COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE POLICY AND PROCEDURES MANUAL				
Chapter **Program Quality**	**Section** **Compliance**	**Chapter** **05**	**Section** **04**	**Subject** **07**
Subject **Deficit Reduction Act (DRA)**	**Authorization**		**Approved: 12/27/16** **Replaces: None**	

Updated: October 2024; October 2025

I. PURPOSE: To ensure compliance with federal and state laws and regulations and to inform Gogebic Community Mental Health Authority (GCMHA) employees, contract providers, and agents about the requirement of federal and state health care laws and regulations regarding fraud, waste and abuse, including Section 6032 of the Deficit Reduction Act of 2005.

II. APPLICATION: All GCMHA employees, all contract providers, and agents.

III. DEFINITIONS:

1) Abuse (CMS): Provider practices that are inconsistent with sound fiscal, business, or clinical 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 of care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program (42 CFR **§** 455.2).

2) Claim: Any request or demand for money or property if the United States Government provides any portion of the money requested or demanded.

3) GCMHA Employees: Employees hired by GCMHA on a full- or part-time basis, students, volunteers, interns and Board Members as applicable.

4) Contract Provider or Agent: Any contractor, subcontractor, agent or other person employed or under contract with GCMHA, which or who on behalf of GCMHA furnish, or otherwise authorized the furnishing of Medicaid health care items or services, or performs billing or coding functions.

5) Fraud (CMS): Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law including but not limited to the Federal False Claims Act and the Michigan False Claims Act (42 CFR **§** 455.2).

6) Knowingly: Means that a person (1) has actual knowledge of false information on the claim, (2) acts in deliberate ignorance of the truth or falsity of the information, (3) acts in reckless disregard of the truth to falsity of the information, and no proof of specific intent to defraud is required.

7) Waste: Overutilization of services, or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather the misuse of resources.

8) Other Wrongdoings: Means an act which is not necessarily a violation of a Federal or State regulation but is something that is a departure from what is ethically/morally acceptable.

IV. POLICY: GCMHA employees, contract providers and agents are prohibited from knowingly submitting to a federal or state health care program, including the Medicare and Medicaid programs, a false claim for reimbursement or a claim that an employee suspects is false. Such conduct is unlawful under federal and state law. GCMHA strives to ensure that its employees, contract providers and agents are fully aware of conduct that constitutes a false claim and has implemented a Compliance Program to ensure GCMHA's business is conducted with the highest level of integrity.

V. PROCEDURE:

A. Education: GCMHA's Chief Executive Officer (CEO)/designee shall provide information to all employees, contract providers and agents regarding the federal and state False Claims Act, the Whistleblower's Protection Act and GCMHA's compliance and quality programs that address the detection and prevention of fraud, waste, abuse or other wrongdoings. This policy shall be distributed to all employees, contract providers and agents at orientation and/or included in the Provider Manual for contract providers as required by the Deficit Reduction Act of 2005, as well as included in employee handbooks, as applicable.

B. Reporting: If any GCMHA employee, contractor provider or agent has knowledge or information or suspicion that fraud, waste, abuse or other wrongdoings activity as prohibited by federal or state law may have taken place, the employee must immediately notify GCMHA's Compliance Liaison (reference agency policy Report-Investigate [#05-04-05]), who will contact NorthCare Network's Compliance Officer to determine if further action should be taken. For fraud, waste or abuse activity in the Medicare and/or Medicaid programs, GCMHA will complete and submit NorthCare Network's Provider Fraud Referral form to NorthCare Network's Compliance Officer.

C. Investigation: GCMHA will follow investigation procedures as outlined in agency policy Report-Investigate (#05-04-05). GCMHA will cooperate fully in any investigation by the MDHHS or Office of the Attorney General, and with any subsequent legal action that may arise from such investigation. GCMHA employees, contractor providers, and agents are also expected to fully cooperate in any such investigation.

D. Non-Retaliation/No Reprisal: GCMHA is also committed to protecting employees from any form of reprisal, retaliation or discrimination if they, in good faith, report suspected unlawful activity. An employee who believes he or she has suffered reprisal, retaliation, or discrimination shall immediately report the incident(s) to the Human Resources Department, Compliance Liaison, or Chief Executive Officer (CEO) as set forth in GCMHA compliance policies. GCMHA considers retaliation to be a major offense that will result in disciplinary action against the offender, up to and including termination of employment.

E. Federal Laws:

1) Federal False Claims Act (31 U.S.C. §§ 3729. Et seq.): The False Claims Act (FCA) imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. It prohibits a health care provider from knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment. The FCA prohibits a healthcare provider from knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid by the federal government or its agents, such as a fiscal intermediary, claims processor, or state Medicaid program.

