Second Regular Session
Seventy-first General Assembly
STATE OF COLORADO

PREAMENDED

This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading

LLS NO. 18-0358.01 Conrad Imel x2313 **HOUSE BILL 18-1211**

HOUSE SPONSORSHIP

Wist and Foote,

SENATE SPONSORSHIP

Smallwood and Aguilar,

House Committees
Judiciary

Senate Committees

A BILL FOR AN ACT

101 **CONCERNING CONTROLLING MEDICAID FRAUD.**

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

The bill establishes the medicaid fraud control unit (unit) in the department of law. The unit is responsible for investigation and prosecution of medicaid fraud and waste, as well as patient abuse, neglect, and exploitation. The department of health care policy and financing is authorized to require medicaid providers to include information about reporting medicaid fraud to the unit in any explanation of benefits provided to a medicaid beneficiary.

The bill creates offenses related to making false statements on

applications, medicaid fraud, and credit and recovery of medicaid payments. The bill makes it unlawful to receive certain kickbacks, bribes, and rebates related to the administration of a medicaid service. Actions brought under the provisions of the bill must commence within 3 years after the discovery of the offense.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly hereby finds and declares that:

(a) The Colorado attorney general's office continues to prosecute medicaid provider fraud and waste, as well as patient abuse, neglect, and exploitation cases, both criminal and civil, pursuant to executive order D1787 signed by Governor Roy Romer in March 1987 and 42 U.S.C. sec. 1396b (q); and

(b) The functions of the medicaid fraud control unit are important to protect the integrity of Colorado's medicaid program, including federal funding for that program, as well as to protect some of Colorado's most vulnerable citizens from abuse, neglect, and exploitation.

(2) The general assembly finds, therefore, that the medicaid fraud control unit should be recognized in statute and its authority to prosecute medicaid provider fraud and waste, as well as patient abuse, neglect, and exploitation cases, should be codified in order to provide clarity to providers and others regarding what constitutes medicaid fraud and waste under Colorado law, including that convictions for medicaid fraud and waste are limited to providers who knowingly and willfully violate the law.

SECTION 2. In Colorado Revised Statutes, **add** part 8 to article 31 of title 24 as follows:

PART 8

MEDICAID FRAUD CONTROL

24-31-801. Definitions. AS USED IN THIS PART 8, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "ABUSE" MEANS WILLFUL INFLICTION OF INJURY, UNREASONABLE CONFINEMENT, INTIMIDATION, OR PUNISHMENT WITH RESULTING PHYSICAL OR FINANCIAL HARM OR PAIN OR MENTAL ANGUISH, INCLUDING ANY ACTS OR OMISSIONS THAT CONSTITUTE A CRIMINAL VIOLATION UNDER STATE LAW.

(2) "BENEFICIARY" MEANS ANY INDIVIDUAL WHO RECEIVES GOODS OR SERVICES FROM A PROVIDER UNDER THE MEDICAID PROGRAM.

(3) "BENEFIT" MEANS ANY BENEFIT AUTHORIZED UNDER THE "COLORADO MEDICAL ASSISTANCE ACT".

(4) "CLAIM" MEANS ANY COMMUNICATION SUBMITTED TO THE MEDICAID PROGRAM OR TO A PERSON THAT HAS CONTRACTED WITH THE MEDICAID PROGRAM, WHETHER ORAL, WRITTEN, ELECTRONIC, OR MAGNETIC, THAT IDENTIFIES A GOOD, ITEM, OR SERVICE AS REIMBURSABLE UNDER THE MEDICAID PROGRAM; IS USED TO AUTHORIZE THE PROVISION OF SERVICES UNDER THE MEDICAID PROGRAM; SERVES AS AN INVOICE FOR SERVICES PROVIDED UNDER CONTRACT WITH THE MEDICAID PROGRAM; OR STATES INCOME OR EXPENSE AND IS OR MAY BE USED TO DETERMINE A RATE OF PAYMENT UNDER THE MEDICAID PROGRAM.

(5) "COLORADO MEDICAL ASSISTANCE ACT" MEANS ARTICLES 4 TO 6 OF TITLE 25.5.

(6) "EXPLOITATION" MEANS THE WRONGFUL TAKING OR USE OF FUNDS OR PROPERTY OF A PATIENT RESIDING IN A HEALTH CARE FACILITY OR BOARD AND CARE FACILITY THAT CONSTITUTES A CRIMINAL VIOLATION UNDER STATE LAW.

