

Improving Medicaid Fraud Prosecution

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

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Summary

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

The following amounts were identified for state fiscal year 2024-2025 (SFY 2024-25):

- **\$48,266,477** - total aggregate Health First Colorado savings for members and providers.
- **\$330,821** - total member fraud reported by the counties.
- **\$139,298.51** - total provider criminal restitution identified by the Colorado Medicaid Fraud Abuse & Neglect Unit (the “MFANU” or “Unit”).
- **\$45,645,088.85** - total provider civil settlements identified by the MFANU.

The following fraud trends were identified for SFY 2024-25:

- In regard to member fraud, waste, and abuse investigations, the majority of cases continue to involve inaccurate reporting of household composition, failure to report income, and failure to update residency information.
- In regard to only provider fraud, fraud continues to involve the provision of in-home services and off-site services, including billing the Medicaid program for services that were not provided and overbilling for services rendered. Several of these schemes involved providers of in-home nursing care, providers of day habilitation services for developmentally disabled Medicaid clients, and adult day service providers.

Background

This report is submitted pursuant to the provisions of Colorado Revised Statute (C.R.S.) § 25.5-1-115.5 for the period of July 1, 2024, to June 30, 2025. This section requires the Department of Health Care Policy & Financing (HCPF) to submit a written report by Nov. 1 of each year regarding Medicaid fraud prosecution. HCPF compiles the report from self-reported information from each of Colorado’s 64 counties and from the MFANU report. The reported numbers for SFY 2024-25 are available in Appendix A and Appendix B.

This provider and member fraud report includes:

- Investigations of provider and member fraud during the year;
- Termination of member Health First Colorado benefits due to fraud;
- District attorney actions, including, at a minimum, criminal complaints requested, cases dismissed, cases acquitted, convictions, and confessions of judgment;
- Recoveries, including fines and penalties, restitution ordered, and restitution collected;

- Trends in methods used to commit provider and member fraud, excluding law enforcement-sensitive information; and
- An estimate of the total savings, total cost, and net cost-effectiveness of fraud detection and recovery efforts.

Each of the counties has the responsibility, on behalf of HCPF, for determining eligibility for medical assistance programs. Subject to policy changed by the Centers for Medicare and Medicaid Services (CMS), which will be discussed in detail later in this report, persons who are found to be ineligible for Medicaid due to fraud or error on the part of the applicant are required to pay back the state for claim payments made on their behalf. No recovery shall be made where the overpayment occurred through no fault of the member (C.R.S. § 25.5-4-301(2)(a)(II)). Member fraud investigation is delegated to the counties, and HCPF provides fraud-related education to all counties. HCPF also provides policy directives and specific guidance upon request from individual counties. When HCPF receives a member fraud referral directly, HCPF staff review and document the referral, retrieve relevant case information from the Colorado Benefits Management System (CBMS), and send the referral to the county of residence for investigation. Because of the inconsistency in member fraud investigation efforts across counties, HCPF is considering alternatives intended to improve results.

The Social Security Act provides the conditions that must be met in order for individual states to receive federal matching dollars for “State plans for medical assistance” such as Medicaid. Title 42 U.S.C. 1396a(a)(61) requires that a state “must demonstrate that it operates a [M]edicaid fraud and abuse control unit described in section 1396b(q) of this title that effectively carries out the functions and requirements described in such section, as determined in accordance with standards established by the Secretary” in order to receive federal matching funds for its Medicaid program.

To ensure that Medicaid Fraud Control Units adhere to federal requirements, state programs must be recertified annually and are periodically audited by the Office of the Inspector General of the U.S. Department of Health and Human Services (OIG-HHS). OIG-HHS reviewed the MFANU for the time period of April 1, 2024, through March 31, 2025, and determined that the Unit was in compliance with the federal statutory and regulatory requirements for state Medicaid Fraud Control Units. OIG-HHS recertified the MFANU for an additional one-year period (July 1, 2025, through June 30, 2026).

