Policy and Procedure

Policy Name: False Claims Acts	**Policy#:** CMP-212	**Version#:** 18
Author Department: Compliance	**Origination Date:** 7/30/2008	
Business Units Impacted: All	**Date Last Reviewed:** 12/04/2025	
Products/LOBs: All	**Date Approved by CPT:** 12/04/2025	

Unless otherwise specified, the terms used in this policy are defined in accordance with:

- ***Exhibit D – Terminology of Contract No. 25-196888 (RAE4) and Contract No. 23-176730 & 23-176730A6 (CHP+) between Colorado Access (COA or organization) and the Department of Health Care Policy and Financing (HCPF or the Department); and***
- ***The Definitions section within the body of the same Contract.***

Where there is a conflict between a definition in this policy and one in the Contract, the definition in the Contract shall take precedence. Any additional terms used in this policy that are not defined in the Contract are defined below for the purposes of clarity and consistent application.

DEFINITIONS:

Abuse: Practices that are inconsistent with sound fiscal, business, or medical practices, and that result in an unnecessary cost to government programs, or in seeking reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes Member practices that result in unnecessary cost to Medicaid programs.

Contracted Provider: A health care practitioner, facility, or organization that has entered into a formal agreement with Colorado Access to provide covered health care services to members. The agreement specifies reimbursement rates, responsibilities, and compliance with applicable policies, procedures, credentialing requirements, and quality standards. Contracted Providers are considered part of Colorado Access ‘s participating or “in-network” provider network.

False Claim: A claim knowingly submitted for services or supplies that were not provided as presented or for which the entity is otherwise not entitled to payment.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to them or some other person. This includes any act that constitutes fraud under any federal or state law.

Knowingly: Having actual knowledge, acting in deliberate ignorance, or demonstrating reckless disregard for the truth or falsity of information. Specific intent to defraud is not required to establish liability under the False Claims Act.

Member: An individual who is enrolled in a HCPF-administered health care program and assigned to Colorado Access (COA or organization) for care coordination or service delivery.

Retaliation: Any adverse employment action for reporting a compliance issue or concern, including termination, demotion, harassment, or other negative consequences.

Waste: Inappropriate utilization that results in unnecessary costs. This includes incurring unnecessary costs as a result of deficient management, practices, systems, or controls; the over-utilization of services (not caused by criminally negligent actions); and the misuse of resources.

Whistleblower: An individual who reports suspected or actual violations of law in good faith and is protected from retaliation.

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Workforce Member(s): Individuals who are employed by, or affiliated with COA, including full-time and part-time employees, temporary staff, contractors, volunteers, interns, and other personnel who perform work on behalf of the organization.

SCOPE:
This policy applies to all COA Workforce Members, Contracted Providers, and business partners across all business units and lines of business. It encompasses any conduct related to state and federal healthcare program reimbursements, including activities addressing fraud, waste, and abuse (FWA) prevention and detection.

PURPOSE:
The purpose of this policy is to ensure compliance with federal and state False Claims Acts, including the Colorado Medicaid False Claims Act, and to promote ethical behavior in the prevention and detection of FWA. This policy sets forth expectations for COA Workforce Members, Contracted Providers, vendors, and business partners to safeguard the integrity of public healthcare programs and maintain transparency and accountability.

STATEMENT OF POLICY:
COA is committed to compliance with state and federal laws addressing FWA prevention, detection, and resolution. COA prohibits knowingly submitting or facilitating false claims or statements to any government program. All Workforce Members must adhere to the principles outlined in COA's Compliance Plan, Code of Conduct, and this policy. COA implements a Compliance Program to promote integrity and ensure workforce members understand the standards of conduct related to the False Claims Act. Key statutes include:

Federal False Claims Act:[1]
- Prohibits Knowingly submitting fraudulent claims to the federal government.
- Violations may result in civil penalties of $5,000-$10,000 per claim and treble damages.

Colorado Medicaid False Claims Act:[2]
- Prohibits Knowingly submitting fraudulent claims to the Colorado Medicaid program.
- Civil penalties range from $5,000-$11,000 per claim plus treble damages.

Colorado Fraudulent Acts Statute:[3]
- States that a person commits theft when they knowingly obtain, or willfully aid or abet another to obtain, public assistance, vendor payments, or medical assistance through false statements, impersonation, or other fraudulent devices.
- Violations may result in disqualification from public assistance programs.

[1] 31 U.S.C. §§ 3729–3733
[2] C.R.S. §§ 25.5-4-303.5 to 25.5-4-310
[3] C.R.S. § 26-1-127

- Criminal penalties for violations may include felony or misdemeanor charges, depending on the damages.

