$69,169,156.11	\$77,687,934.27	\$91,290,643.55	\$83,418,916.16	\$99,597,713.69
Medicare Buy-In (Part A & B combined)	\$1,180,099,118.61	\$1,379,190,685.27	\$1,505,844,129.52	\$1,497,987,753.41	\$1,545,863,120.32

Health Insurance Buy-In (HIBI)

HIBI, also known as Health Insurance Premium Payments or HIPP in other states, is a premium assistance program that helps pay for commercial coverage premiums for individuals eligible for Medicaid or the Children’s Health Insurance Program (CHIP). When cost effective, HCPF pays a member’s commercial insurance premium to assist in retaining the policy of the primary payer. The commercial insurance is billed as primary for services, lessening the costs being spent by Medicaid and ensuring Medicaid remains the payer of last resort. Rejected claims resulting from primary coverages are tracked for cost savings and reported to CMS quarterly.

Commercial Insurance Verification

HCPF utilizes commercial insurance data from carriers, Pharmacy Benefit Managers (PBMs), and other sources, to ensure Medicaid remains the payer of last resort. Commercial insurance data is added to the member’s record in the MMIS and is then used to ensure providers are properly coordinating payment of claims. If a claim is billed to Medicaid prior to the primary insurance being billed, Medicaid rejects the claim and advises the provider to bill the member’s primary coverage. Rejected claims resulting from commercial coverage verifications are tracked for cost savings and reported to CMS quarterly.

Medicare Buy-In

HCPF pays Medicare Part A and Part B premiums for members who are enrolled in an eligible Medicaid program, particularly Medicare Savings Programs (MSPs). Most members receive Medicare Part A automatically without cost so HCPF only pays the Part A premiums for individuals who meet the criteria for the Qualified Medicare Beneficiary



(QMB) program. Medicare Buy-In programs not only offer significant cost savings for Medicaid but cost savings for low-income seniors and people with disabilities. HCPF pays a member's Medicare premium to assist in retaining the coverage. Medicare is billed as primary for services, lessening the costs being spent by Medicaid and ensuring Medicaid remains the payer of last resort. Rejected claims resulting from commercial coverage verifications are tracked for cost savings and reported to CMS quarterly.

Question 3. Describe the process for making criminal referrals for suspected Medicaid fraud to state, local, and federal law enforcement agencies.

Provider Fraud Referral Process

Medicaid provider fraud referrals may be submitted to HCPF by anyone via phone, email, mail, fax, or via our Department's online form:

<https://hcpf.colorado.gov/how-report-suspected-fraud> Additionally, provider fraud referrals are generated by internal HCPF data review and by Department staff.

Once a provider fraud referral has been received, if needed, HCPF's Referral Specialist follows up with the referral source to collect additional details of the alleged fraud. Next, the HCPF Referral Specialist enters the referral into the case management system and brings the referral to an internal weekly fraud referral meeting. This weekly fraud referral meeting is attended by the Referral Specialist, Reviewers, and Unit Supervisors. This is a meeting where any questions related to referrals can be addressed, and at which time referrals are assigned to individual Reviewers for a preliminary investigation.

After a referral has been assigned, the assigned Reviewer conducts a preliminary investigation, including reviewing the provider enrollment and any involved member enrollments, pulling claims data, reviewing prior authorizations, and analyzing applicable rules, regulations, statutes, provider bulletins etc. Thereafter, if the allegations in the referral are substantiated by the findings of the preliminary investigation, the Reviewer will begin drafting a formal and comprehensive fraud referral written narrative, summarizing the referral and the results of the preliminary investigation, and including attachments of all relevant supporting data.

Once the fraud referral narrative is complete, the Reviewer drafts and signs a credible allegation of fraud form, clearly stating how the allegations in the referral, combined with the results of the preliminary investigation, suggest that there is a likelihood of fraud. The Reviewer sends the fraud referral narrative and the credible allegation of fraud form to a Unit Supervisor for review and approval.



After making any needed edits, if the Unit Supervisor approves the fraud referral narrative, they will sign the credible allegation of the fraud form and submit the referral narrative and all of the attachments to the MFANU. In sending this to the MFANU, HCPF's Unit Supervisor will request that the MFANU respond and inform HCPF if they are accepting the referral for investigation, and if so, if they are requesting the law enforcement exception to the suspension of payments under 42 CFR § 455.23. At this time, HCPF's Reviewer will also send a Suspension of Payment Policy Input form to the relevant HCPF policy staff to advise if there is an applicable good cause exception under 42 CFR § 455.23.

If the MFANU accepts the referral and opens an investigation, they will send a formal case opening form to HCPF, which includes whether or not they are requesting the law enforcement exception. If the law enforcement exception is not requested by the MFANU, and if HCPF policy staff does not find an applicable good cause exception under 42 CFR § 455.23, payments to the provider will be promptly suspended and a notice to the provider is sent out. If the CO MFANU does not accept the referral, they will provide a case closure form stating the reasons they are not opening an investigation.

Once the CO MFANU has opened a case, HCPF staff provide ongoing support for the investigation, including providing enrollment applications, pulling additional claims information, collecting provider call center recordings and HCPF email communications, clarifying relevant HCPF rules and guidance, connecting CO MFANU investigators with HCPF policy staff to better understand particular benefits, and testimony. HCPF staff also provide ongoing support to other law enforcement agencies when those agencies become involved in a Medicaid provider fraud investigation.