The MFANU operates in accordance with C.R.S. § 24-31-801 et seq., C.R.S. § 25.5-4-303.5 et seq., 42 U.S.C. § 1396b(q), 42 C.F.R. § 1007.1 et seq., and 42 C.F.R. § 455 et seq. The Unit was established in 1978, is housed within the Department of Law, and has both criminal and civil prosecutorial authority. It generally pursues three categories of cases:

1. Fraudulent conduct by Medicaid providers and individuals involved with providing Medicaid services;



2. Abuse, neglect, and exploitation of individuals in health care facilities that receive Medicaid funds or are classified as board and care facilities; and
3. Recovery of Medicaid overpayments identified in the investigation of fraud, patient abuse and neglect, and financial exploitation of clients.

The MFANU receives referrals from numerous sources. When the entirety or a portion of a case is determined not to be appropriate for investigation, the MFANU provides the referring party with resources and assistance to ensure that all concerns are addressed. In appropriate circumstances, the MFANU will refer a matter to a different governmental agency with jurisdiction to address the situation presented. The MFANU's jurisdiction does not extend to the investigation of fraud by recipients, for example. Complaints involving false statements of income or eligibility for Medicaid are referred by the MFANU to other applicable state and federal agencies that have jurisdiction.

Matters referred to the MFANU often require substantial investigation as they may involve hundreds of patients and tens of thousands of pages of documents, and it may take months or years to complete an investigation. Once fully investigated, it is not uncommon for a matter to be closed without the filing of charges. This can occur for a variety of reasons, such as an inability to prove criminal intent, lack of evidence to substantiate a charge, or inconsistencies and vagueness of the applicable rules of the Medicaid program. The Unit endeavors to be as quick and responsive as possible in receiving referrals, opening investigations, and bringing cases through the court system either through civil or criminal filings.

Definitions

Total member case count - Total number of Medicaid members

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

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

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

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

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



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

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

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

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

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

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

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

Overall Totals

Member Fraud - As reported by the counties

- **2,574** investigations of member fraud during the fiscal year. This is an increase of 23% from last fiscal year.
- **87** terminations of services of member Medicaid benefits due to fraud. This is an increase of 36% from last fiscal year.
- Number of District Attorney actions:
 - **22** criminal complaints requested
 - **0** cases dismissed
 - **0** cases acquitted
 - **8** convictions
 - **2** confessions of judgment
- **\$330,821** of fraud identified, as reported by the counties. This is a decrease of 38% from last fiscal year.
- **\$0** of non-fraud identified, as reported by the counties. This is a decrease of 100% from last fiscal year.
- **\$6,499** of fines and penalties recovered and retained by counties. This is a decrease of 57% from last fiscal year.
- Amount of Restitution:
 - **\$168,765** ordered. This is a decrease of 59% from last fiscal year.
 - **\$217,573** collected. This is a decrease of 16% from last fiscal year.

Analysis of Investigations and Estimated Member Fraud Cost Avoidance

During SFY 2024-25, there was a 38% decrease in member fraud recoveries from last fiscal year, down to **\$330,821**, but with a 23% increase in the number of investigations of member fraud. The COVID-19 Public Health Emergency, as declared and extended by the U.S. Department of Health and Human Services (PHE), officially ended on May 11, 2023. However, in accordance with the Families First Coronavirus Response Act, signed into law on March 18, 2020, (FFCRA), which led to corresponding HCPF policy guidance issued, remaining in place for all of SFY 2024-25, no overpayments could be collected for any ineligibility period falling within the previous PHE period.

On October 17, 2022, CMS issued guidance in the form of a frequently asked questions document (FAQ), entitled, "COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies."¹ Within this guidance, as FAQ 31, and through subsequent conversations with HCPF and other states, CMS conveyed a new policy prohibiting all administrative overpayment recoveries from Medicaid members. CMS stated that the only permissible means to recover from a Medicaid member are through three narrow exceptions appearing in federal regulation, which they cited in the FAQ, and through state criminal process.

