VALLEY AREA AGENCY ON AGING	POLICY False Claims Act
Implementation Date March 6, 2014 **Revision** April 1, 2019 September 1, 2023 March 1, 2024 June 1, 2024	**Departments** Quality Management Contract Management Fiscal Long-Term Care Programs Human Resources
Manual	**Department Distribution** ☐ All staff ☐ All providers

Purpose: The purpose of this policy is to educate employees, volunteers, contractors, and members on the Standards of Conduct of Fraud, Waste and Abuse (FWA). VAAA is required to provide employees, volunteers, contractors, and members 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 VAAA programs for detecting and preventing FWA in Medicaid programs on an annual basis.

ENFORCEMENT

The Board of Directors, Chief Executive Officer, management, and supervisors are responsible for enforcing this policy. All **employees, volunteers, contractors, and members** will be given a copy of this policy annually and requested to sign an attestation of compliance. VAAA reserves the right to modify or amend this policy at any time as it may deem necessary.

Definitions:

- Fraud is an intentional act of deception, misrepresentation, or concealment to gain something of value. Fraud includes false representation of facts, making false statements, or by concealment of information.
- Waste is the over utilization of services and the misuse of resources. Waste also includes incurring unnecessary costs resulting from inefficient or ineffective practices, systems, or controls.
- Abuse is excessive or improper use of services or actions that are inconsistent with acceptable business or medical practice. Abuse refers to incidents that, although not fraudulent, may directly or indirectly cause monetary loss. Abuse can occur in financial or non-financial settings.

Requirements:

The policy is intended to cover the following Acts:

Federal False Claims Act

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

The State of Michigan has a companion law known as the Medicaid False Claims Act. This act imposes prison terms of up to ten (10) 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 (punishable by imprisonment up to four (4) years or 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.

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 can 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 and not more than $11,000 per claim, plus three times the amount of damage that the government sustains.

Michigan Medicaid False Claims Act

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.

Whistleblower Protection Laws

In addition to VAAA's 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.

Detection of Potential Fraud or Abuse

VAAA 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, which includes the following:

- Proactive review of claims and analysis of billing patterns, overpayments, and other types of data
- Recommending and implementing claims processing safeguards
- Conducting employee education on fraud and abuse prevention, recognition, and reporting
- Encouraging and promoting the reporting of fraud or abuse by employees and contractors
- Conducting participant home visits to confirm service delivery
- Reviewing areas in which VAAA is at risk for potential FWA.
- Conducting onsite Provider Audits
- Regular review of employee and provider credentials and licenses

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 to show better-than-actual performance
- Performing inappropriate or unnecessary medical procedures

- Providing inappropriate or unnecessary medical equipment
- Billing to increase revenue instead of billing to reflect actual work performed.
- Up coding, or inflating bills by using diagnosis billing codes that suggest more expensive illness or treatment.
- Double billing or charging more than once for the same service or goods.
- Prescribing medicine or recommending a type of treatment regimen to earn kickbacks from hospitals, labs, or pharmaceutical companies
- Billing for unlicensed or unapproved drugs
- Forging physician 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 slip: charging employees that were not actually on the job or billing them for made-up hours to maximize reimbursements.
- A grant recipient charging the grantor for costs not related to the program.

NOTICE/INFORMATION

VAAA prohibits the actions listed above, and any other action (or in action) that results in fraud, waste, or abuse of public resources. Providers may be subject to disciplinary action including contract termination if in violation of this policy or at the request of Michigan Department of Health and Human Services division of The Office of The Inspector General.
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 Whistleblowers' Protection Act:
http://www.legislature.mi.gov/(S(sd0gkwnskdhodsf00xmjpb55))/mileg.aspx?page=GetObject&objectname=mcl-Act-469-of-1980

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

RESPONSE/REPORTING

VAAA must become aware of or suspected non-compliance including fraud or abuse, it is obligated to respond in accordance with Federal and State regulations and report suspicions to the Michigan Department of Health and Human Services division of The Office of The Inspector General.

- All allegations of FWA must be reported to VAAA within 48 hours of entity becoming aware of the tip.
- VAAA to track and monitor all tips.
- Entity to provide written outcome of investigation to VAAA's Compliance Officer and Contract Manager within 30 calendar days.
- VAAA to respond with request for additional information, education, recommendations, or no further action needed within 10 business days.

	Phone	Email/ Mail	Website
VAAA	1-810-249-6549	fwa@valleyaaa.org	https://valleyareaaging.org/fraud-waste-abuse/ (Anonymous reporting)
MDHHS -OIG		Michigan Department of Health and Human Services -Office of Inspector General P.O. Box 30062 Lansing, MI 48909	https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/report-medicaid-fraud-and-abuse

- All participants, staff, board members, providers and provider staff members are encouraged to report concerns or incidents of wrongdoing without fear of retaliation or retribution when making a good faith report of noncompliance.

Subcontractor Requirements:

- Have a process in place to educate and train their staff in the State and Federal False Claims Act and FWA.

- Provide annual training for staff and ensure staff receive information on how to report suspicions of FWA.
- Coordinate and conduct business practices that detect and prevent False Claims and FWA.
- **Service provisions: Must be reported within 24 hours of the provider's knowledge** of the issue.
    - Non-service delivery with reason
    - Participant Hospitalized
    - Participant Institutionalized
    - Participant requested a change in day of service: prior vendor view authorization required for payment.
    - Participant requested a permanent time change for the service.

Policy References	**Cross Reference**
Exclusion Compliance Monitoring Program Integrity Auditing & Reporting Procedure DPOS Audit Procedure	MI Choice Waiver Contract Attachment D, E, P 42 CFR 438.608