NORTHCARE NETWORK

POLICY TITLE: Deficit Reduction Act (DRA)	**CATEGORY:** Compliance	
EFFECTIVE DATE: 1/1/15	**BOARD APPROVAL DATE:** 2/18/15 retro to 1/1/15	
REVIEW DATE: 5/1/23	**REVISION(S) TO POLICY STATEMENT:** ☐ **Yes** ☒ **No**	**OTHER REVISION(S):** ☐ **Yes** ☒ **No**
RESPONSIBLE PARTY: Chief Executive Officer Compliance and Privacy Officer	**CEO APPROVAL DATE:** 5/2/23 Megan Rooney, Interim CEO	

APPLIES TO

NorthCare Network Personnel
Network Providers
Contractors and Agents

POLICY

NorthCare Network Personnel, Network Providers, Contractors 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. NorthCare Network strives to ensure that its Personnel, Network Providers and Contractors and Agents are fully aware of conduct that constitutes a false claim and has implemented a Compliance Program to ensure our business is conducted with the highest level of integrity.

PURPOSE

To ensure compliance with federal and state laws and regulations regarding fraud, waste, and abuse, including Section 6032 of the Deficit Reduction Act of 2005, NorthCare Network has developed policy which serves to inform NorthCare Network Personnel, Network Providers and Contractors and Agents about the requirement of certain federal and state health care laws.

DEFINITIONS

1. ***Abuse*** (CMS): means 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*** - includes any request or demand for money or property if the United States Government provides any portion of the money requested or demanded.

3. ***Contractor or agent*** - includes any contractor, subcontractor, agent, or other person which or who on behalf of the entity, furnish, or otherwise authorized the furnishing of Medicaid health care items or services, or performs billing or coding functions.

4. ***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.

5. ***Fraud*** (CMS): means an 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. ***Network Providers*** - includes all providers employed or under contract or subcontract with NorthCare Network and includes Member CMHSPs, SUD, and other community Providers.

7. ***NorthCare Network Personnel*** - includes personnel assigned to NorthCare Network on a full-or part-time basis, students, volunteers, interns, and Board Members applicable.

8. ***Waste****:* (CMS) means 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.

REFERENCES

- 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
- MDHHS/PIHP Contract
- NorthCare Network Compliance Plan
- Applicable NorthCare Network Compliance, Quality Management and HR Policies

HISTORY

NEW POLICY 1/1/15
REVISION DATE: 8/30/16, 6/15/17, 5/1/18, 3/25/19, 12/11/19, 10/21/20, 8/23/21, 6/10/22
REVIEW DATE: 1/15/15, 2/3/15, 11/24/15, 8/30/16, 6/15/17, 5/1/18, 3/25/19, 12/11/19, 10/21/20, 8/23/21, 6/10/22, 5/1/23
CEO APPROVAL DATE: 2/3/15, 12/1/15, 9/6/16, 7/13/17, 5/10/18, 4/1/19, 1/7/20, 11/3/20, 9/7/21, 7/12/22, 5/2/23
BOARD APPROVAL DATE: 2/18/15 Retro Approval to 1/1/15

PROCEDURES

1. **EDUCATION**
   NorthCare Network's Chief Executive Officer (CEO)/Compliance Officer shall provide information to all NorthCare Network Personnel, Network Providers and Contractors regarding the federal and state False Claims Act, the Whistleblower's

Protection Act and NorthCare Network's compliance and quality programs that address the detection and prevention of fraud, waste, and abuse. The information from this policy shall be distributed to all personnel and contractors as required by the Deficit Reduction Act of 2005, as well as included in employee handbooks, as applicable.

2. **REPORTING**

If any NorthCare Network Personnel, Network Provider or Contractor has knowledge or information or suspicion that fraud, waste, or abuse activity as prohibited by federal or state law may have taken place, the employee/Provider/Contractor must immediately notify NorthCare Network's Compliance Officer. Because Michigan Department of Health and Human Services (MDHHS) has the responsibility and authority to make fraud and/or abuse referrals to the Office of the Attorney General, Health Care Fraud Division, NorthCare Network will immediately report directly to the MDHHS Office of Inspector General (OIG). In order to facilitate this report to MDHHS-OIG, NorthCare Network will complete, or request the provider/contractor/agent to complete and submit a Provider Fraud Referral form.

3. **INVESTIGATION**

Per the MDHHS/PIHP specialty supports and services contract, NorthCare Network will not attempt to investigate or resolve the reported alleged fraud ~~and/~~or abuse without prior consultation with the MDHHS-OIG. NorthCare Network will cooperate fully in any investigation by the MDHHS-OIG and with any subsequent legal action that may arise from such investigation. Network Providers and Contractors are also expected to fully cooperate in any such investigation.

4. **NON-RETALIATION/NO REPRISAL**

NorthCare Network is 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 Office, or Chief Executive Officer (CEO) as set forth in NorthCare Network Policy. NorthCare Network considers retaliation to be a major offense that will result in disciplinary action against the offender including termination of employment.

