Region 9 AAA	Local Policy #	V-6
Policy Name:	**False Claims Act Policy – Contracted Providers**	
Original Policy Date:	September 2014	
Revise Date:	August 2016, September 2019, August 2022, July 2024, September 2025	
Review Date:	January 2015, June 2017, January 2019	

Policy:

Under the Deficit Reduction Act of 2005, the Region 9 Area Agency on Aging (AAA) is required to provide employees, providers, and volunteers 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 Region 9 AAA's methods for detecting and preventing fraud, waste, and abuse in Medicaid programs. The AAA is committed to ensuring Medicaid programs, the participants served, and providers of service are protected through the implementation of fraud, waste, and abuse mitigation activities.

Purpose:

The purpose of this policy is to ensure that employees, providers, and volunteers fully understand the requirements of the Deficit Reduction Act of 2005 which contains provisions to combat fraud and abuse in government health care programs.

Procedure:

The policy is intended to cover the Federal False Claims Act (FCA), the Medicaid False Claims Act (MFCA), and Whistleblowers' Protections under law.

Federal False Claims Act (*31 U.S.C. §3729 et seq.)*

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.
- Fails to detect non-compliance when routine observation or due diligence should have

provided adequate clues or put one on notice.
- Fails to report actual or suspected non-compliance.
- Commits other fraudulent acts enumerated in the statute.

Medicaid False Claim Act (*M.C.L. 400.601 et seq.)*

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
- Concealing or failing to report an event which would affect the person's right to receive or continue to receive benefits
- 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.

Whistleblower Protection Laws:

Both the federal and state laws protect individuals who investigate or report possible False Claims Act violations made by their employer against discharge or discrimination in employment because of participation in such investigation. Employees who are discriminated against or are subjected to adverse employment actions based on good faith participation in an investigation 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.

Safeguards:

Acts of intentional misconduct or retaliation against an individual who reports violations of noncompliance or misconduct will not be tolerated. Any violation of the whistleblower protection carries more stringent disciplinary sanctions and are reviewed on a case-by-case basis. Disciplinary action varies on the degree of intent, the amount of financial harm imposed, and whether the wrongdoing was a single incident or lasted over a long period of time.

Both the federal and Michigan False Claims Acts provide for criminal penalties and include a whistleblower provision to report misconduct involving false claims. This provision allows any private person with actual knowledge of an alleged false claim to file a lawsuit on behalf

of the United States government or state government.

The federal or state government can intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing, or settling the action. If the government decides to intervene, the private person who initiated the action may be eligible for a portion of the proceeds of the action or settlement of the claim. If the government does not proceed with the action, the private person 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 person filing such an action 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 U.S. government sustains. The Michigan act makes violation a felony punishable by imprisonment and fines up to $50,000.00.

Detection of Potential Fraud or Abuse:

The Region 9 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:

- Proactive review of claims and other types of data
- Recommending and implementing claims processing safeguards
- Conducting education on fraud and abuse prevention, recognition, and reporting at the time of hire and at minimum once per each fiscal year with all applicable AAA employees.
- Ensuring that all contracted agencies conduct training related to fraud, waste, and abuse, including the False Claims Acts, at the time of hire and at minimum once per each fiscal year with all employees.
- Mandatory reporting of fraud or abuse by employees and contractors
- Mandatory reporting of overpayments made to providers to the Office of Inspector General (OIG).

Types Of Fraud Prosecuted Under the FCA and MFCA:

The AAA, as well as contracted providers, are required to ensure that they remain up to date with all changes to types of fraud prosecuted under the FCA and MFCA. The following is a list, including but not limited to, the types of fraud prosecuted under 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 a more expensive illness or treatment
- Double billing, or charging more than once for the same service or goods
- Prescribing a medicine or recommending a type of treatment regimen to earn kickbacks from hospital, 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 slips: charging for employees that were not actually on the job, or billing for made-up hours to maximize reimbursements
- A grant recipient charging grantor for costs not related to the program
- Making or inducing another to make false statements or using false records to obtain or continue Medicaid eligibility.

Notice/Information:

The Region 9 AAA prohibits the actions listed above, and any other action, or inaction, 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. This policy can be referred to in the vendor Contract Standards as well as distributed to all contractors and agents as required by the Deficit Reduction Act of 2005.

The following online resources outline the provisions of the Acts:

Federal False Claims Act: https://www.justice.gov/civil/false-claims-act

Michigan's The Whistleblowers' Protection Act:
https://www.legislature.mi.gov/documents/mcl/pdf/mcl-Act-469-of-1980.pdf

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

Response/Reporting:

Any evidence of fraud, waste or abuse, or suspicion of, should be reported immediately. All allegations and suspicions are taken seriously and investigated by the Special Investigations Unit (SIU), which consists of the Compliance Officer and other designated staff members. Individuals can report compliance issues or sensitive matters concerning Region 9 AAA using a variety of methods.

Contact the MI Choice Waiver Compliance Officer at (989) 358-4683 or email aaa-compliance@nemcsa.org

Contact the Corporate Compliance Officer at 989-358-4645 or email report@nemcsa.org

To Report Information to the Corporate Compliance Officer Anonymously:
https://forms.office.com/pages/responsepage.aspx?id=RhdvgLLNgky00GlIKlk61m7mzBgGHxBEvgOIk5EAK45UQzlMR1k1TVVRS0Q0QlRVTFVQkJFQVhNMC4u

Compliance issues involving fraud, waste, or abuse may also be reported directly to the Michigan Department of Health and Human Services, by visiting www.michigan.gov/fraud or by calling 855-MI-FRAUD.

To Report Medicaid Fraud:
https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/report-medicaid-fraud-and-abuse

To the extent that Region 9 AAA becomes aware or suspects fraud or abuse, the Region 9 AAA is obligated to respond in accordance with Federal and State regulations and report to the MDHHS-OIG and Attorney General's Health Care Fraud Division (AG-HCFD).

Unless prior written approval is obtained from MDHHS-OIG and/or Region 9 AAA, a provider must not take any of the following actions as they specifically relate to Michigan Medicaid claims:

- Contact the subject of an investigation about any matters related to the investigation.
- Enter or attempt to negotiate any settlement or agreement regarding the incident or
- Accept any monetary or other thing of valuable consideration offered by the subject of an investigation in connection with the incident.

Enforcement:

All management level personnel are responsible for enforcing this policy. All **employees, vendors and volunteers** will be given a copy of this policy and required to sign an attestation of compliance at hire during their orientation period and annually thereafter. Region 9 AAA reserves the right to modify or amend this policy at any time as it may deem necessary.

False Claims Act Policy Attestation:

I hereby attest that I have read, understand, and agree to abide by the False Claims Act Policy. As a contracted provider of services reimbursed by Medicaid, I acknowledge my provider agency is obligated to promptly report any identified or suspected fraud, waste, and abuse to the appropriate channels. I agree to ensure that all employees of my agency will receive training related to fraud, waste, and abuse, including the False Claims Act, at the time of hire and at minimum once per fiscal year. As a provider of services reimbursed by Medicaid, I will ensure that my provider agency verifies the eligibility of employees and volunteers utilizing the System for Award Management (SAM), the Michigan OIG Exclusions List, List of Excluded Individuals/Entities (LEIE) database and the Michigan Department of Licensing and Regulatory Affairs (LARA) online system, if applicable, prior to hire or start date and at minimum once per fiscal year.

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Provider Representative Signature

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Provider Representative Name (Printed)

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Provider Agency Name

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Date