Member Fraud Referral Process

Medicaid member fraud referrals may be submitted to HCPF by anyone via phone, email, mail, fax, or via HCPF's online form:

<https://hcpf.colorado.gov/how-report-suspected-fraud>. Member fraud referrals are also generated internally.

Once a member fraud referral has been received, if needed, HCPF's Referral Specialist follows up with the referral source to collect additional details of the alleged fraud. Next, the HCPF Referral Specialist enters the referral into the case management system and assigns the referral to the Unit Supervisor specializing in member fraud referrals and policy.

HCPF's Unit Supervisor then conducts a preliminary investigation into the member fraud referral, utilizing the Case Benefit Management System (CBMS), Colorado's eligibility and enrollment system. Within CBMS, the Unit Supervisor confirms the



member’s eligibility span for Medicaid and other benefit programs, reviews case comments, determines the head of household, and examines household makeup and reported income.

If the CBMS review supports the possibility of the allegations reported in the member fraud referral, the Unit Supervisor prepares a brief member fraud referral narrative to send to the member’s county of residence. HCPF keeps a list of member fraud contacts for each county, ensuring that referrals reach the correct contacts throughout the state. County investigators possess the necessary authority to formally investigate member fraud referrals to their conclusion. If appropriate, a county makes a referral to their local district attorney’s office for criminal prosecution. Counties may also terminate benefits of members determined by the investigation to be ineligible for Medicaid. While a county conducts their member fraud investigation, they continue to be supported by HCPF for any questions, issues, or need for guidance that may arise.

Question 4. What steps are being taken to sanction or disenroll fraudulent Medicaid providers? Please provide information about any sanctions or disenrollments of fraudulent providers, including all evidence supporting disenrollment proceedings.

Where appropriate, HCPF terminates providers for cause. This authority is outlined in 42 CFR § 1002 and 10 CCR 2505-10, Section 8.076.5, Section 8.076.1.7. In the termination process, HCPF removes terminated providers from the network and reports terminations for cause to DEX, for review by other states’ Medicaid Programs, Medicare, and the OIG to determine whether to take their own actions. Below is the total number of terminations for cause issued by HCPF by year, between 2021 and 2026 to date. The list of providers terminated for cause is attached as Attachment 2.

	2021	2022	2023	2024	2025	2026
Terminations for Cause	20	30	34	48	25	1

In accordance with C.R.S. § 25.5-4-301(16), HCPF may suspend the enrollment of a provider believed to be participating in an alleged and ongoing organized crime or organized fraud scheme. This is determined by considering several factors that are outlined in statute. Once the Suspension of Enrollment is implemented, providers are prohibited from rendering services while HCPF investigates. Suspensions are



temporary, lasting for a period of six months, unless HCPF provides written notice to the provider that it is being extended in order for HCPF to complete its investigation.

HCPF proposed and supported the statute change, which was passed in 2023, and was utilized to address an NEMT fraud scheme. HCPF suspended the enrollments of 64 NEMT providers, allowing HCPF to investigate these providers and make fraud referrals, terminate providers for cause, or place providers on a corrective action plan in order to ensure future compliance with HCPF's statutes, rules, and guidance. To date, the NEMT investigation has also resulted in 93 providers not having their provider participation agreements renewed and 56 corrective action plans.

Question 5. How are Medicaid service providers screened for compliance with federal law? Please describe the process for screening, enrolling, and revalidating Medicaid providers, including but not limited to credentialing and site visits.

HCPF assigns each Medicaid provider type risk levels (Limited, Moderate, or High) in accordance with applicable federal and state regulations, including 42 CFR Part 455, Subpart E. Risk level determinations are based on provider type and specialty, consistent with federally defined screening categories.

To enroll, providers must submit all required documentation specific to their provider type, which may include licenses, tax information, malpractice insurance, and other supporting materials. Enrollment requirements by provider type are publicly available at:

<https://hcpf.colorado.gov/find-your-provider-type>

All providers must revalidate at least every five (5) years. Failure to complete revalidation results in suspension of claim payments until the process is successfully completed.

All enrolling and revalidating providers undergo automated screening through LexisNexis, which performs mandatory federal database checks, including the Death Master File (DMF), SSA Death Master File, OIG List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM/EPLS), and the National Plan and Provider Enumeration System (NPPES).

Screening requirements vary by assigned risk level:

- **Limited Risk:** LexisNexis federal database screening
- **Moderate Risk:** LexisNexis screening and a successful site visit
- **High Risk:** LexisNexis screening, a successful site visit, and a Fingerprint Criminal Background Check (FCBC)



Providers who cannot be verified through the automated screening must undergo a manual review and may be referred for further departmental evaluation.

Providers with positive LexisNexis findings are referred for review, and positive FCBC results are reviewed by Program Integrity for appropriate action.

HCPF applies these requirements consistently to ensure compliance with federal regulations and to protect the integrity of the Colorado Medicaid program.

a. Are additional provider screening efforts imposed in addition to federal requirements to screen, enroll, and revalidate Medicaid providers? If yes, please describe these processes.