5. **FEDERAL LAWS**

5.1. Federal False Claims Act (31 U.S.C. §§ 3729. Et seq.): https://www.govinfo.gov/content/pkg/USCODE-2011-title31/pdf/USCODE-2011-title31-subtitleIII-chap37-subchapIII-sec3729.pdf

The False Claims Act 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:

5.1.1. A claim for a service or supply that was never provided.
5.1.2. 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).
5.1.3. A claim indicating a higher level of service than was actually provided.
5.1.4. A claim for a service that the provider knows is not reasonable and necessary.
5.1.5. A claim for services provided by an unlicensed individual.
5.1.6. 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
5.1.7. A claim resulting in an unreturned overpayment.

While the False Claims Act 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.

5.2. Civil Monetary Penalties Law (CMPL)
https://www.govregs.com/uscode/title42_chapter7_subchapterXI_partA_section1320a-7a
The CMPL, 42 U.S.C. Section 1320a-7a, authorizes OIG to seek CMPs 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:

- Presenting a claim you know, or should know, is for an item or service not provided as claimed or that is false and fraudulent
- Violating the AKS
- 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 45 C.F.R. Section 102.3 for the yearly adjustment for inflation.
https://www.govinfo.gov/content/pkg/CFR-2019-title45-vol1/pdf/CFR-2019-title45-vol1-sec102-3.pdf

5.3. Federal False Claims (FCA) Act *Qui Tam* Provisions

5.3.1. The FCA also allows individuals to bring civil suites, 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.

5.3.2. 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 maybe 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 attorneys' fees and costs.

5.3.3. 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.

5.4. Whistleblower Provisions https://www.whistleblowers.gov/

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.

5.5. Federal Program Fraud Civil Remedies Act of 1986 (31 U.S.C. Ch.38 §§ 3801, *et seq.*) https://uscode.house.gov/view.xhtml?req=granuleid%3AUSC-prelim-title31-chapter38&edition=prelim

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 Office of Inspector General (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 ranging from $11,665 to $23,331 for each false claim. [Congress's Bipartisan Budget Act of 2015]

6. STATE LAWS

6.2. Medicaid (State of Michigan) False Claims Act (MCL §§ 400.601 et seq.): http://www.legislature.mi.gov/(S(yxmmsgji3kj2meelnttzslkn))/mileg.aspx?page=getObject&objectName=mcl-Act-72-of-1977

The Michigan Medicaid False Claims Act (the "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.

6.3. Penalties for Unlawful Conduct

The civil penalty for violating the MI Medicaid 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 10 years in prison and a $50,000 fine.

6.4. State *Qui Tam* Provisions

6.4.1. 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.

6.4.2. 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.

6.5. MI Whistleblower's Protection Act – Act 469 of 1980

https://www.legislature.mi.gov/documents/mcl/pdf/mcl-Act-469-of-1980.pdf

An ACT to provide protection to employees who report a violation or suspected violation of state, local, or federal law; to provide protection to employees who participate in hearings, investigations, legislative inquiries, or court actions; and to prescribe remedies and penalties. The MI FCA provides protection to employees from retaliation. An employer 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.

6.5.1 Public Health Code (Excerpt) Act 368 of 1978
http://www.legislature.mi.gov/(S(wnwbdfi4yuxktujq3qvpcqca))/mileg.aspx?page=getObject&objectName=mcl-333-20180
A person employed by or under contract to a health facility or agency or any other person acting in good faith who makes a report or complaint including, but not limited to, a report or complaint of a violation of this article or a rule promulgated under this article; who assists in originating, investigating, or preparing a report or complaint; or who assists the department in carrying out its duties under this article is immune from civil or criminal liability that might otherwise be incurred and is protected under the whistleblowers' protection act, 1980 PA 469, MCL 15.361 to 15.369. A person described in this subsection who makes or assists in making a report or complaint, or who assists the department as described in this subsection, is presumed to have acted in good faith. The immunity from civil or criminal liability granted under this subsection extends only to acts done pursuant to this article.

6.6. Michigan Health Care False Claims Act (Mich. Comp. Laws § 752.1005)
http://www.legislature.mi.gov/(S(wnwbdfi4yuxktujq3qvpcqca))/mileg.aspx?page=getObject&objectName=mcl-Act-323-of-1984
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.

6.7. Michigan Public Health Code (Mich. Comp. Laws § 333.16221(d)(iii))
http://www.legislature.mi.gov/(S(wnwbdfi4yuxktujq3qvpcqca))/mileg.aspx?page=getObject&objectName=mcl-333-16221
The Michigan Public Health Code authorizes disciplinary proceedings against a licensed individual who fraudulently obtains or attempts to obtain third-party reimbursement.

6.8. Michigan Social Welfare Act (Mich. Comp. Laws §§ 400.111b, 400.111e)
http://www.legislature.mi.gov/(S(wnwbdfi4yuxktujq3qvpcqca))/mileg.aspx?page=getObject&objectName=mcl-400-111
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.