Fraud, Waste, and Abuse

Region IV Area Agency on Aging Policy and Procedure

Policy:

To comply with Section 6032 of the Deficit Reduction Act of 2005. The Act requires providers of services to Medicaid beneficiaries ("Medicaid Providers") who receive more than $5,000,000 in Medicaid dollars to establish written policies on providing information to its employees regarding federal and state false claims laws, administrative remedies under those laws, whistle-blower protections to employees who report incidents of false claims, and Region IV Area Agency on Aging policies and procedures for detecting and preventing fraud, waste and abuse.

This policy also provides guidance regarding Region IV Area Agency on Aging responsibilities under the Deficit Reduction Act of 2005, Federal and State False Claims Acts, responsibilities of employees and contractors to report suspected or actual instances of fraud, waste, or abuse, and whistleblower protections under these laws when such reports are made.

Definitions:

Fraud – An intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit under a state or federally funded program to himself or herself, the entity, or some other person. It also includes any act that constitutes fraud under applicable federal or state laws.

Waste – An over-utilization of services or other practices that, directly or indirectly, result in unnecessary costs to federal and state funded programs. Waste is generally not considered to be caused by criminally negligent actions but rather misuse of resources.

Abuse – Provider or enrollee practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to state and federally funded programs, including, but not limited to practices that result in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes enrollee practices that result in unnecessary cost to state and federally funded programs.

This policy is intended to cover the following Acts:

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:

- Knowingly presents a false or fraudulent claim for payment or approval.

- Knowingly makes or uses a false record or statement to get a false or fraudulent claim paid or approved.
- Conspires with another to get a false or fraudulent claim paid or allowed.
- Knowingly makes or uses a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property.
- Commits other fraudulent acts enumerated in the statute

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 (4) years and fines up to $50,000 for:

- 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;
- Soliciting, offering or receiving kickbacks or bribes for referrals to another for Medicaid-funded services (fine up to $30,000);
- Entering an agreement with another to defraud Medicaid through a False Claim; or
- Making or presenting to the State of Michigan a False Claim for payment.

Administrative Remedies

In addition to the civil remedies available under the FCA, the Program Fraud Civil Remedies act ("PFCRA"), provides the administrative remedies for False Claims and Statements made in violation of the FCA.

Administrate Remedies for False Claims

Under the PFCRA, a false claim occurs when a person makes, or submits, or causes to be made or submitted, a claim that the person knows or has reason to know is fictitious, fraudulent or false, and includes or is supported by a written statement which asserts a material fact which is false, fraudulent or fictitious, or is fraudulent as the result of an omission of a material fact, or is for the payment for the provision of services or property which the person has not provided as claimed. Upon the finding of a false claim, the person shall be assessed a civil penalty of not more than $5,500 for each such claim in addition to other civil remedies, including those available under the FCA. The person may also be assessed twice the amount of the false claim, or twice the amount of any portion of a claim found to be fraudulent.

Administrative Remedies for False Statements

Under the PFCRA, a false statement occurs when a person makes or submits, or causes to be made or submitted, a written statement that the person knows or has reason to know asserts a material fact which is false, fraudulent or fictitious, or is fraudulent as the result of an omission of a material fact and is accompanied by an affirmation or an express certification of the truthfulness and accuracy of the statement. Upon the finding of a false statement, the person shall be subject to a penalty of not more than $5,500 per false statement.

PROCEDURE:

A. Billing, Claims and Cost Reporting

Region IV Area Agency on Aging has an obligation to its clients, third party payers and the state and federal government to exercise diligence, care and integrity when submitting claims for payment. The right to bill the Medicaid program carries a responsibility that may not be abused. Region IV Area Agency on Aging is committed to maintaining the accuracy of every claim it processes and submits. Each of the individuals responsible for entering charges and codes is expected to monitor compliance with applicable billing rules. Any false, inaccurate, or questionable claims should be reported immediately to the employee's supervisor or the Chief Financial Officer. False billing is a serious offense. Medicaid rules prohibit knowingly and willfully making or causing to be made any false statement or representation of the material fact in an application for benefits or payment. It is also unlawful to conceal or fail to disclose the occurrence of an event affecting the right to payment with the intent to secure payment that is not due. Examples of false claims include knowingly:

1. Claiming reimbursement for services that have not been rendered;
2. Characterizing the service differently than the service actually rendered;
3. Falsely indicating that a particular health care professional attended a procedure;
4. Filing duplicate claims;
5. Forging or altering a prescription or claim;
6. Including inappropriate or inaccurate costs on cost reports to be submitted under the Medicaid program;
7. Billing for services or items that are not medically necessary;
8. Failing to provide medically necessary services or items; and
9. Billing excessive charges.