Following the publication of the FAQ document, CMS stated that further formal written guidance would be provided to states. On December 5, 2024, CMS issued SMD 24-005, entitled "RE: Protecting Medicaid Beneficiaries Against Impermissible Fraud and Abuse Sanctions." This written guidance was CMS's follow up to FAQ 31 and reaffirmed their previous position that administrative overpayment recoveries from members are, and always have been, prohibited.

However, on May 1, 2025, SMD #24-005 was then rescinded by CMS². In rescinding SMD #24-005, CMS merely noted on the same document, that the document was rescinded. CMS did not include any clarifying guidance as to where this rescinded guidance leaves states now, especially considering that the original underlying guidance, found in FAQ 31, has itself not been rescinded.

In accordance with the earlier CMS guidance, HCPF first issued Operational Memo 23-034, entitled "Temporary Prohibition on Administrative Overpayment Recoveries from Medicaid Members."³ Under this Memo, counties could not recover an overpayment from a current or

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

² See: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd24005.pdf>

³ Operational Memo 23-034, entitled "Temporary Prohibition on Administrative Overpayment Recoveries from Medicaid Members", and related attachments, can be found here: <https://hcpf.colorado.gov/2023-memo-series-communication>

past Medicaid member outside of the criminal court process. Owing to the temporary nature of this type of Memo, Operational Memo 23-034 was subsequently superseded first by Operational Memo 23-046⁴, and then most recently by Operational Memo 25-051⁵, with all such Memos still entitled “Temporary Prohibition on Administrative Overpayment Recoveries,” and containing substantively similar provisions, still temporarily prohibiting all administrative recoveries, pending further written guidance from CMS. As of the date this report is being drafted, no clarifying guidance from CMS has yet been received as to what is permissible or expected for recovering overpayments from members.

Counties have been instructed to continue to investigate fraud referrals, and to terminate eligibility for currently ineligible members. During SFY 2024-25, counties could still refer cases to their local county district attorneys for potential criminal charges and criminal restitution.

The CMS policy change of prohibiting administrative recoveries continued to substantially reduce fraud and non-fraud recovery numbers. Eligibility terminations are up 36% this fiscal year, as it continued to be required to terminate eligibility for those members who were found to be ineligible for Medicaid benefits following a fraud investigation.

Cost avoidance increased this year, coinciding directly with the increase in eligibility terminations. This fiscal year there was a resulting cost avoidance of approximately **\$988,002**, up from **\$555,136**, identified last fiscal year. This cost avoidance calculation is explained further in the Member Fraud Cost Savings Section of this report.

Court-imposed fines and penalties, restitution ordered, and restitution collected all decreased in SFY 2024-25, down to **\$6,499**, **\$168,765**, and **\$217,573**, respectively. While the CMS policy prohibiting administrative recoveries made criminal court proceedings the only means of recovering from Medicaid members, many counties are not able to effectively build cases for potential criminal prosecutions due to limited county resources and staffing. Additionally, local district attorney offices have differing priorities and case load levels, as well as varying threshold requirements for accepting Medicaid cases.

Provider Fraud - As reported by the MFANU

Between July 1, 2024, and June 30, 2025, the MFANU received 497 complaints, which is generally consistent with the number of recorded complaints and referrals received in prior state fiscal years. Included in that number are fifteen referrals received from HCPF, from

⁴ Operational Memo 23-046, entitled “Temporary Prohibition on Administrative Overpayment Recoveries from Medicaid Members”, and related attachments, can be found here: <https://hcpf.colorado.gov/2023-memo-series-communication>

⁵ Operational Memo 25-051, entitled “Temporary Prohibition on Administrative Overpayment Recoveries from Medicaid Members”, and related attachments, can be found here: <https://hcpf.colorado.gov/2025-memo-series-communication>

which eight new cases were opened by the MFANU for preliminary review, and two ongoing investigations continue.