(7) "KNOWINGLY" AND "WILLFULLY" HAVE THE SAME MEANING AS SET FORTH IN SECTION 18-1-501 (6).

(8) "MATERIAL INFORMATION" MEANS AN ASSERTION OR INFORMATION DIRECTLY PERTAINING TO A CLAIM, RECORD, STATEMENT, OR REPRESENTATION THAT A REASONABLE PERSON KNOWS OR SHOULD KNOW WILL AFFECT THE ACTION, CONDUCT, OR DECISION OF THE PERSON WHO RECEIVES OR IS INTENDED TO RECEIVE THE ASSERTED INFORMATION IN A MANNER THAT WOULD DIRECTLY OR INDIRECTLY BENEFIT THE PERSON MAKING THE ASSERTION.

(9) "MEDICAID FRAUD AND WASTE" MEANS ANY ACT, BY COMMISSION OR OMISSION, AS DESCRIBED IN SECTION 24-31-808.

(10) "MEDICAID PROGRAM" MEANS THE MEDICAL ASSISTANCE PROGRAM AUTHORIZED BY TITLE XIX OF THE FEDERAL "SOCIAL SECURITY ACT" AND IMPLEMENTED BY THE "COLORADO MEDICAL ASSISTANCE ACT".

(11) "NEGLECT" MEANS WILLFUL FAILURE TO PROVIDE GOODS AND SERVICES NECESSARY TO AVOID PHYSICAL HARM, MENTAL ANGUISH, OR MENTAL ILLNESS, INCLUDING ANY NEGLECT THAT CONSTITUTES A CRIMINAL VIOLATION UNDER STATE LAW.

(12) "PERSON" MEANS AN INDIVIDUAL, PUBLIC OR PRIVATE INSTITUTION, CORPORATION, PARTNERSHIP, ASSOCIATION, OR MANAGED CARE ENTITY.

(13) "PROVIDER" MEANS ANY PERSON, EMPLOYEE, AGENT, REPRESENTATIVE, CONTRACTOR, OR SUBCONTRACTOR OF A PERSON:

(a) WHO HAS ENTERED INTO A PROVIDER AGREEMENT WITH THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING TO PROVIDE GOODS OR SERVICES PURSUANT TO THE MEDICAID PROGRAM;

(b) WHO HAS ENTERED INTO AN AGREEMENT WITH A PARTY TO SUCH A PROVIDER AGREEMENT UNDER WHICH THE PERSON AGREES TO PROVIDE GOODS OR SERVICES THAT ARE REIMBURSABLE UNDER THE MEDICAID PROGRAM;

(c) WHO IS REIMBURSED OR RECEIVES COMPENSATION FOR DELIVERING, PURPORTING TO DELIVER, OR ARRANGING FOR THE DELIVERY OF HEALTH CARE GOODS OR SERVICES FROM THE MEDICAID PROGRAM;

(d) WHO IS DEFINED AS SUCH IN SECTION 25.5-4-103 (19); OR

(e) WHO IS DEFINED AS SUCH IN SECTION 25.5-4-416 (1).

(14) "RECORDS" MEANS ANY MEDICAL, PROFESSIONAL, OR BUSINESS RECORDS RELATING TO THE TREATMENT OR CARE OF ANY BENEFICIARY, TO GOODS OR SERVICES PROVIDED TO ANY BENEFICIARY, OR TO RATES PAID FOR GOODS OR SERVICES PROVIDED TO ANY BENEFICIARY AND ANY RECORDS THAT ARE REQUIRED TO BE KEPT BY THE RULES OF THE MEDICAID PROGRAM.

(15) "STATEMENT OR REPRESENTATION" MEANS ANY ORAL, WRITTEN, OR ELECTRONIC COMMUNICATION THAT IS USED TO IDENTIFY AN ITEM OF GOODS OR A SERVICE FOR WHICH REIMBURSEMENT MAY BE MADE UNDER THE MEDICAID PROGRAM OR THAT STATES INCOME AND EXPENSE AND IS OR MAY BE USED TO DETERMINE A RATE OF REIMBURSEMENT UNDER THE MEDICAID PROGRAM, THAT MAY SERVE AS THE BASIS FOR THE CALCULATION OF A PAYMENT TO A PROVIDER, OR THAT MAY SERVE AS A BASIS FOR RECEIVING PAYMENT.