Yes. For example, due to identified risks, Non-Emergent Medical Transportation (NEMT) providers in Colorado must be credentialed through the State's contracted transportation broker before enrolling as Medicaid providers. Credentialing requirements include driver background screenings, vehicle safety verifications, and proof of appropriate insurance coverage. To help prevent fraud, the broker updates the watermark on provider credential documents each month, making unauthorized reproduction or reuse of credentialing documents more difficult.

While all providers are subject to compliance with the federal Medicaid provider screening rules based on risk level, additional credentialing requirements may be imposed for certain provider types to enroll as Medicaid providers relative to the Provider Type and/or Specialty the provider is seeking. Such requirements are based on a provider's national/state professional requirements, or as codified in state regulation and federal Home and Community Based Services (HCBS)/Community First Choice (CFC) Waiver Agreements, as applicable to the provider and/or service. For example, a Class A License issued by the State of Colorado is required for HCBS or CFC providers to provide certain skilled, hands-on patient care.

Providers may also be subject to service- or specialty-specific credentialing or enrollment requirements. For example, providers enrolling to provide certain Community Mental Health Services on the HCBS Brain Injury Waiver must provide Curriculum Vitae or resumes for Master's or Doctoral level therapists, with evidence of two years of mental health counseling experience and education.

b. How frequently are on-site visits conducted by your state for Medicaid providers by federal screening risk category (limited, moderate, and high risk), including out-of-state providers?



In accordance with CMS categorical risk-based screening requirements, providers are assigned a risk level of limited, moderate, or high at the time of enrollment and revalidation. Risk levels are determined based on provider type and the potential program integrity risk to Medicaid. Providers designated as moderate or high risk are subject to site visits during initial enrollment and revalidation. Providers designated as limited risk are not required to undergo site visits. These screening requirements are consistent with the standards established in federal law under 42 C.F.R. § 424.518 and 42 C.F.R. § 455.432, and in state regulation at 10 CCR 2505-10 § 8.125.

c. Are any programs, provider types, or enrollment pathways exempt from onsite visits, and what statutory or regulatory authority permits those exemptions? Screening levels for Medicaid providers, 42 C.F.R. § 455 subpart E (2011).

No. No program, provider type, or enrollment pathway is exempt from onsite visits. However, federal law does not require site visits for limited risk providers. See 42 CFR § 424.518 (Screening levels for Medicare providers and suppliers); 42 CFR § 455.432 (Site visits); 10 CCR 2505-10 8.125 (Provider Screening).

Question 6. How does your state designate and evaluate risk level of provider types in the Medicaid program in accordance with 42 C.F.R. § 455 subpart E? Please provide the state's current Medicaid programs classified by screening risk level (limited, moderate, and high categorical risk).

In accordance with 42 C.F.R. Part 455, Subpart E, Colorado applies CMS's categorical risk-based screening framework to all Medicaid providers. HCPF aligns Medicaid provider risk levels (limited, moderate, or high) with the corresponding Medicare-assigned risk level for the same provider type. Screening activities are then conducted consistent with the assigned categorical risk level and applicable federal and state regulations.

The Code of Colorado Regulations for screening levels by provider type (10 CCR 2502-10 8.125) can be found using this link.

<https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=12282&fileName=10%20CCR%202505-10%208.100>



a. Have any Medicaid programs' categorical risk levels been reassigned since January 1, 2021? If so, please describe which program(s) were reassigned, including any supporting evidence that contributed to risk reassignment.

Yes. Since January 1, 2021, HCPF has reassigned categorical risk levels for certain Medicaid provider types based on program integrity findings and federal requirements. HCPF has also raised the risk level for three (3) individual providers. Two of the three providers complied with additional conditions for participation and the other one was terminated. No provider risk levels have been decreased.

Non-Emergent Medical Transportation (NEMT)

The NEMT provider category was elevated from "moderate" to "high" risk based on identified FWA concerns, including program integrity issues that warranted enhanced screening and oversight. As a result, all providers in this category became subject to the enhanced screening requirements applicable to high-risk provider types and were required to complete revalidation prior to the next regularly scheduled revalidation cycle.

Nursing Facilities

The categorical risk levels for Nursing Facilities were revised from "limited/limited" to "high/moderate." This reassignment was made in accordance with updated federal screening requirements applicable to this provider type.

Hospice Providers

For new enrollments, Hospice providers were elevated from "moderate" to "high" risk consistent with federal requirements. This change ensures compliance with enhanced screening standards established at the federal level.

Through these reassessments, HCPF ensures that provider screening levels remain aligned with identified program integrity risks and evolving federal requirements, thereby strengthening oversight and safeguarding the integrity of the Medicaid program.

b. How often does your state reevaluate Medicaid provider screening risk level?

HCPF reevaluates Medicaid provider screening risk levels on an ongoing and as-needed basis to ensure program integrity and compliance with federal requirements.

In addition to conducting screening in accordance with federally prescribed risk categories at enrollment and revalidation, HCPF reassesses provider risk levels



when circumstances warrant heightened oversight. Such circumstances include, but are not limited to:

- Identified FWA concerns; and
- Detection of unusual billing or utilization patterns that may indicate elevated program integrity risk.

When risk indicators are identified, HCPF may increase a provider type's categorical risk level and apply enhanced screening requirements consistent with federal regulations. Please see HCPF's response to Question 6.a., above.

Through this approach, HCPF maintains continuous oversight of provider screening risk levels and adjusts them as necessary to safeguard the integrity of the Medicaid program.

