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Medicaid Fraud, Waste, and Abuse Education

Medicaid fraud, waste, and abuse are serious offenses at both levels of state and federal government. The continuation of Medicaid and the important services it enables depend on the integrity of those who are a part of the program. All ABLED, Inc. staff have an obligation to abstain from and report fraud, waste, and abuse in order to uphold this integrity. The purpose of this document is to inform all ABLED, Inc. staff on the relevant state and federal laws governing Medicaid fraud, and the potential civil and criminal penalties for persons found to be in violation of these laws.

For the purpose of this document fraud, waste, and abuse are to be understood in the following manner;

> **Fraud:** knowingly, intentionally, and willfully executing, or attempting to execute a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any money or property owned by or under the custody or control of any health care benefit program.
>
> **Waste:** the overutilization of services, or other practices that directly or indirectly result in unnecessary costs. Waste overutilization is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
>
> **Abuse:** involves payment for items or services when there is no legal entitlement to that payment even when the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

The relevant federal and state laws governing Medicaid fraud and the potential penalties:

FALSE CLAIMS ACT

The civil False Claims Act, (31 United States Code (U.S.C) Sections 3729-3733) , protects the Federal Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes the submission of, a false or fraudulent claim to the Federal Government. This includes overbilling Medicaid.

The terms “knowing” and “knowingly” mean a person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim. No specific intent to defraud is required to violate the FCA.

Penalties: Violations of the FCA may result in civil penalties, including recovery of up to three times the amount of damages sustained by the government, plus additional penalties per false claim filed. As of February 12, 2024, these additional penalties range from a minimum of $13,946 to a maximum of $27,894 (subject to periodic adjustment) per false claim. Additionally, under the criminal FCA (18 U.S.C. Section 287), individuals or entities may face criminal penalties for submitting false, fictitious, or fraudulent claims, including fines, imprisonment, or both.

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ANTI-KICKBACK STATUTE

The Anti-Kickback Statute (42 U.S.C. Section 1320a-7b(b)) makes it a crime to knowingly and willfully offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward patient referrals or the generation of business involving any item or service reimbursable by a Federal health care program. When a provider offers, pays, solicits, unlawful remuneration, the provider violates the AKS.

Note: Remuneration includes anything of value, such as cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies.

Penalties: Criminal penalties and administrative sanctions for violating the AKS may include fines, imprisonment, and exclusion from participation in the Federal health care program. Under the Civil Monetary Penalty Law, penalties for violating the AKS may include three times the amount of kickback, plus up to $50,000 (subject to periodic adjustment) per kickback. If a provider violates the kickback law, they are also subject to monetary penalties and treble damages under the FCA.

THE STARK LAW

The Stark Law (42 U.S.C. Section 1395nn), prohibits a physician from referring patients to receive "designated health services" payable by Medicare or Medicaid to an entity with which the physician or a member of the physician's immediate family has a financial relationship, unless an exception applies.

Penalties: Penalties for physicians who violate the Stark Law may include fines, civil monetary penalties up to $15,000 (subject to periodic adjustment) for each service, repayment of claims, and potential exclusion from participation in Federal health care programs.

ADMINISTRATIVE REMEDIES FOR FALSE CLAIMS AND STATEMENTS

The Program Fraud Civil Remedies Act (31 U.S.C. Section 3801 *et seq.*), was enacted to provide additional ways for the government to recover losses because of false claims and fraud in its programs and contracts. Under the PFCRA, federal agencies can initiate "in-house" administrative proceedings for claims of $150,000 or less when the Department of Justice elects not to pursue False Claims Act remedies for the claims. The PFCRA authorizes a federal agency, without resorting to judicial proceedings, to impose a penalty upon a person who makes or causes another to make a false claim or statement and does so knowing or with reason to know that it is false, fictitious, or fraudulent.

Penalties: The Department of Health and Human Services may impose on a person who submits false claims to the Federal Government a penalty of up to $13,946 (subject to periodic adjustment) plus twice the amount of the claim.

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FALSE MEDICAID CLAIMS ACT

The False Medicaid Claims Act (Nebraska Revised Statutes Sections 68-934 to 68-947) is designed to provide for the investigation and prosecution of Medicaid fraud in the State of Nebraska. The FMCA sets forth civil penalties for Medicaid fraud and establishes a Medicaid fraud control unit under the Nebraska Attorney General. The FMCA makes it unlawful in the State of Nebraska to commit any of the following acts in relation to the Nebraska Medicaid program: (a) knowingly presents or causes to be presented, a false or fraudulent claim for payment or approval; (b) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (c) conspires to commit a violation of the

FMCA; (d) has possession, custody, or control of property or money used, or to be used, by the state and knowingly delivers, or causes to be delivered, less than all of the money or property; (e) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the state and, intending to defraud the state, makes or delivers the receipt knowing that the information on the receipt is not true; (f) knowingly buys, or receives as a pledge of an obligation or debt, public property from any officer or employee of the state who may not lawfully sell or pledge such property; or (g) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state or knowingly conceals, avoids, or decreases an obligation to pay or transmit money or property to the state.

Penalties: Penalties for violating the False Medicaid Claims Act include a civil penalty of not more than $11,000 (subject to periodic adjustment), damages in the amount of three times the amount of the false claim, and the state's costs and attorney's fees if the state prevails in bringing suit.

WHISTLEBLOWER PROTECTIONS

The False Claims Act has what is known as *qui tam* provisions. These provisions enable private persons (relators) with knowledge of fraud committed against the Government to file a lawsuit under seal on behalf of the United States. If the case is successful, the relator may share in the Government's monetary recovery, 15% to 25% of any award or settlement amount, and recover attorney's fees and costs from the defendant. Relators who proceed without the Department of Justice may potentially receive a higher relator's share, a maximum of 30% of any award or settlement amount. Congress created these monetary incentives, along with provisions protecting whistleblowers from reprisal or retaliation to encourage whistleblowers to come forward and also incentivize private lawyers to commit legal resources to representing said whistleblowers in prosecuting fraud on the Government's behalf.

ABLED, INC. POLICIES AND PROCEDURES

ABLED, Inc. is committed to preventing, identifying, investigating, correcting, and appropriately reporting suspected cases of fraud, waste, and abuse.

- ABLED, Inc. will ensure that all staff are educated on the state and federal laws pertaining to Medicaid fraud and trained on how to report suspected Medicaid fraud. All staff will be promptly notified to any change in these laws.

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- ABLED, Inc. will utilize the safeguards offered through Therap and Tellus software to hold staff accountable for honest recording of attendance and billing.
- ABLED, Inc. will review billing each payroll cycle and account for services provided. Further review of services billed may be accounted for during home visits, team meetings, service coordinator reviews or on an individual basis.

If any ABLED, Inc. staff suspects a violation of the laws pertaining to Medicaid fraud, they are to:

1. Contact ABLED, Inc. Administration
2. Contact the Nebraska Medicaid Fraud and Patient Abuse Unit
   a. 402-471-3549
   b. ago.medicaid.fraud@Nebraska.gov

By signing below, I hereby acknowledge that I have read and been informed about the following;

- The False Claims Act established under Sections 3729 through 3733 of Title 31, United States Code;
- Administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States Code;
- The Nebraska False Medicaid Claims Act established in the Nebraska Revised Statues Sections 68-934 through 68-947;
- Whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in the Medicaid program; and
- ABLED, Inc.'s policies and procedures for preventing and detecting fraud, waste, and abuse in the Medicaid program.

_____ _____

Staff (Print) Date

_____

Signature