(16) "UNIT" MEANS THE MEDICAID FRAUD CONTROL UNIT CREATED IN SECTION 24-31-802.

24-31-802. Medicaid fraud control unit - creation - duties. THERE IS CREATED WITHIN THE DEPARTMENT OF LAW AND UNDER THE

CONTROL OF THE OFFICE OF THE ATTORNEY GENERAL THE MEDICAID FRAUD CONTROL UNIT. THE UNIT SHALL INVESTIGATE AND PROSECUTE FRAUD, MISUSE, WASTE, AND ABUSE COMMITTED BY MEDICAID PROVIDERS AND INVESTIGATE AND PROSECUTE CASES OF PATIENT ABUSE, NEGLECT, AND EXPLOITATION.

24-31-803. Medicaid fraud reporting. THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING; THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT; MANAGED CARE ENTITIES; AND THEIR FISCAL AGENTS, CONTRACTORS, OR SUBCONTRACTORS, SHALL REFER ALL CASES WHERE THE AGENCY OR ENTITY HAS REASONABLE CAUSE TO BELIEVE THAT THERE IS SUSPECTED MEDICAID FRAUD AND WASTE AS WELL AS PATIENT ABUSE, NEGLECT, AND EXPLOITATION TO THE UNIT FOR THE PURPOSE OF INVESTIGATION, CIVIL ACTION, OR CRIMINAL ACTION. NOTHING CONTAINED IN THIS PART 8 PROHIBITS THE ATTORNEY GENERAL FROM PURSUING CASES OF SUSPECTED MEDICAID FRAUD AND WASTE OR PATIENT ABUSE, NEGLECT, AND EXPLOITATION CASES ABSENT SUCH A REFERRAL.

24-31-804. Medicaid fraud control unit - displayed information. THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING MAY REQUIRE THAT A NOTIFICATION BE INCLUDED IN ANY EXPLANATION OF BENEFITS PROVIDED TO A BENEFICIARY THAT EXPLAINS THE PROCESS AND CONTACT INFORMATION FOR REPORTING TO THE UNIT SUSPECTED MEDICAID FRAUD AND WASTE AS WELL AS PATIENT ABUSE, NEGLECT, AND EXPLOITATION. ANY NOTIFICATION REQUIRED PURSUANT TO THIS SECTION MUST BE PLACED IN A CONSPICUOUS LOCATION WITHIN THE EXPLANATION OF BENEFITS AND MUST INCLUDE A STATEMENT THAT ALL REPORTS TO THE UNIT MAY BE FILED ANONYMOUSLY BY PERSONS SUSPECTING FRAUDULENT ACTIVITY.

24-31-805. Medicaid fraud control unit authority and responsibilities. (1) IN CARRYING OUT THE RESPONSIBILITIES OF THIS SECTION, THE UNIT HAS THE AUTHORITY TO:

(a) INVESTIGATE AND PROSECUTE CIVIL ACTIONS AND PROCEEDINGS, PURSUANT TO SECTION 25.5-4-301 (2) OR SECTIONS 25.5-4-303.5 TO 25.5-4-310;

(b) INVESTIGATE AND PROSECUTE CRIMINAL MEDICAID FRAUD AND WASTE PURSUANT TO THIS PART 8 AND TITLE 18;

(c) INVESTIGATE AND PROSECUTE PATIENT ABUSE, NEGLECT, OR EXPLOITATION PROVIDED THAT PRIOR TO THE FILING OF ANY CRIMINAL CHARGES INVOLVING PATIENT ABUSE, NEGLECT, OR EXPLOITATION BY EITHER COMPLAINT OR GRAND JURY INDICTMENT THE UNIT SHALL FIRST CONSULT WITH THE DISTRICT ATTORNEY OF THE JUDICIAL DISTRICT WHERE THE PROSECUTION WOULD BE INITIATED. IF AFTER SUCH CONSULTATION, THE DISTRICT ATTORNEY AGREES WITH THE FILING OF CHARGES, THE UNIT SHALL CROSS-DESIGNATE THE DISTRICT ATTORNEY OR HIS OR HER DESIGNATED ASSISTANT OR DEPUTY DISTRICT ATTORNEY AS A SPECIAL ASSISTANT ATTORNEY GENERAL ON THE CASE. IF AFTER SUCH CONSULTATION THE DISTRICT ATTORNEY DOES NOT AGREE WITH THE FILING OF CHARGES, THE UNIT MAY FILE THE CASE INDEPENDENTLY;

(d) ISSUE OR CAUSE TO BE ISSUED CIVIL INVESTIGATIVE DEMANDS AND SUBPOENAS OR OTHER PROCESS IN AID OF INVESTIGATIONS AND PROSECUTIONS;

(e) ADMINISTER OATHS AND TAKE SWORN STATEMENTS UNDER PENALTY OF PERJURY; AND

(f) SERVE AND EXECUTE, IN ANY COUNTY, SEARCH WARRANTS THAT RELATE TO INVESTIGATIONS.

