State of Mississippi
False Claims Act

1. The Division of Medicaid, the Mississippi single state agency, will incorporate into the provider enrollment agreement, the responsibilities of the affected providers in implementing Section 6032 of the Deficit Reduction Act of 2005, the "Employee Education about False Claims Recovery."
2. The Division of Medicaid will request copies of an affected provider's written policies, and the plan to disseminate those policies to staff, within three (3) months of State Plan approval.
3. The Division of Medicaid will conduct an audit of the affected providers written policies and procedures and provide a written response of approval and/or suggestions. Policies and procedures will include explanation of the false claims act; the provider's policies and procedures for detecting and preventing waste, fraud and abuse; the rights of the employee to be protected as whistle blowers and telephone numbers and/or addresses for reporting fraud and abuse.
4. Thereafter, the Division will contact affected providers on a yearly basis for any update or change to its written policies. The Division will accomplish this verification by provider survey.
5. New affected providers identified each year will be required to submit their policies and dissemination plan and will be handled per #2, 3, and 4.
6. The Division of Medicaid has a range of sanctions contained in its administrative regulation for non-compliance with Medicaid policies. These sanctions range from requiring a plan of correction to termination from the Medicaid program. These sanctions will be applied to non-compliance with the "Employee Education about False Claim Recovery."

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Citation
1902(a)(68) of
the Act,
P.L. 109-171
(section 6032)

4.42 Employee Education About False Claims Recoveries.

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

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health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

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(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on 01-01-07 (date).

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.