MCCMH MCO Policy 1-015

Chapter: **CORPORATE COMPLIANCE**
Title: **FALSE CLAIMS ACT; REPORTING, INVESTIGATION, WHISTLEBLOWER PROTECTIONS**

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Chief Executive Officer Date

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County Executive Office Date

I. ABSTRACT

As a Prepaid Inpatient Health Plan (PIHP) that receives or makes annual Medicaid payments under a State plan of at least five million dollars ($5,000,000), Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, must ensure that all of its employees, contractors, and agents receive appropriate information related to federal and state False Claims Act provisions and whistleblower protections. The purpose of this policy is to provide such information in compliance with the requirements of Section 1902(a)(68) of the Social Security Act (42 U.S.C. 1396a).

II. APPLICATION

This policy shall apply to the MCCMH Board, all MCCMH administrative/management staff, Access staff, all other MCCMH Workforce Members (collectively, "MCCMH Staff"), as well as the contract network providers of the MCCMH Board and their workforce members, including but not limited to, their employees, independent contractors, and volunteers (collectively, the "Contract Network Providers").

III. POLICY

It is the policy of the MCCMH, as an official agency of the County of Macomb, to provide MCCMH Staff and Contract Network Providers with detailed information about the federal False Claims Act, administrative remedies for false claims and statements, state civil and criminal false claims laws and penalties, and whistleblower protections under such laws.

IV. DEFINITIONS

A. Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. 42 CFR § 455.2

B. Centers for Medicare & Medicaid Services (CMS): An agency of the Department of Health and Human Services (HHS) that is responsible for the administration of Medicare and Medicaid under Title XVIII and Title XIX of the Social Security Act, respectively.

C. Enrollees: A Medicaid beneficiary who is currently enrolled in the MCCMH PIHP.

D. Fraud:

1. Federal False Claims Act: Intentional deception or misrepresentation made by a person with the knowledge or reckless disregard that the deception could result in some unauthorized benefit to himself or some other person, including any act that constitutes fraud under applicable Federal or State law. 42 CFR §455.2

2. Michigan False Claims Acts (Medicaid Health Care): An individual who *should have been aware* that the nature of his or her conduct constituted a false claim for Medicaid benefits, akin to constructive knowledge, may be found guilty of Medicaid fraud in Michigan. Errors or mistakes, however, are insufficient to establish "knowing" conduct, unless the person's "course of conduct indicates a systematic or persistent tendency to cause inaccuracies to be present." MCL. 400.602(d) and (f); MCL 752.1002(c) and (h)

E. Waste: As defined by CMS with respect to Medicare Part D, "waste" is the overutilization or inappropriate utilization of services and misuse of resources.

F. Workforce Member: Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for MCCMH, is under the direct control of MCCMH, including but not limited to, administrative and directly-operated network provider employees, independent contractors, and volunteers.

V. STANDARDS

A. MCCMH Staff and Contract Network Providers will be familiar with the following applicable federal and state laws regarding Medicaid false claims:

1. Federal False Claims Act: 31 U.S.C. § 3729

a. Broadly applicable to almost any situation where federal payments are received.

b. Prohibits any person or organization to "knowingly" make a false record or file a false claim regarding any federal health care program which is funded directly, in whole or in part, by the United States Government or any state healthcare system. The Federal False Claims Act prohibits, among other things:

i. Knowingly presenting, or causing to be presented a false claim for payment;
ii. Knowingly making, using, or causing to be made or used, a false record or statement to get a false claim paid or approved by the government;
iii. Conspiring to get a false claim allowed or paid;
iv. Making or using a false record or statement material to a false claim;
v. Concealing, improperly avoiding or decreasing an obligation to pay money to the government; or
vi. "Medical Billing Fraud," including:
    1) Double billing;
    2) Use of untrained personnel to provide services;
    3) Failure to supervise unlicensed personnel;
    4) Distribution of unapproved devices or drugs;
    5) Forgery of physician's signatures;
    6) Creation of phony insurance companies or employee benefit plans;
    7) Up-coding;
    8) Unbundling;
    9) Kickbacks;
    10) Services provided without medical necessity;
    11) Fraudulent cost reports;
    12) Inadequate care;
    13) Use of substandard equipment; and
    14) Failure to report and return any identified overpayment within the later of 60 days of the date the overpayment is identified or the date of the relevant cost report.

c. "Knowingly" means acting with actual knowledge of falsity, deliberate ignorance, or reckless disregard for the truth or falsity of the information. An individual does not have to specifically intend to defraud the government in order to violate the False Claims Act.

d. Civil monetary penalties for violating the False Claims Act may be as much as three times the amount of damages sustained by the Government as a result of each false claim, plus penalties up to $21,916 (in 2017) per false claim filed.

e. A criminal False Claims Act statute exists, under which individuals or entities submitting false claims may face fines, imprisonment, or both. 18 U.S.C. § 3571, 18 U.S.C. § 287

f. Federal "Qui Tam" (Whistleblower) Provision: 31 U.S.C. § 3730

i. Private persons with knowledge of a false claim may bring a civil action for penalties and damages on behalf of the United States Government. The Government may elect to join the suit. If the suit is successful, the whistleblower may be awarded a percentage of the recovery.

ii. Protection from Retaliation:

1) Whistleblowers are protected from retaliation, including termination, demotion, suspension, threats, harassment or discrimination, because of their lawful acts in reporting false claims or bringing legal actions to recover money paid on false claims.

2) If a whistleblower is the subject of retaliation, they may bring an action in the appropriate federal district court. If successful, the whistleblower will be entitled to reinstatement with the same seniority status, two times the amount of back pay, interest on the back pay, and compensation for any special damages as a result of the discrimination, such as litigation costs and reasonable attorney's fees.

