EC.009 – DEFICIT REDUCTION ACT COMPLIANCE

SECTION:	ETHICS AND COMPLIANCE	LAST REVISION DATE:	11.14.2017
SUBJECT:	**Deficit Reduction Act Compliance**	LAST REVIEW DATE:	11.14.2017
POLICY NUMBER:	EC.009	APPROVED BY:	Compliance & Risk Management Committee

I. PURPOSE

The purpose of this policy is to educate workforce members about false claims laws, whistleblower protections, and policies and procedures for detecting and preventing fraud, waste and abuse. This policy has also been developed to comply with certain requirements set forth in the Deficit Reduction Act of 2005 (the "DRA") relating to federal and state false claims laws.

II. POLICY

A. MHN requires compliance with federal and state laws that prohibit the submission of false claims in connection with federal healthcare programs, including Medicare and Medicaid. It is also our policy to comply with the DRA's employee education requirements regarding False Claims Acts and whistleblower protections.

B. We have a compliance program in place and encourage all workforce members to bring any compliance concerns to the attention of management or call the compliance hotline to anonymously report such concerns. It is also our policy to refrain from retaliating against any workforce member who in good faith raises compliance concerns.

III. PROCEDURAL GUIDELINES

A. Information about False Claims Acts and Summary of MHN's Policies and Procedures for Preventing Fraud, Waste and Abuse

1. For MHN employees and contractors, we have prepared detailed information about the Federal False Claims Act, administrative remedies, and the state False Claims Acts for states whose Medicaid programs paid MHN at least $5 million in the most recent federal fiscal year (October 1 to September 30). (See Section B, below, and EC.015.)

2. For MHN employees and contractors, we have prepared a summary of MHN's policies and procedures for detecting and preventing fraud, waste and abuse. (See EC.015.)

B. Information for Employees and Contractors on Laws that Prohibit False Claims

1. The Federal False Claims Act ("FCA")

The False Claims Act, 31 U.S.C. §§ 3729-3732, allows the federal government or private individuals (*qui tam* plaintiffs, or relators, also known as whistleblowers) to file lawsuits

in federal court against individuals or entities for submitting false or fraudulent claims for payment of government funds. The FCA covers fraud involving any federally funded contract or program (including Medicare and Medicaid). If the action is successful, the *qui tam* plaintiff may receive a percentage of the amounts recovered on behalf of government.

a. Under the FCA, any person who knowingly submits a false or fraudulent claim for payment by the government is liable to the government for up to three times the amount of the government's loss, plus penalties that, as of 2017, are up to $21,916 for each false claim. Penalty amounts are adjusted periodically for inflation.
b. The False Claims Act provides legal protections for whistleblowers. It prohibits any adverse employment action (e.g., demotion or termination) to be taken against an employee who lawfully participates in activities relating to a false claims investigation or suit.

2. Administrative Remedies

There are also federal administrative remedies for false claims or statements, which include recoupment for overpayments, program exclusions, and civil monetary payments. See the United States Code, Title 31, Chapter 38.

3. State False Claims Acts

Some states, including Illinois, have enacted their own false claims laws modeled on the federal False Claims Act. Like the federal FCA, these state laws establish civil liability for individuals and entities that submit false or fraudulent claims to the state. Other states have passed false claims laws that are limited solely to false Medicaid claims.

a. Currently, if a state obtains a recovery as the result of a state action relating to false or fraudulent claims submitted to the Medicaid program, it must share the damages recovered with the federal government in the same proportion as the federal governments share in the cost of the state Medicaid program.

4. The American Recovery and Reinvestment Act of 2009 (ARRA)

"Covered funds" under ARRA means any contract, grant, or other payment received by MHN if (a) the Federal Government provides any portion of the money or property that is provided, requested, or demanded; and (b) at least some of the funds are appropriated or otherwise made available by ARRA. MHN may receive covered funds under ARRA through its contracts directly with state Medicaid agencies and as a subcontractor through its contracts with other entities that have contracts with state Medicaid agencies, such as Medicaid Managed Care Organizations.

a. MHN may not retaliate against employees for disclosing information that the employee reasonably believes is evidence of gross mismanagement of an agency contract or grant relating to covered funds; a gross waste of covered

funds; a substantial and specific danger to public health or safety related to the implementation or use of covered funds, an abuse of authority related to the implementation or use of covered funds; or a violation of law, rule, or regulation related to an agency contract or grant awarded or issued relating to covered funds.

5. The Patient Protection and Affordable Care Act (PPACA) of March 2010

PPACA links the retention of program overpayments to potential liability under the False Claims Act. Retained overpayments can also be grounds for program exclusion. Additionally, states are required to terminate the participation of any individual or entity that has been excluded under any other State plan or Medicare.

IV. RELATED POLICIES

- EC.001 - Code of Business Conduct and Ethics
- EC.003 - Conflicts of Interest Policy
- EC.007 - Reporting Compliance Issues
- EC.010 - Internal Handling of Hotline Calls
- MHN Employee Manual

V. REFERENCES AND ACCREDITATION AUTHORITIES

- United States Sentencing Commission, Guidelines Manual, §8B2.1 ("Effective Compliance and Ethics Program) (Nov. 2012), available at: *http://www.ussc.gov/Guidelines/2012_Guidelines/Manual_PDF/2012_Guidelines_Manual_Full.pdf*
- Basic Compliance Program resources available on the HHS OIG website: *https://oig.hhs.gov/compliance/101/index.asp*
- Compliance Program Guidance, available at: *https://oig.hhs.gov/compliance/compliance-guidance/index.asp*

VI. REVIEW STATEMENT

MHN will maintain the status of this activity and conduct audits as appropriate to ensure compliance. This policy will be reviewed annually to determine whether additional state false claims laws must be added. Modifications to the procedure will be made as needed.