Question 7. Does your state collect data on Medicaid programs with abnormal or statistically significant increases in provider enrollment or claims over time, including programs which greatly exceed their estimated cost upon enactment?

Yes. HCPF analyzes claims data by program, benefit and code for significant or unexpected increases. If unexpected programmatic increases are detected, a multi-disciplinary team at HCPF works to determine the underlying cause using a variety of data and analyses including trend analysis, individual provider claims history analysis, or analysis by billing code. If the underlying cause is related to FWA (e.g., abuse of a new code rather than unexpected popularity of a new program), recommendations for policy changes are generated for review by appropriate stakeholders and referrals are made to program integrity or MFANU as appropriate.

a. If so, please detail the programs that have experienced abnormal or statistically significant increases since January 1, 2021, the data that was collected on the programs, and how this data has been used to inform assessments of program vulnerability to FWA.

Programs that have demonstrated unexpected increases and that have resulted in program integrity referrals, or policy changes to curtail cost growth, include:

- Pediatric Behavioral Therapy (PBT)/Applied Behavioral Analysis (ABA)
- NEMT
- Long-Term Services and Supports (LTSS)
- Independent Laboratories
- Durable Medical Equipment



HCPF takes a multipronged approach to address issues in identified areas of concern. For example, we are implementing MMIS edits as an automated prepayment review to ensure PBT/ABA providers incorporate specific required data and documentation, which will result in a claims denial if not submitted. Simultaneously, we are preparing for manual prepayment reviews of claims for certain PBT/ABA providers shown to have unusually high volumes of claims or Medicaid revenue over the past year. In addition to these actions, we also have two RAC audits underway for PBT/ABA providers, with at least one additional RAC audit in the planning phase.

Similarly, HCPF has implemented pre- and post-payment reviews and UPIC audits for NEMT, conducted RAC audits for independent laboratories, and are preparing RAC audits for DME and LTSS, as well as conducting ongoing post payment reviews of 5,000 HCBS claims per year. Additionally, HCPF is in the process of building an annual audit plan for targeted case management for LTSS.

Beyond these specific FWA activities, HCPF's policy and program teams use information gathered from data analytics and FWA efforts to inform policy and benefit changes that may be needed to tighten control of utilization, or proactively close any potentially exploitable loopholes.

b. Is your state utilizing innovative tools, including but not limited to identity verification, artificial intelligence, and data analytics, to detect irregular Medicaid claims activity? If so, please describe these tools. c. If you don't collect this data, why not?

Yes. As described below, HCPF uses multiple innovative and modern tools to detect and address FWA.

HCPF analysts use open-source coding platforms, such as R and Python, to create statistical models that detect potential FWA. These models include:

- **Descriptive and exploratory analytics** e.g., outlier detection and spike/strike analysis;
- **Supervised and unsupervised modeling** e.g. logit/probit regression and clustering methods (K-means, DBSCAN); and
- **Network analysis** such as link analysis.

HCPF uses a third-party FWA platform to identify where further investigation is needed through more robust analytical processes. The tool also has a large library of statistical models that HCPF reconstructs to ensure they align with specific program and billing guidance, have replicable results, and reflect HCPF's definition of risky behavior. HCPF currently has 45 analytic models that run monthly to detect



irregular Medicaid claims activity in all provider types and services. The models identify patterns of risk in providers, members, groups, and across spectrums. HCPF uses the results to determine areas for further investigation.

Question 8. Please provide information on active Section 1115 and 1915 demonstrations and waivers, from January 1, 2021, to present, including:

1115 Waiver

HCPF has one Section 1115 waiver with four components.

- A. Program Name:** Expanding the Substance Use Disorder Continuum of Care 1115 Demonstration Waiver which includes four components: (1) Substance Use Disorder (SUD) services; (2) Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) services; (3) Re-Entry services for those leaving carceral settings; and (4) Health Related Social Needs (HRSN) including housing and nutrition.
- B. Provider Category Risk Level:** Varies across programs and includes limited, moderate and high-risk providers.
- C. Effective Date:** Original SUD components approved for January 1, 2021. Amendment submitted and approved for January 1, 2025 for SMI/SED, Re-Entry and HRSN. Some components approved but yet to be implemented.
- D. Spending:** Approximately \$15.7 million
- E. Enrollment:** Approximately 5,000 individuals served across programs
- F. Services Offered:** For various programs:
 - a. SUD:** SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as Institutions for Mental Disease (IMD).
 - b. SMI/SED:** Reimbursement for acute inpatient and residential stays in IMDs for individuals diagnosed with a serious mental illness (SMI) or serious emotional disturbance (SED).
 - c. Re-Entry:** “Re-Entry” Services include Case Management (up to 90 days), Medication Assisted Treatment (up to 90 days), and pharmacy (30 day supply).
 - d. HRSN:** Housing and nutrition supports, including case management for housing; tenancy and sustaining services; short-term rental assistance; pantry stocking; home delivered and medically tailored meals.
 - e. FWA Measures:** The 1115 utilizes the same FWA prevention measures that are used across HCPF. The relevant program integrity measures include but are not limited to: regular, rigorous program audits; robust screening, enrollment and revalidation process for providers; sanctioning or disenrolling fraudulent providers; leveraging



provider risk levels to determine appropriate oversight; data monitoring to identify statistically significant changes in or any abnormal benefit/program utilization; screening and monitoring fiscal intermediaries participating in Medicaid programs; and support to intermediaries and providers to ensure provider billing and services furnished are accurate and verifiable.