A false claim is a claim for payment, which the provider knowingly submits for services or supplies that were not provided specifically as presented, or for which the provider is otherwise not entitled to payment. Examples of false claims include, but are not limited to:

a) A claim for a service or supply that was never provided;
b) A claim indicating the service was provided for some diagnosis code other than the true diagnosis code in order to obtain reimbursement for the service (which would not be covered if the true diagnosis code were submitted);
c) A claim indicating a higher level of service than was actually provided;
d) A claim for a service that the provider knows is not reasonable and necessary;
e) A claim for services provided by an unlicensed individual;
f) A claim for services that were performed as a result of a kickback in violation of the Anti-Kickback Statue (42 U.S.C. § 1320a-7b); or
g) A claim resulting in an unreturned overpayment.

While the FCA imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729.

2) Civil Monetary Penalties Law (CMPL): The CMPL, 42. U.S.C. Section 1320a-7a, authorizes the Office of Inspector General (OIG) to seek Civil Monetary Penalties (CMP) and sometimes exclusion for a variety of health care fraud violations. Different amounts of penalties and assessments apply based on the type of violation. CMPs also may include an assessment of up to **three** times the amount claimed for each item or service, or up to **three** times the amount of remuneration offered, paid, solicited or received. Violations that may justify CMPs include:

a) Presenting a claim you know, or should know, is for an item or service not provided as claimed or that is false and fraudulent.
b) Violating the Anti-Kickback Statute.
c) Making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs.

NOTE: Each year, the Federal Government adjusts all CMPs for inflation. Refer to 42 C.F.R. Section 102.3 for the yearly adjustment for inflation.

3) Federal False Claims (FCA) Act *Qui Tam* Provisions

a) The FCA also allows individuals to bring civil suits, called *qui tam* actions against a person in the name of the United States government for a violation for the FCA. Generally, the suit must be brought within six years after the violation, but in no event more than ten. When an individual files the action, it remains under seal (not public) for at least 60 days. The government may choose to join in the lawsuit and assume primary responsibility for prosecuting, dismissing, or settling the action. If the government chooses not to join the suit, the individual who initiated the lawsuit has the right to conduct the action independent of the government.

b) In the event the government proceeds with the lawsuit, the *qui tam* plaintiff may receive 15%-25% of the proceeds of the action or settlement. Under certain circumstances, this amount may be reduced to not more that 10%. If the *qui tam* plaintiff proceeds with the action without the government, the qui tam plaintiff may receive 25%-30% of the recovery. In either case, the plaintiff may also receive an amount for reasonable expenses plus reasonable attorney's fees and costs.

c) If the plaintiff planned or initiated the violation, the plaintiff's share of the proceeds may be reduced and, if the *qui tam* plaintiff is found guilty of a crime associated with the violation, no share will be awarded the plaintiff. If the *qui tam* plaintiff's civil action is frivolous or brought primarily to harass the provider, the *qui tam* plaintiff may have to pay the defendant's fees and costs.

4) Whistleblower Provisions: The FCA also provides for protection for employees from retaliation. An employee who is discharged, demoted, suspended, threatened, harassed or discriminated against because of lawful acts conducted in furtherance of an action under the FCA, may bring an action in federal district court seeking reinstatement, two times the amount of back pay, plus interest and recovery of litigation costs, including attorney's fees.

5) Federal Program Fraud Civil Remedies Act of 1986 (31 U.S.C. §§ 3801, *et seq.*): The Program Fraud Civil Remedies Act of 1986 established an administrative remedy against any person who, among other things, presents or causes to be presented a claim to a Federal health care program that a person knows or has reason to know is false, fictitious, or fraudulent, or that contains an omission of material fact. The OIG may investigate, and with the Attorney General's approval, commence administrative proceedings regarding potential violations of this statute. A violation of the statute may result in civil monetary penalties of $10,781, with maximum per-claim penalties of $21,563 [per Congress's Bipartisan Budget Act of 2015; effective 8/1/16].

F. State Laws:

1) Medicaid (State of Michigan) False Claims Act (MCL §§ 400.601 et seq.): The Michigan Medicaid False Claims Act (MI FCA) prohibits fraud in the obtaining of benefits or payments in connection with the medical assistance program; to prohibit kickbacks or bribes in connection with the program; to prohibit conspiracies in obtaining benefits or payments; to authorize the attorney general to investigate alleged violations of this act; to provide for the appointment of investigators by the

attorney general; to ratify prior appointments of attorney general investigators; to provide for civil actions to recover money received by reason of fraudulent conduct; to provide for receiverships of residential health care facilities; to prohibit relation; to provide for certain civil fines; and to prescribe remedies and penalties.