R4AAA has long standing quality assurance and review procedures in place to assure the accuracy and validity of MI Choice Medicaid reimbursement claims. These procedures include, but are not limited to the following:

1. Every service or product being requested must have Supervisory approval.
2. Every service or product ordered has written approval by Region IV Area Agency on Aging staff.
3. Each service provider will have a written approval detailing the name of the agency authorized to provide the service, the service name, the number of units approved, a specific time frame for the service delivery (dates), units to be provided, and cost allowed per unit. Additional comments on service delivery (days and time may vary) may also be noted.
4. Each provider is required to sign up with Vendor View as a part of the contracting process with Region IV Area Agency on Aging. Each provider must have access either to a facsimile machine or to a computer to receive written Service Authorizations.
5. Providers must have either a verbal or written approval from Region IV Area Agency on Aging prior to service delivery.
6. Providers must detail the units provided per day per participant on billing forms submitted to the Area Agency.
7. Each provider must sign each billing submitted to Region IV Area Agency on Aging stating the information is accurate.

8. Area Agency Data staff cross-checks every day of billing submitted to match it to an approved Service Authorization prior to approving payment. Claims submitted without an authorization are returned to the provider unpaid.
9. On-site reviews are conducted by Region IV Area Agency on Aging staff with provider agencies. Providers must produce signed time sheets/documentation to back up billing. Any undocumented billing will be re-cooperated by Region IV Area Agency on Aging. Providers may have to submit a remediation plan.
10. All other Area Agency practices, procedures, and policies for Direct Service Purchase also apply.

B. Safeguards

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

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.

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.

1. <u>Michigan Medicaid False Claims Act</u>
   Any person (Qui Tam Relater) 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.

2. <u>Whistleblower Protection Laws</u>
   In addition to Federal whistleblower protections, the State of Michigan has enacted the Whistleblower's to 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.

C. Detection of Potential Fraud or Abuse

Region IV Area Agency on Aging 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:

- Proactive review of claims and other types of data
- Recommending and implementing claims processing safeguards
- Conducting new employee education and annual training on fraud and abuse prevention, recognition and reporting.
- Check of OIG & SAMs (System for Award Management) prior to hiring and contracting and monthly thereafter for employees and downstream entities.
- Encourage and promote the reporting of fraud or abuse by employees and contractors.

<u>Types of Fraud Prosecuted Under the FCA and MFCA:</u>

- 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

D. Notice/Information

Region IV Area Agency on Aging prohibits the actions listed above, and any other action (or in action) that results in fraud, waste, or abuse of public resources, and shall provide all employees, contractors and agents with a copy of this policy to inform them about the federal and state false claim laws. Region IV Area Agency on Aging and its downstream entities will ensure employees required by Centers for Medicare & Medicaid receive Fraud, Waste, and Abuse and General Compliance training within 90 days of hire and annually thereafter. Training completion records should be retained for 10 years. Any employee who discovers an error or inaccuracy in any claim for payment for health care services or in any cost report that has been submitted or will be submitted should alert his or her supervisor or the Region IV Area Agency on Aging Chief Financial Officer.

This policy shall be included in the employee Region IV Area Agency on Aging Human Resources Policies and referred to in the Region IV Area Agency on Aging Human Resource Handbook. This policy shall also be posted online for all Region IV Area Agency on Aging Contractors' notice/information: http://www.areaagencyonaging.org/doing-business-with-us/1210-direct-service-purchase

Any suspected fraud will be reported to the Office of Inspector General and, as required, any relevant Third-Party Payor(s). This can be fraud and abuse by the beneficiary, provider, vendor, etc. The Michigan Department of Health & Human Service Inspector General Administration Integrity Division MCO-Fraud Referral form will be completed and submitted per the instructions provided on the Fraud Referral form (see attachment: **MDHHS Inspector General Administration Integrity Division MCO – Fraud Referral**).

Waiver agencies will utilize the MDHHS secure File Transfer Protocol System to submit fraud, waste and abuse referrals. This system will be used to submit/receive files from MDHHS Inspector General Administration. https://miloginworker.michigan.gov

Please visit the following websites to review the provisions of the Acts:
Federal False Claims Act: http://www.justice.gov/civil/docs_forms/C-FRAUDS_FCA_Primer.pdf

Michigan's The Whistleblowers' Protection Act:
http://www.legislature.mi.gov/(S(sd0gkwnskdhodsf00xmjpb55))/mileg.aspx?page=GetObject&objectname=mcl-Act-469-of-1980

Michigan's The Medicaid False Claim Act:
http://legislature.mi.gov/doc.aspx?mcl-act-72-of-1977

To report Medicaid Fraud: On-line or by sending a letter
http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-220188--,00.html

Office of Inspector General
PO Box 30062
Lansing, MI 48909
(855) MI-FRAUD (643-7283)

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Theresa M. Uhl 3/2/18

Care Management Director Date