Whistleblower Provisions:[4]

- Allows individuals to bring civil actions on behalf of the government.
- Protects employees who report violations in good faith from retaliation.
- Colorado Access strictly prohibits retaliation against any individual who, in good faith, reports a suspected violation of the False Claims Act or participates in an investigation. Whistleblowers are protected under both federal and state law and may be entitled to remedies if retaliation occurs.

PROCEDURES:

A. Identifying Potential Violations

1. Recognizing potential violations requires an understanding of FWA indicators. Below are examples and warning signs that may suggest non-compliance**:**
   a. Examples of Common Violations Under the False Claims Act:
      - **Billing for services not provided:** Submitting claims for patient care, procedures, or services that never occurred.
      - **Upcoding:** Claiming reimbursement for a more expensive service or procedure than what was actually performed.
      - **Unbundling:** Separating services that should be billed together as a single procedure into multiple claims to increase reimbursement.
      - **Misrepresentation of medical necessity:** Submitting claims for services, treatments, or supplies that are not medically necessary according to standard care guidelines.
      - **False certification:** Certifying compliance with Medicaid program rules (e.g., quality standards or qualifications) when the Contracted provider knows they are not in compliance.
      - **Kickbacks:** Offering or receiving compensation in exchange for referrals or preferential use of products or services, which indirectly causes the submission of false claims.
      - **Improper coding or documentation:** Submitting claims with incorrect diagnosis or procedure codes that result in higher reimbursement, even if unintentional.
      - **Duplicate billing:** Submitting claims multiple times for the same service, either to the same or different payers.
      - **Failure to return overpayments:** Retaining known overpayments for services instead of promptly refunding the amount to the government payer.

[4] 31 U.S.C. § 3730(h), C.R.S. § 25.5-4-306(7)

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- **Improper cost-shifting:** Billing Medicaid for services that should have been paid by another program or payer.
- **Identity fraud:** Using someone else's Medicaid ID to access healthcare services, which causes false claims to be submitted.
- **Falsified eligibility:** Providing false information during application processes to qualify for Medicaid benefits improperly.
- **Prescription fraud:** Selling prescription medications obtained through Medicaid or altering prescriptions for personal gain.

B. Reporting Potential Violations

1. Workforce Members, Contracted Providers, and business partners must report potential or actual violations through the following channels:
   - **Compliance Hotline**: 877-363-3065 (Available 24/7)
   - **Email**: compliance@coaccess.com
   - **Online Portal Link**: EthicsPoint - Access Management Services, LLC
   - **Direct Reporting**: Concerns may also be reported directly to a supervisor, manager, the Director of Compliance Programs or a member of the Compliance Department.
2. Supervisors receiving reports must forward the concern to the Compliance email within one (1) business day of receipt.
3. Reports will be investigated and treated confidentially to the extent possible. COA enforces a non-Retaliation policy for good-faith reporting. For more details, refer to CMP-201 Compliance Problem Reporting and Non-Retaliation Policy.

C. Training and Education

1. All Workforce Members will complete mandatory compliance training upon hire and annually thereafter. For more details refer to CMP-204 Compliance Education and Training policy.
2. COA will include information about the False Claims Act in the provider manual, on the company website, in provider bulletins, company policies and procedures, vendor contracts, and in other communications.

D. Review and Updates

1. This policy will be reviewed annually and updated as necessary to ensure compliance with applicable laws and regulations.

E. Record Retention

1. COA will retain records in accordance with CMP-210 Record Retention and Destruction policy.

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REFERENCES:
31 USC §§3729-3733
CRS §25.5-4-303.5 to §25.5-4-310
CRS § 26-1-127
31 U.S.C. § 3730(h)
C.R.S. § 25.5-4-306(7)
CMP-201 Compliance Problem Reporting and Non-retaliation policy.
CMP-204 Compliance Education and Training policy
CMP-210 Record Retention and Destruction policy

ATTACHMENTS:
None

POLICY HISTORY:

SUMMARY OF REVIEW/REVISION/APPROVAL DATES:
Version 1: 7/30/2008, Version 2: 9/24/2009, Version 3: 8/5/2010, Version 4: 7/8/2011, Version 5: 9/18/2012, Version 6: 9/18/2013, Version 7: 8/20/2014, Version 8: 3/1/2016, Version 9: 3/1/2017, Version 10: 3/1/2018, Version 11: 3/1/2018, Version 12: 3/1/2019, Version 13: 2/15/2020, Version 14: 7/12/2021, Version 15: 7/6/2022, Version 16: 12/1/2023, Version 17: 12/5/2024, Version 18: 12/04/2025 Annual review, minor updates.

APPROVAL BODY: COA Core Policy Team **APPROVAL DATE:** 12/04/2025