In addition to referrals received from the HCPF, the MFANU also received complaints from a diverse group of referral sources that includes: medical professionals; local law enforcement agencies; statewide agencies, such as Adult Protective Services, the Office of the State Ombudsman, and the Department of Public Health and Environment; federal agencies, such as OIG-HHS and the Federal Bureau of Investigation; and Medicaid clients and their caregivers. After a preliminary review of the 497 complaints that the MFANU received in SFY 2024-25, the Unit made formal decisions to open 131 cases. The Unit was active across Colorado, having received referrals from many areas of the state.

The Unit has continued to integrate and refine new internal procedures that contributed to an increased number of cases being opened and assigned to investigators and attorneys for investigation. During SFY 2024-25, the MFANU opened a total of 172 matters for initial investigation overall, including complaints received during prior fiscal years. This number included 148 fraud cases, 24 abuse and neglect cases, and 0 drug diversion cases. Of the fraud cases, 74 were civil cases, and 74 were criminal cases. Additionally, in the last week of the State Fiscal Year 2024-2025, MFANU had 295 active investigations, of which 69 were criminal investigations, including 16 abuse/neglect matters, 1 drug diversion matter, and 52 fraud matters.

During SFY 2024-25, criminal restitution to the Medicaid program was ordered in the amount of **\$139,299**. Also during this time period, MFANU collected **\$22,229** in criminal restitution, both directly through checks sent to the Unit, and indirectly through checks sent to HCPF from the courts based on MFANU cases. In addition to criminal prosecutions, MFANU recovered **\$45.6⁶** million in civil matters, and collected over **\$1.7 million**. Civil recoveries include over **\$34.7** million in penalties, interest and damages.

Total Cost Savings from Members and Providers

In SFY 2024-25, the total aggregate Medicaid savings for members and providers was **\$48,266,477⁷**. Additional details on cost savings are presented separately below for both members and providers.

Cost Savings - Members

⁶ Note, however, that a default judgment against Premier Medical, Inc. accounts for slightly over \$34 million of the total reportable recoveries and of the recovery from penalties, interest, and damages. Consent judgments against two other defendants in this matter account for an additional \$8.2 million. It is unlikely that more than a small fraction of this award will be collected.

⁷ From the member side, this total cost savings figure includes **\$330,821** in fraud recoveries, **\$0** in non-fraud recoveries, **\$6,499** in fines and penalties, **\$168,765** in restitution ordered, and **\$988,002** in estimated cost savings from terminating ineligible members. On the provider side, the total cost saving figure reflects **\$139,299** in criminal restitution, and **\$45,645,089** in civil recoveries



Using the number of terminations from the counties, HCPF calculated the average yearly Medicaid amount of all state Medicaid members in order to obtain a yearly amount of Medicaid dollars saved. This fiscal year, there were 87 terminations. The average cost per Medicaid member for this past fiscal year, per month, was **\$946**, or **\$11,356⁸** per year. Therefore, the estimated cost savings is **\$988,002**. This savings is in addition to the **\$330,821** fraud recovery amount.

The cost savings formula is laid out below:

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

$$\$11,356 \times 87 = \$988,002$$

During SFY 2024-25, HCPF had one position who worked heavily on member fraud, waste, and abuse, allowing for additional investigation resources at the state level. The position assisted county investigators, worked to develop training, and provided resources to the counties. This position continued to work closely with other HCPF staff regarding the CMS policy change prohibiting administrative recoveries from Medicaid members.

During this time period, this position, along with other HCPF staff, continued to work closely with county representatives throughout the state and helped county investigators with investigation and policy questions and support. For all of SFY 2024-25, this position and others continued to be actively involved in the nationwide Beneficiary Fraud Technical Assistance Subgroup. This subgroup shares national best practices and collaborates with other states and CMS representatives to answer questions and address important issues involving Medicaid beneficiary fraud. Within HCPF, member and provider fraud are both housed within the Fraud, Waste, and Abuse Division (FWA Division). HCPF will continue to support training programs for the counties and provide technical and policy guidance while working to ensure that best practices are followed, and that investigations and policy are consistent across the State.