24-31-806. Civil investigative demands and subpoenas. (1) CIVIL INVESTIGATIVE DEMANDS ISSUED PURSUANT TO THIS PART 8 ARE SUBJECT TO THE REQUIREMENTS OF SECTION 25.5-4-309.

(2) SUBPOENAS ISSUED PURSUANT TO THIS PART 8 MUST COMPLY WITH THE PROVISIONS OF ARTICLE 90 OF TITLE 13 AND ANY COURT RULE.

(3) ANY TESTIMONY OBTAINED PURSUANT TO A CIVIL INVESTIGATIVE DEMAND ISSUED PURSUANT TO THIS SECTION IS NOT ADMISSIBLE IN EVIDENCE IN ANY CRIMINAL PROSECUTION AGAINST THE PERSON COMPELLED TO TESTIFY PURSUANT TO THE CIVIL INVESTIGATIVE DEMAND. THE PROVISIONS OF THIS SUBSECTION (3) DO NOT PREVENT THE ATTORNEY GENERAL FROM INDEPENDENTLY PRODUCING OR OBTAINING THE SAME OR SIMILAR FACTS, INFORMATION, OR EVIDENCE FOR USE IN ANY CRIMINAL PROSECUTION.

24-31-807. Provider applications - false statements - penalties. (1) EACH APPLICATION TO PARTICIPATE AS A PROVIDER IN THE MEDICAID PROGRAM, INCLUDING AMENDMENTS, UPDATES, RENEWALS, OR REVALIDATIONS THEREOF; EACH REPORT STATING INCOME OR EXPENSE UPON WHICH RATES OF PAYMENT ARE OR MAY BE BASED; AND EACH INVOICE FOR PAYMENT FOR A GOOD OR SERVICE PROVIDED TO A BENEFICIARY MUST CONTAIN A STATEMENT THAT ALL MATTERS STATED THEREIN ARE TRUE AND ACCURATE, AND THE STATEMENT MUST BE SIGNED BY THE INDIVIDUAL AUTHORIZED BY THE PROVIDER.

(2) AN APPLICATION UNDER SUBSECTION (1) OF THIS SECTION IS A PUBLIC RECORD OR INSTRUMENT AS DESCRIBED IN SECTION 18-5-102 (1)(d).

24-31-808. Medicaid fraud and waste - penalties - definition.

(1) A PERSON COMMITS MEDICAID FRAUD AND WASTE WHEN THAT PERSON KNOWINGLY AND WILLFULLY:

(a) WITH INTENT TO DEFRAUD, MAKES A CLAIM, OR CAUSES A CLAIM TO BE MADE, KNOWING THE CLAIM CONTAINS MATERIAL INFORMATION THAT IS FALSE, IN WHOLE OR IN PART, BY COMMISSION OR OMISSION;

(b) WITH INTENT TO DEFRAUD, MAKES A STATEMENT OR REPRESENTATION, OR CAUSES A STATEMENT OR REPRESENTATION TO BE MADE, FOR USE IN OBTAINING OR SEEKING TO OBTAIN AUTHORIZATION TO PROVIDE A GOOD OR A SERVICE, KNOWING THE STATEMENT OR REPRESENTATION CONTAINS MATERIAL INFORMATION THAT IS FALSE, IN WHOLE OR IN PART, BY COMMISSION OR OMISSION;

(c) WITH INTENT TO DEFRAUD, MAKES A STATEMENT OR REPRESENTATION, OR CAUSES A STATEMENT OR REPRESENTATION TO BE MADE, FOR USE BY ANOTHER IN OBTAINING A GOOD OR A SERVICE UNDER THE MEDICAID PROGRAM, KNOWING THE STATEMENT OR REPRESENTATION CONTAINS MATERIAL INFORMATION THAT IS FALSE, IN WHOLE OR IN PART, BY COMMISSION OR OMISSION;