f. Eligibility:

- **SUD & SMI/SED:** Medicaid-eligible Individuals primarily receiving treatment and withdrawal management services for a SUD, or a SMI, or a SED who are short-term residents in facilities that meet the definition of an IMD. Evidence based tools are used to determine eligibility (e.g. American Society of Addiction Medicine (ASAM) Criteria and Adult Needs and Strengths Assessment (ANSA).
- **Re-Entry:** Individuals residing in a correctional facility must have been determined eligible for Medicaid or CHIP (or be eligible for CHIP but for their incarceration status) pursuant to an application filed before or during incarceration and have an expected release date within 90 days.
- **HRSN:** Medicaid eligible individuals who meet clinical and social risk factor criteria and who are enrolled in one of three state housing voucher programs.

Section 1915(c) and Associated Waivers

HCPF administers 10 (ten) § 1915(c) Home and Community-Based Services (HCBS) waivers authorized under the Social Security Act to provide community-based alternatives to institutional care for eligible Medicaid members to ensure individuals can receive services in their homes and communities rather than more costly institutional settings. These waivers include: (1) Elderly, Blind and Disabled (EBD); (2) Developmental Disabilities (DD); (3) Community Mental Health Supports (CMHS); (4) Brain Injury (BI); (5) Supported Living Services (SLS); (6) Children’s Habilitation Residential Program (CHRP); (7) Children with Complex Health Needs (CwCHN), formerly Children with Life-Limiting Illness (CLLI); (8) Complementary and Integrative Health (CIH), formerly Persons with Spinal Cord Injury (SCI); (9) Children’s Home and Community-Based Services (CHCBS), which is scheduled to sunset on June 30, 2026; and (10) Children’s Extensive Supports (CES).

Colorado also operates two (2) § 1915(b)(4) selective contracting waivers that function concurrently with the § 1915(c) HCBS waivers. The first is the Colorado HCBS Wellness Education Benefit (WEB), which operates alongside all ten § 1915(c) waivers and authorizes HCPF to contract with a single provider for delivery



of the Wellness Education Benefit service. The second is the Colorado Home and Community-Based Case Management waiver, which authorizes selective contracting for providers of Targeted Case Management (TCM) and operates concurrently with the EBD, BI, CwCHN, CIH, and CHCBS waivers. The two § 1915(b)(4) waivers were not included in the comprehensive response; however, please let us know if you would like any additional information.

HCPF also operates a § 1915(k) Community First Choice (CFC) authority, which allows select home- and community-based services to be provided in the State Plan. HCPF launched this new authority on July 1, 2025, and members are moving onto this program throughout the transition year (July 1, 2025 - June 30, 2026). Once the transition year is complete, if services are available through CFC, they will be removed from § 1915(c) waivers.

Given the scope and complexity of Colorado's § 1915(c), § 1915(k), and § 1915(b)(4) waiver authorities, HCPF maintains a FWA prevention framework to safeguard federal and state Medicaid funds. These waiver programs serve diverse populations with varying service needs, which require pre-payment controls, post-payment review, data-driven risk monitoring, and coordinated program integrity oversight. HCPF's oversight structure is designed to ensure that services are authorized, delivered, documented, and reimbursed in compliance with federal waiver authority and applicable state and federal requirements.

Across waivers, enrollment and spending growth are not necessarily consistent because in large part following the COVID-19 pandemic, Colorado made deliberate policy investments in its Long-Term Services and Supports (LTSS) system to stabilize and strengthen the direct care workforce and expand access to community-based services for older adults and individuals with disabilities. These investments included targeted rate increases and the establishment of a direct care worker base wage. These actions were designed to address longstanding workforce shortages, reduce turnover, and ensure individuals could receive services in their homes and communities rather than more costly institutional settings. As a result, Colorado has seen substantial improvements in the compensation of direct care workers, with average wages increasing from roughly \$12 per hour prior to the pandemic to over \$19 per hour in many areas today, strengthening the stability and availability of this essential workforce.

At the same time, Colorado recognizes that the trajectory of LTSS spending growth observed during this period is not sustainable over the long term. The state has therefore proposed significant policy action to address utilization trends—particularly the growing reliance on certain service delivery models—while preserving access for individuals with the highest needs. Through proposed program reforms, utilization



limits, and other policy changes, Colorado is working to rebalance its LTSS system to ensure fiscal sustainability while maintaining the progress made in lowering utilization in costly institutionalized settings, strengthening the direct care workforce, and protecting access to community-based services.

For detailed breakdowns of program name, provider category risk level, effective date, spending, enrollment, services offered, FWA measures, and eligibility, please see Attachment 3, 1915(c) Waivers.