2) Penalties for Unlawful Conduct: The civil penalty for violating the MI FCA is a minimum of $5,000, and up to $10,000, for each violation. In addition to the penalty, a provider could be found liable for up to three times the amount of damages, plus the costs associated with bringing the action, including attorney's fees. In addition to the penalty, a provider could be found guilty of a felony and receive up to four years in prison and a $50,000 fine.

3) State *Qui Tam* Provisions:

a) The MI FCA allows an individual to bring a civil suit, called a *qui tam* action, against a provider in the name of the State for a violation of the MI FCA. When an individual files the action, it remains under seal (not public) for a period of at least 90 days. The attorney general may choose to join in the lawsuit and assume primary responsibility for prosecuting, dismissing, or settling the action. If the attorney general chooses not to join the suit, the individual who initiated the lawsuit has the right to conduct the action independent of the attorney general.

b) In the event the attorney general proceeds with the lawsuit, the plaintiff may receive 15%-25% of the proceeds of the action or settlement. If the plaintiff proceeds with the action without the attorney general, the plaintiff may receive 25-30% of the recovery. If a court finds that the plaintiff planned or initiated the violation, the plaintiff's share of the proceeds may be reduced and, if the plaintiff is found guilty of a crime associated with a violation of the MI FCA, no share will be awarded the plaintiff. Under certain other circumstances, the plaintiff's award may be reduced to less than 10% of the recovery. In addition, if the attorney general decides not to join in the case and the court ultimately decides for the defendant, the court will award attorney's fees and costs against the person bringing the action upon a finding of bad faith or that such claim was frivolous.

4) Michigan's Whistleblower Protection Act: The MI FCA provides protection to employees from retaliation. An employee shall not discharge, threaten, or otherwise discriminate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee, or a person acting on behalf of the employee, reports or is about to report, verbally or in writing, a violation or a suspected violation of a law or regulation or rule promulgated pursuant to law of this state, a political subdivision of this state, or the United States to a public body, unless the employee knows that the report is false, or because an employee is requested by a public body to participate in an investigation, hearing or inquiry held by that public body or a court action.

5) Michigan Health Care False Claims Act (Mich. Comp. Laws § 752.1005): The Michigan Health Care False Claims Act prohibits, among other things, knowingly presenting (or causing to be presented) a false or fraudulent claim for payment or approval. Additionally, it prohibits knowingly making or using (or causing to be made or used) a false record or statement to obtain payment or approval of a claim by the State or any governmental agency. A violation of the Health Care False Claims Act is a felony punishable with up to 4 years in prison and/or a $50,000 fine.

6) Michigan Public Health Code (Mich. Comp. Laws § 333.16221(d)(iii)): The Michigan Public Health Code authorizes disciplinary proceedings against a licensed individual who fraudulently obtains or attempts to obtain third-party reimbursement.

7) Michigan Social Welfare Act (Mich. Comp. Laws §§ 400.111b, 400.111e): The Michigan Social Welfare Act provides that failure to repay or return to the State an overpayment constitutes conversion of the money by the provider and may result in termination from participation in the State's Medicaid program.

8) Michigan Whistleblowers' Protection Laws (Mich. Comp. Laws §§ 15.361*et seq*., § 333.20180): The Michigan Whistleblowers' Protection Act prohibits an employer from taking any adverse action against an employee because the employee reports a suspected violation of law. Additionally, the Michigan Health Facility Whistleblowers' Protection Act provides that an employee of a health facility who reports a violation of the State's health facilities laws may be further immune from civil or criminal penalties for conduct related to the violation. An employee who alleges a violation of this provision may bring a civil action for injunctive relief, back pay, damages, and a $500 fine. The employee also may recover the costs of suit, including attorney's fees.

VI. REFERENCES AND LEGAL AUTHORITY: Federal False Claims Act – Title 31; Whistle Blowers' Protection Act 469 of 1980; 42 CFR 438.608; 42 CFR 455.2; Michigan Medicaid False Claims Act 72 of 1977; Other Federal and State Laws Identified in the following Procedures; MDCH/PIHP Specialty Supports and Services Contract 1915 (b)/(c)Waiver Program; NorthCare Network Compliance Plan; Applicable GCMHA Compliance, Quality Improvement, and Human Resources Policies; NorthCare Deficit Reduction Act Policy

VII. EXHIBITS: NorthCare Network's Provider Fraud Referral