(d) WITH INTENT TO DEFRAUD, MAKES A STATEMENT OR REPRESENTATION, OR CAUSES A STATEMENT OR REPRESENTATION TO BE MADE, FOR USE IN QUALIFYING AS A PROVIDER OF A GOOD OR SERVICE UNDER THE MEDICAID PROGRAM, KNOWING THE STATEMENT OR REPRESENTATION CONTAINS MATERIAL INFORMATION THAT IS FALSE, IN WHOLE OR IN PART, BY COMMISSION OR OMISSION;

(e) WITH INTENT TO DEFRAUD, SIGNS OR SUBMITS, OR CAUSES TO BE SIGNED OR SUBMITTED, A STATEMENT DESCRIBED IN SECTION

24-31-807 WITH THE KNOWLEDGE THAT THE APPLICATION, REPORT, CLAIM, OR INVOICE FOR SERVICES PROVIDED UNDER CONTRACT CONTAINS MATERIAL INFORMATION THAT IS FALSE, IN WHOLE OR IN PART, BY COMMISSION OR OMISSION;

(f) EXCEPT AS AUTHORIZED BY LAW, AND WITHOUT CONSENT OF THE BENEFICIARY, CHARGES ANY BENEFICIARY MONEY OR OTHER CONSIDERATION IN ADDITION TO OR IN EXCESS OF RATES OF REMUNERATION ESTABLISHED UNDER THE MEDICAID PROGRAM FOR THE SERVICES PROVIDED TO THE BENEFICIARY;

(g) HAVING SUBMITTED A CLAIM FOR OR RECEIVED PAYMENT FOR A GOOD OR A SERVICE UNDER THE MEDICAID PROGRAM:

(I) ALTERS, FALSIFIES, OR CONCEALS ANY RECORDS THAT ARE NECESSARY TO FULLY DISCLOSE THE NATURE OF ALL GOODS OR SERVICES FOR WHICH THE CLAIM WAS SUBMITTED, OR FOR WHICH REIMBURSEMENT WAS RECEIVED; DESTROYS OR REMOVES SUCH RECORDS WITH THE INTENT TO PREVENT THEIR REVIEW BY REPRESENTATIVES OF THE STATE OR THEIR DESIGNEES; OR FAILS TO MAINTAIN SUCH RECORDS AS REQUIRED BY LAW OR THE RULES OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FOR A PERIOD OF AT LEAST SIX YEARS FOLLOWING THE DATE ON WHICH PAYMENT WAS RECEIVED; OR

(II) ALTERS, FALSIFIES, OR CONCEALS ANY RECORDS THAT ARE NECESSARY TO DISCLOSE FULLY ALL INCOME AND EXPENDITURES UPON WHICH RATES OF REIMBURSEMENTS WERE BASED, OR DESTROYS OR REMOVES SUCH RECORDS WITH THE INTENT TO PREVENT THEIR REVIEW BY REPRESENTATIVES OF THE STATE OR THEIR DESIGNEES;

(h) MAKES OR CAUSES TO BE MADE A STATEMENT OR REPRESENTATION FOR USE IN QUALIFYING AS A PROVIDER OF A GOOD OR

SERVICE UNDER THE MEDICAID PROGRAM STATING THAT HE OR SHE IS IN COMPLIANCE WITH ALL PROVISIONS OF SECTION 25.5-4-416, KNOWING THAT THE STATEMENT OR REPRESENTATION CONTAINS MATERIAL INFORMATION THAT IS FALSE, IN WHOLE OR IN PART, THROUGH COMMISSION OR OMISSION; OR

(i) EXCEPT AS AUTHORIZED BY LAW, AND WITHOUT CONSENT OF THE BENEFICIARY, RECOVERS OR ATTEMPTS TO RECOVER PAYMENT FROM A BENEFICIARY UNDER THE MEDICAID PROGRAM OR FROM THE BENEFICIARY'S FAMILY OR FAILS TO CREDIT THE STATE FOR PAYMENTS RECEIVED FROM OTHER SOURCES.

(2) ABSENT KNOWING OR WILLFUL CONDUCT, A PROVIDER IS NOT LIABLE FOR MEDICAID FRAUD AND WASTE COMMITTED BY A THIRD PARTY. A PROVIDER DOES NOT KNOWINGLY AND WILLFULLY VIOLATE A REQUIREMENT, STANDARD, OR DIRECTIVE CONTAINED IN WRITTEN MATERIALS ISSUED BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING THAT WAS NOT PROMULGATED IN ACCORDANCE WITH THE "STATE ADMINISTRATIVE PROCEDURE ACT", ARTICLE 4 OF TITLE 24, UNLESS THE PROVIDER HAS ACTUAL KNOWLEDGE OF SUCH REQUIREMENT, STANDARD, OR DIRECTIVE AT THE TIME OF THE VIOLATION.