1915(b)(3) Waiver

HCPF has one 1915(b)(3) waiver, through which HCPF’s contracted Managed Care Entities (MCEs) and Managed Care Organizations (MCOs) deliver physical health services.

a. Program Name: Accountable Care Collaborative (ACC), which includes the following managed care entities: Primary Care Case Management Entity (PCCM Entity)-Prepaid Inpatient Health Plan (PIHP) and Managed Care Organization (MCO).

b. Provider Category Risk Level: All providers involved in managed care are required to enroll with the state following the processes outlined in the response to question 5 and will have different risk levels assigned across specialty types that range from limited, moderate to high risk.

c. Effective Date: The initial 1915(b)(3) waiver was approved July 1, 2018. The most recent renewal was approved April 1, 2024. An amendment to this waiver was submitted in spring 2025 and approved for July 1, 2025.

d. Spending:

	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Expenditures	\$7,625,890,821	\$8,141,919,001	\$8,619,344,854	\$8,717,460,086	\$10,119,446,942

e. Enrollment:

	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Enrollment	1,418,756	1,540,761	1,510,613	1,094,436	1,121,790



f. Services Offered: There are two types of managed care entities authorized by the 1915(b)(3) waiver within the ACC: ACC PCCM Entity-PIHP and MCO. The PCCM Entity-PIHPs are required to provide behavioral health services via a capitated risk program, whereas the MCOs provide full-risk physical health services.

Behavioral health-related State Plan services covered by the PCCM Entity-PIHP include:

1. Hospital
 - a. Inpatient Psychiatric Hospital Services
 - i. Acute Care / General Hospital
 - ii. Free-Standing Psychiatric Hospitals
 - iii. State Hospitals
 - b. Outpatient Hospital Services
2. Emergency and Post-Stabilization Care Services
3. Professional Hospital Services
4. Substance Use Disorder (SUD) Residential Services
5. Residential Treatment for Members Under the Age of 21
6. High-Intensity Outpatient Services
 - a. Intensive Outpatient Program
 - b. Partial Hospitalization Program
7. Outpatient Services
 - a. Crisis Services
 - i. Mobile Crisis Response
 - ii. Behavioral Health Secure Transportation
 - b. Screening and Assessment Services
 - c. Treatment Services
 - d. Physician Services

In addition to the Behavioral Health State Plan Services, PCCM Entity-PIHPs also provide (b)(3) services authorized via the waiver:

1. Mental Health Residential Services
2. Crisis Stabilization Units
3. Acute Treatment Units
4. Adult Mental Health Transitional Living Homes
5. Intensive Outpatient Services, including SUD Partial Hospitalization Program
6. Outpatient Services
 - a. Recovery Supports
 - b. Assertive Community Treatment
 - c. Supportive Housing



d. Respite Services

7. "Special Connections," which include SUD benefits from 60 days to 12 months postpartum for perinatal members.

Physical Health State Plan services covered by the MCOs include:

1. Inpatient Hospital Services
2. Outpatient Services
3. Physician Services
4. Rehabilitation
5. Emergency and Post Stabilization Care Services
6. Prescription Drugs
7. Laboratory Services
8. Durable Medical Equipment
9. Family Planning Services
10. Medical Services
11. Occupational and Physical Therapy
12. Surgical Services
13. Vision Services

g. FWA Measures:

As part of HCPF's commitment to preventing, identifying, and combating FWA, the ACC PCCM Entity-PIHPs and MCOs must have a program in place for ensuring compliance with the ACC program rules, contract requirements, state and federal regulations (including all applicable CMS regulations in 42 CFR Part 438) and confidentiality regulations, and a program to detect FWA. The ACC PCCM Entity-PIHPs and MCOs must ensure that all aspects of the ACC are focused on providing high-quality services that are medically necessary for the members they serve and in accordance with their contract requirements. Key activities these entities must complete for maintaining compliance and program integrity include:

1. Screening all provider claims processed or paid by ACC PCCM-Entity-PIHPs and MCOs collectively and individually, for suspected FWA.
2. Identifying overpayments to providers, including but not limited to instances of up-coding, unbundling of services, services that were billed for but never rendered, inflated bills for services and goods provided or any other improper payment.
3. Recovering overpayments made to providers.
4. Identifying and promptly reporting to HCPF instances of suspected FWA. ACC MCEs and MCOs must search for FWA by reviewing for provider outliers in utilization and billing, and cross-check with member complaints.
5. Member verification of services, meaning entities must provide individual notices to all or a statistically significant sample of members who received



services to verify and report whether services billed by providers were actually received by members.

6. Annual site reviews of ACC PCCM Entity-PIHPs'/MCOs', subcontractors', or contracted providers' locations on an annual basis or more frequently if HCPF determines more frequent reviews are necessary.
7. ACC PCCM Entities-PIHPs/MCOs must have a process for the prompt referral to HCPF and the MFANU of all cases where HCPF or the managed care entity has actual and reasonable cause to believe that there is suspected Medicaid FWA, patient abuse, patient neglect, patient exploitation, or false representation.

To support programs to detect FWA, the ACC PCCM Entity-PIHPs and MCOs are required to regularly report information to HCPF, such as:

1. Annual compliance plans, with necessary revisions as applicable.
2. Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Reports.
3. Semi-Annual Program Integrity Compliance and Fraud, Waste, and Abuse Consolidated Activity Reports.
4. Notifications to HCPF of the decision to terminate any existing network provider on the basis of quality or performance issues or for cause per 10 CCR 2505-10, § 8.076.1.7.
5. Notifications to HCPF consistent with 42 CFR § 438.608(a)(3) when entities receive information about changes in a member's circumstances that may affect the member's eligibility including, but not limited to, changes in the member's residence or the death of a member.
6. Monthly reports of suspended payments when entities have suspended payments to a provider due to a Credible Allegation of Fraud.

h. Eligibility.