HCPF has also continued proactive efforts to assist counties in fighting member fraud and promoting cost avoidance. The FWA Division's work is complemented by additional HCPF and county staff efforts to further improve the accuracy of initial eligibility determinations, limiting ineligible individuals from being approved to receive medical assistance benefits.

Cost Savings - Providers

During this review period, the State of Colorado tasked the MFANU's law enforcement team with investigation authority and civil or criminal prosecution authority to protect the funds and beneficiaries of Colorado's approximately \$15 billion Medicaid program. MFANU's recoveries for the state Medicaid program resulted in significant savings to the state,

⁸ Source of data for average monthly cost is based on HCPF's Nov. 1, 2025, budget request.



significantly exceeding the cost of the MFANU. The MFANU was able to recover a total of \$45.78 million in fraudulent Medicaid billing.⁹ Additionally, it should be noted that if the providers responsible for such billings had not been identified, the fraudulent activity would likely have continued and the losses to the Medicaid program would likely have been far higher than the amounts that were recovered.

Despite staffing additions over the last few years, the pace of incoming referrals continues to exceed existing staffing. Over time, funding for the Medicaid program has continued to rise faster than funding for the MFANU, resulting in a backlog of cases and the inability to pursue certain leads and complaints. The Unit has historically needed to “triage” investigative cases, turning down matters involving lower monetary losses and at times limiting the scope of ongoing investigations. For example, if interviews with 200 individual patients are required to determine the true dollar loss to the Medicaid program as a result of a provider’s fraudulent conduct, the number of interviews conducted may be capped at twenty or thirty, simply to allow a case to be filed and a partial recovery obtained, allowing the investigator to work on other matters. The MFANU continues to experience a need to triage referrals and investigations. Since December 2023, the MFANU’s investigator caseloads have tripled, and attorney caseloads have increased five-fold. Nevertheless, the Unit received 56 referrals in SFY 2024-25 that have been preliminarily approved for initial investigation, but which have not yet been assigned to investigators for follow-up due to continuing staffing limitations. This number has continued to increase, and the Unit anticipates that the need to triage investigations will continue through the next reporting period.

In addition, the number of high priority abuse and neglect referrals and investigations is expected to increase moving forward. It should be noted that during the triage process, cases that involve allegations of the abuse or neglect of patients, and involve patient harm or death, take priority over cases involving the theft of state funds. Colorado’s 65-and-over population has grown much faster than most other states¹⁰. From 2010 to 2020, Colorado had the second fastest-growing population over the age of 65 in the nation, and this trend is expected to continue into the next decade.¹¹ By 2050, the number of older adults in Colorado is expected to double to 1.7 million.¹² This is significant, for though Medicare is considered an insurance program for older Americans, Medicare does not cover long-term

⁹ Note that approximately \$42.2 million of this amount is unlikely to be collected, as discussed in footnote 6.

¹⁰ Colorado Department of Local Affairs. (2016, Sept. 20). *Aging in Colorado Part 1: Why is Colorado Aging So Quickly?* Retrieved from: <https://gis.dola.colorado.gov/crosstabs/aging-part-1/#why-is-co-aging-so-fast>.

¹¹ London, N. (2024, April 8). Colorado’s Population is Getting Older. It Will Impact Everyone. *CPR*. Retrieved from <https://www.cpr.org/2024/04/08/colorado-aging-population/>.