(3) MEDICAID FRAUD IN VIOLATION OF SUBSECTIONS (1)(a) TO (1)(c) OR (1)(f) OF THIS SECTION IS:

(a) A CLASS 1 PETTY OFFENSE WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS LESS THAN FIFTY DOLLARS;

(b) A CLASS 3 MISDEMEANOR WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS FIFTY DOLLARS OR MORE BUT LESS THAN THREE HUNDRED DOLLARS;

(c) A CLASS 2 MISDEMEANOR WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS THREE HUNDRED DOLLARS OR MORE BUT LESS THAN SEVEN HUNDRED FIFTY DOLLARS;

(d) A CLASS 1 MISDEMEANOR WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS SEVEN HUNDRED FIFTY DOLLARS OR MORE BUT LESS THAN TWO THOUSAND DOLLARS;

(e) A CLASS 6 FELONY WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS TWO THOUSAND DOLLARS OR MORE BUT LESS THAN FIVE THOUSAND DOLLARS;

(f) A CLASS 5 FELONY WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS FIVE THOUSAND DOLLARS OR MORE BUT LESS THAN TWENTY THOUSAND DOLLARS;

(g) A CLASS 4 FELONY WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS TWENTY THOUSAND DOLLARS OR MORE BUT LESS THAN ONE HUNDRED THOUSAND DOLLARS;

(h) A CLASS 3 FELONY WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS ONE HUNDRED THOUSAND DOLLARS OR MORE BUT LESS THAN ONE MILLION DOLLARS; AND

(i) A CLASS 2 FELONY WHERE THE AGGREGATE AMOUNT OF PAYMENTS ILLEGALLY CLAIMED OR RECEIVED IS ONE MILLION DOLLARS OR MORE.

(4) MEDICAID FRAUD AS A VIOLATION OF SUBSECTION (1)(d), (1)(e), (1)(g), (1)(h), OR (1)(i) OF THIS SECTION IS A CLASS 5 FELONY AND SHALL BE PUNISHED AS PROVIDED IN SECTION 18-1.3-401.

(5) A PERSON MAY NOT BE CONVICTED OF MEDICAID FRAUD AND WASTE IN ADDITION TO THEFT OR FORGERY WITH RESPECT TO THE SAME TRANSACTION.

24-31-809. Unlawful remuneration - penalties. (1) EXCEPT AS PROVIDED IN SUBSECTION (2) OF THIS SECTION, IT IS UNLAWFUL FOR ANY PERSON TO KNOWINGLY OFFER, PAY, SOLICIT, OR RECEIVE ANY REMUNERATION INCLUDING, BUT NOT LIMITED TO, ANY KICKBACK, BRIBE, OR REBATE, DIRECTLY OR INDIRECTLY, OVERTLY OR COVERTLY, IN CASH OR IN KIND:

(a) IN RETURN FOR THE REFERRAL OF AN INDIVIDUAL TO A PERSON FOR THE FURNISHING OR ARRANGING OF ANY GOOD OR SERVICE FOR WHICH PAYMENT MAY BE MADE IN WHOLE OR IN PART PURSUANT TO THE "COLORADO MEDICAL ASSISTANCE ACT"; OR

(b) IN RETURN FOR PURCHASING, LEASING, ORDERING, OR ARRANGING FOR OR RECOMMENDING THE PURCHASE, LEASE, OR ORDERING OF ANY GOOD, FACILITY, SERVICE, OR ITEM FOR WHICH PAYMENT MAY BE MADE IN WHOLE OR IN PART PURSUANT TO THE "COLORADO MEDICAL ASSISTANCE ACT".