Generally, individuals who are eligible for Medicaid benefits, i.e., those eligible for full Title XIX benefits, are eligible for the ACC. HCPF's 1915(b)(3) waiver further breaks down who is and who is not eligible to enroll in an ACC managed care plan. The following populations can enroll in a ACC managed care plan:

- Section 1931 Children and Related Populations
- Section 1931 Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- Former Foster Care Children under twenty-six (26) years of age as described in § 1902(a)(10)(A)(i)(IX) of the Social Security act.



- M-CHIP Populations
- CHP+ 1115 Adult Prenatal Coverage in Child Health Plan Plus
- “Special Connections” program members

The following populations are excluded from enrollment in the ACC:

- Populations Residing in a Nursing Facility or ICF/MR
- SCHIP Title XXI Children
- Medicaid Beneficiaries for the Period of Retroactive Eligibility
- Qualified Medicare Beneficiary only (QMB-only)
- Qualified Disabled and Working Individuals (QDWI)
- Qualified Individuals 1 (QI 1)
- Special Low Income Medicare Beneficiaries only (SLMB-only)
- Undocumented Aliens, including non-qualified, undocumented and qualified aliens who have not met the five-year bar who are eligible for Medicaid for care and services related to the treatment of an approved medical condition
- Individuals Enrolled in the Program of All-Inclusive Care for the Elderly (PACE)
- Individuals between ages 21 and 64 who receive inpatient treatment who are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan
- All individuals while determined presumptively eligible for Medicaid

Question 9. Please provide information regarding improper payments and recovery efforts in your state’s Medicaid program, including:

a. Total Medicaid improper payments identified annually from January 1, 2021, to present, broken out by provider type and service category where available.

HCPF is diligently working to gather information on total improper payments broken out by provider type and service category. Given the high volume of recoveries HCPF has collected in the past several years, HCPF needs additional time to collect this level of detail and will submit this information as soon as it is available.

b. Total recoveries and recoupments of improper Medicaid payments annually from January 1, 2021, to present.

2021	2022	2023	2024	2025	2026
\$111,476,129.43	\$160,104,685.82	\$156,731,331.42	\$168,803,777.78	\$177,295,084.15	\$34,937,501.64



The above table represents the total amounts actually recovered from all FWA activities, including TPL, RAC audits, UPIC, other postpayment audits, provider self-disclosures, and prosecuted cases.

The amounts recovered from a provider may not always equal the identified overpayment amount due to a variety of factors, such as providers failing to pay in full, providers entering into payment plans and settlement agreements with payment schedules, payments that may be uncollectable due to a provider going out of business or receiving a discharge in bankruptcy, appeals that may still be ongoing or result in a different overpayment amount, payment processing delays due to incomplete information from providers, carriers that may not cover services billed for repayment, and where providers subsequently rebill for services rendered as part of a RAC audit.

NF and ICF Post Payment Reviews

The Post-Payment Reviews (PPR) the HCPF Office of Community Living (OCL) conducts result in the identification and recovery of Medicaid dollars as shown in the table below.

Fiscal Year	Recovered Amount	NF Completed Reviews	ICF Completed Reviews
January 2021 through June 2021	\$401,137.27	37	0
July 2021 through June 2022	\$721,515.08	57	0
July 2022 through June 2023	\$915,938.96	89	0
July 2023 through June 2024	\$1,294,762.03	62	20
July 2024 through June 2025	\$1,804,143.77	83	2
July 2025 through February 2026	\$1,556,818.05	36	0
Total	\$6,694,315.16	364	22

These are ongoing reviews and once an overpayment has been identified, the funding is collected, on average, within 30 days of issuing the final notification to the facility. During the course of the PPRs, if OCL identifies any outliers or potentially concerning practices, they are escalated to HCPF’s Fraud Waste and Abuse (FWA) Division for review. While OCL has the authority to utilize payment suspensions, this practice has not been taken at this time as providers have been responsive to requests for information and repayment. OCL is in the process of developing civil enforcement actions within state regulation that, once approved, will be used to enforce compliance when necessary.



c. The average amount of time between identification of suspected fraudulent or improper payments and recovery, enforcement action, or case resolution.

For suspected fraud, the time between the identification of a credible allegation of fraud and the MFANU obtaining a recovery varies widely depending on the case. On average, criminal cases take roughly one to three years to resolve, depending on whether the defendant pleads guilty or elects to go to trial. Similarly, many civil cases resolve quickly if the defendant chooses to settle. Civil cases can take far longer to litigate through trial, due to the complexity of the issues and the absence of constitutional Speedy Trial requirements. *Qui tam* cases usually take the longest to resolve, often due to discovery demands, complex multi-party negotiations, and other factors.

Additionally, the MFANU is limited by the number of investigators and attorneys it has available to pursue cases, the time needed to thoroughly investigate provider fraud allegations, and the time and expense required to secure a settlement or court resolution.

For overpayment recoveries, the average time between identification and recovery is approximately nine to 12 months, depending on the procedural path and any appeal the provider may file. However, several factors can slow the process. These can include the number of claims involved in the review and the complexity of the documentation required for the claim. In some cases, documentation may be incomplete, delayed, or require additional organization and follow-up before review can be finalized. Additionally, established review and appeal timelines, along with the coordination required across multiple stages of the process before final financial processing is completed, can contribute to variations in overall timeframes.