¹² Gomez A. (2019, May 30). *Aging in Communities in Colorado*. Colorado Health Institute. Retrieved from [https://www.coloradohealthinstitute.org/blog/aging-communities-colorado#:~:text=One%20in%20seven%20Coloradans%20\(13.8,population%20is%20white%20non%20DHispanic](https://www.coloradohealthinstitute.org/blog/aging-communities-colorado#:~:text=One%20in%20seven%20Coloradans%20(13.8,population%20is%20white%20non%20DHispanic)



nursing home care, and as of 2019, three in five nursing home patients in Colorado were covered by Medicaid.¹³

The MFANU recently engaged in targeted outreach and training sessions with managed care organizations (“MCOs”), Long Term Care Ombudsmen, and the Colorado Department of Public Health and Environment (“CDPHE”). The MFANU now meets regularly with many of these groups and anticipates that it will receive increased referrals of patient abuse and neglect in the next reporting period as a result. The MFANU has also implemented an outreach program that specifically focuses on increasing awareness of Medicaid fraud among nursing home facilities, patients, and family members. Due to these factors, the Unit anticipates that abuse and neglect referrals, and therefore investigator and attorney caseloads, will continue to increase.

For these reasons, additional consideration should be given to better leverage federal dollars to support the MFANU’s fraud detection and recovery efforts. The benefit to the State of Colorado is significant. The average annual recovery by the MFANU in FY 25 was 35.6 times the level of funding it received from the State. Funding for the MFANU is provided in a 25 percent to 75 percent match arrangement.¹⁴ For every \$25 in Colorado spending used to fund the MFANU operations, the federal government provides \$75 in funding to the Unit. Increased funding for the MFANU for staffing, although only 25 percent of the cost of additional investigator and attorney positions, is expected to result in increased recoveries to the Medicaid program and to the State. Various reports prepared by the federal government indicate that, if resources are directed toward fraud and abuse prevention and recovery, the cost-benefit ratio can be exceptional.”¹⁵ With recent cuts to Medicaid benefits, the recovery of these funds is all the more important. Stevens Amendment Notice¹⁶: The Colorado Medicaid Fraud Control Unit received 75 percent of its funding from the U.S. Department of Health and Human Services under a grant award totaling \$3,858,544.00 for Federal fiscal year (FY) 2025. The remaining 25 percent, totaling \$1,286,181.00 for FY 2025, was funded by the State of Colorado.

Trends

¹³ Henry J. Kaiser Family Foundation. *Colorado Medicaid Fact Sheet*. Retrieved from: <http://files.kff.org/attachment/fact-sheet-medicaid-state-CO>.

¹⁴ 42 USC 1396b(a)(2)(A).

¹⁵ Office of the Colorado State Auditor. (1999). *Medicaid Fraud and Abuse Programs: Performance Audit*. Retrieved from: https://leg.colorado.gov/sites/default/files/documents/audits/1050_medicaid_fraud_perf_july_1999.pdf.

¹⁶ The Stevens Amendment, as contained in the Further Consolidated Appropriations Act of 2020, Pub. L. No. 116-94 (Division A, Title V, Section 505), provides: “When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds included in this Act, including but not limited to State and local governments and recipients of Federal research grants, shall clearly state (1) the percentage of the total costs of the program or project which will be financed with Federal money; (2) the dollar amount of Federal funds for the project or program; and (3) percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources.”



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

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

It is clear there are cost benefits to HCPF's fraud investigation efforts. With the significant limitations of the CMS policy prohibiting administrative recoveries, HCPF still established fraud recovery totaling **\$330,821**. This was while also avoiding an estimated additional **\$988,002** in unnecessary costs by terminating the eligibility of members due to fraud.

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

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

The MFANU continues to investigate referrals related to non-emergent medical transportation. These schemes typically involve billing for services not rendered (e.g., for trips that were far shorter than claimed, or for no-show rides), and for rides with multiple occupants.

This year, the MFANU detected a wide-spread fraud scheme involving Medicaid eyeglass prescriptions. Thus far, the MFANU has recovered \$250,000 through settlement with one provider, and additional investigations are ongoing. In the course of this work, the MFANU advised HCPF on a regulatory change to improve enforcement and prevent further fraud in this area. HCPF estimates that this regulatory change has resulted in an estimated savings of over \$12 million in Medicaid funds thus far.