3) Whistleblowers who planned or participated in the false claims may not be protected or receive a percentage of any funds recovered.

2. Michigan Medicaid False Claims Act: MCL 400.601, et seq.

a. Prohibits, generally: (i) fraud in the obtaining of benefits or payments in connection with the state Medicaid program; (ii) making or receiving kickbacks or bribes in connection with obtaining benefits or payments under the state Medicaid program; (iii) making false/fraudulent statements; (iv) knowingly concealing a material fact, in connection with the state Medicaid Program; or (v) engaging in any other conduct prohibited by the Michigan Medicaid False Claims Act.

b. Violation of the Michigan Medicaid False Claims Act is a felony, and could result in fines and/or imprisonment, as well as civil monetary penalties.

c. State "Qui Tam" (Whistleblower) Provision: MCL 400.610a - 400.615

i. The Michigan Medicaid False Claims Act has a whistleblower provision, similar to the federal False Claims Act qui tam provision, which permits a person to bring suit on behalf of the State government.

ii. Protection from Retaliation:
1) Entities are prohibited from adopting or enforcing any rule, regulation or policy preventing or retaliating against employees who report their employer's potentially false claims.

2) An employer who takes action against an employee in violation of the Michigan Medicaid False Claims Act may be liable to the employee for (i) reinstatement without loss of seniority; (ii) two times the amount of lost back pay; (iii) interest on the back pay; (iv) compensation for any resulting special damages (including litigation costs and reasonable attorneys' fees); and (v) any other relief necessary to make the employee whole.

3) These protections do not apply when a court finds that the whistleblowing employee (i) brought a frivolous claim, (ii) participated, planned, initiated

or participated in the conduct upon which the action is brought, or (iii) is convicted of criminal conduct arising from a violation of that act.

3. Other Methods of Detecting False Claims, Fraud, Waste and Abuse:

   a. MCCMH will endeavor to detect and prevent false claims through already established procedures, including but not limited to claims audits, record reviews, and the investigation of complaints made by staff, consumers, providers or others.

   b. Additional detailed information may be found in the following policies:

      i. MCCMH MCO 1-001, "Overview: Compliance Program / Code of Ethics"

      ii. MCCMH MCO 1-010, "Program Integrity"

4. A summary of the information in this policy shall be included in the any MCCMH employee handbook and distributed to all contractors and agents as required by the Deficit Reduction Act of 2005 (42 U.S.C. 1396a(a)(68)).

VI. PROCEDURES

A. Complaint Process:

1. Any individual who suspects or witnesses Fraud, Waste, Abuse, violation of either the federal or state false claims provisions, or any other illegal or improper conduct should immediately report such violations to their supervisor, the Compliance Officer, or anonymously to the Compliance Telephone Hotline, Compliance Email address, or via routine interoffice mail, or may report directly to the MDHHS-OIG.

   a. Reports to MCCMH Compliance should be made:

      i. Via email @ ComplianceReporting@mccmh.net

      ii. Anonymously on the MCCMH website – select the Corporate Compliance section under the "Quick Links" section at the bottom of the home page.

      iii. Anonymously via the Telephone Compliance/Fraud, Waste, and Abuse Reporting Hotline: 586-469-6481

   b. Reports directly to Michigan's Office of Inspector General (OIG) can be made:

      i. Online at www.michigan.gov/fraud

      ii. Via telephone at 855-MI-FRAUD (643-7283) (voicemail available for after hours)

      iii. Send a Letter to the Office of Inspector General, PO Box 30062 Lansing, MI 48909

ii. The Compliance Officer will provide assistance with completing complaints, as necessary, while maintaining anonymity when requested, if possible. (Note: Recipient Rights complaints should be referred to the Recipient Rights Office. Concurrent investigations can be conducted if appropriate).

c. The process for reporting suspected compliance complaints will be posted on all sites.

B. Investigation Process:

1. Reports of suspected compliance violations, including those related to potential false claims, will be thoroughly investigated by the Office of Compliance.

2. Investigations will be commenced within two (2) weeks of the Office of Compliance's receipt of a complaint and will be conducted consistent with the standards and procedures defined in the MCCMH Corporate Compliance Program. See Exhibit A to MCO 1-001.

3. If the results of an investigation indicate that a compliance violation has occurred, a remediation plan will be completed and responsible employees/individual contractors and/or providers will be disciplined, as appropriate.

4. If a violation of civil or criminal federal or state law is detected, the violation will be reported to the appropriate government agency as soon as possible. If the violation has resulted in an overpayment, the Board will promptly return the overpayment in compliance with applicable law, the PIHP Contract, and MCO 1-010, "Program Integrity".

5. Under no circumstances will any individual be retaliated against for submitting a compliance issue or inquiry.

VII. REFERENCES / LEGAL AUTHORITY

A. 18 U.S.C. § 287

B. 18 U.S.C. § 3571

C. 31 U.S.C. § 3729

D. 31 U.S.C. § 3730

E. 42 U.S. Code § 1396a(a)(68)

F. 42 CFR § 455.2

G. 42 CFR Parts 438.608(a)(6)

H. MCL. 400.602(d) and (f)

I. MCL 752.1002(c) and (h)

J. MCCMH MCO Policy 1-001, "Overview: Compliance Code / Code of Ethics"

K. MCCMH MCO Policy 1-010, "Program Integrity"

L. Prescription Drug Benefit Manual Chapter 9 - Compliance Program Guidelines and Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines, https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf

M. Medicaid Managed Specialty Supports and Services Program FY20Amendment #1 https://www.michigan.gov/documents/mdhhs/MA_PIHP_Amendment_1_678753_7.pdf

VIII. EXHIBITS

None