For TPL recoveries, claims paid are identified and included in direct billing of carriers and provider retractions. The actual collection of funds can vary between one month and several years depending on the adjudication timeframes for carriers, appeals, etc.

d. The extent to which the state utilizes payment suspension authority pursuant to 42 CFR § 455.23, including the number of payment suspensions issued annually since January 1, 2021, and the provider types or services impacted.

In accordance with 42 CFR § 455.23 and 10 CCR 2505-10, Section 8.076.4, once HCPF makes a determination that an allegation of fraud is credible and refers the case to law enforcement, it also conducts a review to determine whether suspension of payments is legally and procedurally appropriate. This review includes asking the MFANU if they will be requesting the law enforcement exception



and asking HCPF policy staff if any good cause exceptions apply. In the majority of cases, the MFANU requests the law enforcement exception when it accepts a case in order to ensure that the provider is not alerted to the investigation. If the MFANU does not request the law enforcement exception, or if they subsequently lift the exception, assuming HCPF policy staff does not identify any good cause exceptions, HCPF will promptly suspend payment to the provider and send out notice.

	2021	2022	2023	2024	2025	2026
Payment Suspensions Implemented	2	1	2	3	3	1
Provider Types Impacted	HCBS Clinic - Practitioner	Transportation	Transportation SUD Continuum	HCBS Pharmacy (2)	HCBS (2) Pharmacy	Non-Physician Practitioner - Group

e. The extent to which the state has pursued civil enforcement actions, including actions under state or federal False Claims Act authorities, related to Medicaid FWA since January 1, 2021.

The Colorado Attorney General’s Office, through its MFANU, has opened 260 civil cases since January 1, 2021, involving violations of the federal or state False Claims Act. Just over two hundred of those cases were federal *qui tam* matters. Fifty-eight (58) of those cases were state-run civil investigations.

The MFANU obtained total reportable recoveries of \$68,028,885.09 since January 1, 2021, for the Medicaid program. The MFANU collected actual payments of \$7,334,288.21 on civil matters since that date.

Question 10. Please provide information regarding screening, oversight, and enforcement actions related to Medicaid fiscal intermediaries, including:

a. Screening, enrollment, credentialing, and monitoring requirements for fiscal intermediaries participating in Medicaid programs.



In Colorado, the Medicaid fiscal agent (Gainwell Technologies) is not enrolled as a Medicaid provider. Instead, the fiscal agent is selected through a competitive state procurement process and operates under a formal contract with HCPF.¹

The contract establishes comprehensive requirements related to information security and privacy compliance, staffing qualifications, subcontractor oversight, performance standards, and operational controls. HCPF monitors performance through defined deliverables, operational reporting, Service Level Agreements (SLAs), and structured governance processes, including change management, testing/User Acceptance Testing (UAT), and production verification. In addition, the fiscal agent is required to undergo independent System and Organizational Controls (SOC) audits.

b. Oversight mechanisms used to monitor caregiver time reporting, billing accuracy, and verification of services furnished through fiscal intermediaries.

HCPF maintains oversight of claims processing and related functions through a combination of automated system controls, operational monitoring, and audit activities.

For billing accuracy and verification of services, oversight mechanisms include system edits and pricing logic, benefit plan validation, prior authorization checks, fund code assignment controls, and exception reporting. Claims processing functions are subject to performance monitoring and periodic review to ensure compliance with state and federal requirements.

Where applicable to specific service delivery models (e.g., self-directed services), oversight may also include validation of authorized service units, time entry controls, reconciliation processes, and post-payment review activities. These controls are designed to ensure services are properly authorized, documented, and paid in accordance with program rules. For Consumer-Directed Attendant Support Services (CDASS), HCPF contracts with two Financial Management Services (FMS) vendors for the management and disbursement of funds for provided services. FMS vendors display the member's authorized budget in their system and employ safeguards to disallow the approval of services beyond the budget that is prior-authorized for the member. Verification of provided services is a CDASS employer responsibility (i.e., the responsibility of the member receiving self-directed services); however, the FMS vendors provide employers access to real-time budget data and utilization statements, and will provide referrals for training/coaching, if additional support is needed. Electronic Visit Verification (EVV) complements the FMS oversight by requiring that EVV is collected to support caregiver time reporting and billing accuracy.

¹ Please note: Colorado Medicaid contracts with other vendors who pay claims or encounters on HCPF's behalf under certain circumstances, Managed Care Entities for behavioral health services, and MCOs for full-risk managed care plans, PACE programs, and more.



c. The frequency and scope of audits conducted on fiscal intermediaries since January 1, 2021, including audits conducted by the state or third-party contractors.

HCPF maintains ongoing oversight of the Medicaid fiscal agent through structured monitoring activities, including routine operational reviews and monthly or quarterly audits of provider enrollment and claims processing functions.

d. The number of fiscal intermediaries that have been terminated, sanctioned, suspended, or otherwise subject to corrective action since January 1, 2021, and the basis for those actions.

Since January 1, 2021, HCPF has not imposed any sanctions, suspensions, or corrective enforcement actions against the Medicaid fiscal agent.