(2) IT SHALL NOT BE UNLAWFUL UNDER SUBSECTION (1) OF THIS SECTION IF THE REMUNERATION OBTAINED BY THE PROVIDER OR OTHER ENTITY IS:

(a) PERMITTED PURSUANT TO SECTION 25.5-4-414 OR ANY STATUTORY EXCEPTIONS OR SAFE HARBOR REGULATIONS UNDER THE FEDERAL "ANTI-KICKBACK STATUTE", 42 U.S.C. SEC. 1320a-7b (b), AS AMENDED;

(b) PROPERLY DISCLOSED AND APPROPRIATELY REFLECTED IN THE CLAIMS OR COST DOCUMENTS SUBMITTED UNDER THE "COLORADO MEDICAL ASSISTANCE ACT";

(c) PAID BY AN EMPLOYER TO AN EMPLOYEE WHO HAS A BONA FIDE EMPLOYMENT RELATIONSHIP WITH SUCH EMPLOYER FOR EMPLOYMENT IN

PROVIDING THE SERVICE; OR

(d) PAID BY A VENDOR OF GOODS OR SERVICES TO A PERSON AUTHORIZED TO ACT AS A PURCHASING AGENT FOR A GROUP OF PROVIDERS, AND:

(I) THE PERSON HAS A WRITTEN CONTRACT WITH THE PROVIDERS THAT SPECIFIES THE AMOUNT TO BE PAID TO THE PERSON, WHICH AMOUNT MAY BE A FIXED AMOUNT OR A FIXED PERCENTAGE OF THE VALUE OF THE PURCHASE MADE BY THE PERSON; OR

(II) IN THE CASE OF A PROVIDER OF SERVICES, THE PERSON DISCLOSES, IN SUCH FORM AND MANNER AS THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING REQUIRES, TO THE PROVIDER AND, UPON REQUEST, TO THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING THE AMOUNT RECEIVED FROM EACH SUCH VENDOR WITH RESPECT TO PURCHASES MADE BY OR ON BEHALF OF THE PROVIDER.

(3) A VIOLATION OF THIS SECTION IS A CLASS 1 MISDEMEANOR AND SHALL BE PUNISHED AS PROVIDED IN SECTION 18-1.3-501.

24-31-810. Other remedies available. (1) THE PROVISIONS OF THIS PART 8 ARE NOT INTENDED TO BE EXCLUSIVE REMEDIES AND DO NOT PRECLUDE THE USE OF ANY OTHER CRIMINAL PROSECUTION DIRECTLY RELATED TO CRIMINAL MEDICAID FRAUD AND WASTE, AS WELL AS CRIMINAL PATIENT ABUSE, NEGLECT, AND EXPLOITATION, OR ANY OTHER CIVIL REMEDY FOR ANY ACT THAT IS IN VIOLATION OF THIS PART 8.

(2) IN ADDITION TO ANY PENALTIES PROVIDED FOR IN THIS PART 8, A CLAIM UNDER THE "COLORADO MEDICAL ASSISTANCE ACT" THAT INCLUDES ITEMS OR SERVICES RESULTING FROM A VIOLATION OF THIS PART 8 OR THE FEDERAL "ANTI-KICKBACK STATUTE", 42 U.S.C. 1320a-7b (b), AS AMENDED, CONSTITUTES A FALSE CLAIM FOR PURPOSES OF THE

"COLORADO MEDICAID FALSE CLAIMS ACT", SECTIONS 25.5-4-303.5 TO 25.5-4-310.

24-31-811. Limitation of action - three years. AN ACTION BROUGHT UNDER THIS PART 8 MUST BE COMMENCED WITHIN THREE YEARS AFTER THE DATE OF DISCOVERY OF THE COMMISSION OF THE OFFENSE, BUT NO LATER THAN SIX YEARS AFTER THE DATE OF THE COMMISSION OF THE OFFENSE. WHEN A VIOLATION OF THIS SECTION IS BASED ON A SERIES OF ACTS PERFORMED AT DIFFERENT TIMES, THE LIMITATION PERIOD STARTS AT THE TIME THE LAST ACT IN THE SERIES IS DISCOVERED.

SECTION 3. Potential appropriation. Pursuant to section 2-2-703, C.R.S., any bill that results in a net increase in periods of imprisonment in state correctional facilities must include an appropriation of money that is sufficient to cover any increased capital construction, any operational costs, and increased parole costs that are the result of the bill for the department of corrections in each of the first five years following the effective date of the bill. Because this act may increase periods of imprisonment, this act may require a five-year appropriation.

SECTION 4. Act subject to petition - effective date. This act takes effect January 1, 2019; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within the ninety-day period after final adjournment of the general assembly, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2018 and, in such case, will take effect on January 1, 2019, or on the date of the official declaration of the vote thereon by the governor, whichever is later.