Abuse/ False Claims Act (Sec 6032) Deficit Reduction Act

Policy Statement

The purpose of this policy is to educate employees and volunteers, contractors, and members ("service providers") on the requirements of the Deficit Reduction Act (DRA) of 2005 which contains provisions to combat fraud and abuse in government health care programs. Under the Deficit Reduction Act, Region IV Area Agency on Aging (the "Agency") is required to provide employees and services providers with information regarding federal and state false claims laws, administrative remedies under those laws, whistle-blower protections to employees who report incidents of false claims, and Senior Resources' programs for detecting and preventing fraud, waste and abuse in Medicaid programs.

Policy Interpretation and Implementation

The policy is intended to cover the following Acts:

A) Federal False Claims Act (FCA): The False Claims Act prohibits any person from knowingly presenting or causing to be presented, a false or fraudulent claim to the United States government for payment. The False Claims Act imposes civil liability on any person who:
   a. Knowingly presents a false or fraudulent claim for payment or approval.
   b. Knowingly makes or uses a false record or statement to get a false or fraudulent claim paid or approved.
   c. Conspires with another to get a false or fraudulent claim paid or allowed.
   d. Knowingly makes or uses a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property.
   e. Commits other fraudulent acts enumerated in the statute.

B) Medicaid False Claim Act (MFCA): The State of Michigan has a companion law known as the Medicaid False Claims Act. This act imposes prison terms of up to four (10) years and fines up to$50,000 for:
   a. Knowingly making a false statement or false representation of a material fact in any application for Medicaid benefits or for use in determining rights to a Medicaid benefit;
   b. Soliciting, offering or receiving kickbacks or bribes for referrals to another for Medicaid-funded services (fine up to $30,000);
   c. Entering an agreement with another to defraud Medicaid through a False Claim; or
   d. Making or presenting to the State of Michigan a False Claim for payment.

1. The federal False Claims Act includes a "qui tam," or whistleblower provision to report misconduct

2. involving false claims. The qui tam provision allows any private person (Qui Tam Relater) with actual knowledge of allegedly false claims to file a lawsuit on behalf of the United States government.

3. The federal government has the opportunity to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing or settling the action. If the federal government decides to intervene, the private person (Qui Tam Relater) who initiated the action may be eligible for a portion of the proceeds of the action or settlement of the claim. If the federal government does not proceed with the action, the Qui Tam Relater may continue with the lawsuit or settle the claim and he or she may

receive a portion of the proceeds of the action or settlement. The Qui Tam Relater may also receive an amount for reasonable expenses, including reasonable attorney fees and costs incurred in connection with bringing the lawsuit.

4. Violations of the federal false claims act can result in penalties of not less than $5,500.00 and not more than $11,000.00 per claim, plus three times the amount of damages that the government sustains.

5. Michigan Medicaid False Claims Act: Any person (Qui Tam Relator) may bring a civil action on behalf of the State of Michigan to recover losses that the State suffered from a person violating the Michigan Medicaid False Claims Act, and the Michigan Attorney General is to be notified and has an opportunity to appear and intervene in the action brought on behalf of the State of Michigan. If the Michigan Attorney General intervenes, in addition to the person (Qui Tam Relater) receiving his or her expenses, costs and reasonable attorney fees, the person may also receive a portion of the monetary proceeds resulting from the action or any settlement. If the Michigan Attorney General does not intervene, the Qui Tam Relater will receive a portion of the monetary proceeds.

6. Whistleblower Protection Laws: In addition to AAAs' Whistleblowing policy, both the federal and state laws protect individuals who investigate or report possible False Claims made by their employer against discharge or discrimination in employment because of such investigation. Employees who are discriminated against based on whistleblower activities may sue in court for damages. Under either the federal or state law, any employer who violates the whistleblower protection law is liable to the employee for (1) reinstatement of the employee's position without loss of seniority, (2) two times the amount of lost back pay, (3) interest and compensation for any special damages, and such other relief necessary to make the employee whole.

7. Detection of Potential Fraud or Abuse: AAA combats Medicaid fraud, waste and abuse by investigating complaints, raising awareness of anti-fraud initiatives, and assuring compliance with state and federal laws. Quality measures are also used to detect and prevent potential fraud, waste or abuse that includes the following:

   a. Proactive review of claims and other types of data

   b. Recommending and implementing claims processing safeguards

   c. Conducting employee education on fraud and abuse prevention, recognition and their responsibility/obligation on reporting.

   d. Encourage and promote the reporting of fraud or abuse by employees and contractors.

   e. Monthly check of OIG, SAMS (System for AWARD Management), and Sanctioned Provider List for employees and downstream entities.

8. Types of Fraud Prosecuted Under The FCA and MFCA:

- Billing for goods or services that were not delivered or rendered
- Submitting false service records or samples in order to show better-than-actual performance
- Performing inappropriate or unnecessary services without documented medical need

- Providing inappropriate or unnecessary medical equipment
- Billing in order to increase revenue instead of billing to reflect actual work performed
- Up-coding, or inflating bills by using HCPC billing codes that suggest a more expensive service or treatment
- Double billing, or charging more than once for the same service or goods
- Ordering a service or recommending a type of treatment regimen in order to earn kickbacks from hospital, labs or in-home service agencies
- Billing for unapproved services or at levels greater than approved
- Forging signatures when such signatures are required for reimbursement from Medicare or Medicaid
- Billing for work or tests that were not performed
- Phantom employees and doctored time/activity slips: charging for workers that were not actually on the job, or billing for made-up hours in order to maximize reimbursements
- Falsification of any report or document used to record the cost of utilization of services
- A grant recipient charging grantor for costs not related to the program

References	
MI Choice Contract	Attachment E FY 2019 (A)(1)(f)
Medicaid	42 CFR § 422.503 (vi)(A); M.C.L. 400.601 et seq., "Medicaid False Claim Act"; 31 U.S.C. §3729 et seq., "False Claims Act"
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