General

Section 6032 of the federal Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) set forth administrative requirements which impacts entities receiving annual Medicaid payments of at least $5,000,000. The DRA requires certain governmental, for-profit and non-profit providers and other entities that receive Medicaid funding to provide employee education regarding the False Claims Act and take actions that will address fraud, waste and abuse in health care programs that receive federal funds. Any entity that receives $5,000,000 or more annually must establish the following policies as a condition of participation in the Medicaid program:

- The entity must establish written policies for all employees of the entity (including management), and of any contractor or agency of the entity, that provides detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code.
- The entity must include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.
- The entity must include in any employee handbook for the entity, a specific discussion of the laws described above, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

Annually, the Division of Medicaid (DOM) will identify and mail notices to providers and contractors that provide Medicaid health care items or services that were paid $5,000,000 or more during the prior federal fiscal year. The $5,000,000 threshold will be measured based upon the aggregate payments received by an entity during the federal fiscal year (October 1 – September 30), even if that entity has multiple provider and/or tax id numbers. For example, a health system that includes a hospital, skilled nursing facility and home health program and collectively receives more than $5,000,000 in aggregate reimbursement annually will be subject to this requirement. Once notified, the entity will have thirty (30) calendar days to submit the documentation requested in the letter to confirm compliance.

It is the responsibility of each entity meeting the annual threshold to establish and disseminate written policies. In addition, the entity must provide those policies to the DOM including any revisions. The DOM will perform annual monitoring activities to ensure that entities are in compliance with this section. Providers will be selected on a random basis or as needed.

If an employee or contractor or agent of an entity reports suspected fraud, waste, or abuse in the Medicaid program, the entity must report that information to the Bureau of Program Integrity at the Division of Medicaid by the next business day. Entities must investigate all allegations within a reasonable time period and report the results of the investigation to the Division.

Reporting Requirements

False Claims information may be reported by:

- Calling the Division of Medicaid's Bureau of Program Integrity Fraud Hotline at (601) 576-4162 or 1-800-880-5920; or
- Submitting online at http://www.dom.state.ms.us/PI/FraudAbuse/WebFormFraudAbuse.aspx; or
- Sending an e-mail to FCA@medicaid.state.ms.us; or

- Contacting the Federal Office of Inspector General in the U.S. Department of Health and Human Services hotline at 1-800-HHS-TIPS (1-800-447-8477). For more information on this hotline and other ways to contact the Office of Inspector General, you can go to http://oig.hhs.gov/hotline.html.

Sanctions

If an entity is found not to be in compliance with any part of the requirements noted above, the provider will be given a 30 day notice by the DOM that suspension of the entity's provider number(s) and payment may be held at the sole discretion of the DOM. The entity must submit appropriate documentation to the satisfaction of the Division of Medicaid in order for the non-compliance status to be lifted. The DOM will work in conjunction with the Attorney General's office and the Office of the Inspector General (OIG) on cases of non-compliance.

Definitions

- **Entity**- 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 payment, under a State Plan approved under title XIX or under any waiver of such plan. In addition, persons are considered entities. A "person" includes any natural person, corporation, firm, association, organization, partnership, limited liability company, business or trust.

  If an entity furnishes items or services at more than a single location or under more than once contractual or other payment arrangement, the provisions of this section will 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.

- **Employee**- An "employee" includes any officer or employee of the entity.
- **Contractor or Agent**- 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.

- **Knowingly**- "Knowing" and "Knowingly" is defined to mean that a person:

  - Has actual knowledge of falsity of information in the claim;
  - Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
  - Acts in reckless disregard of the truth or falsity of the information in the claim.

  The federal False Claims Act does not require proof of a specific intent to defraud the United States government. Instead, entities can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to Medicaid. Examples include knowingly making false statements, falsifying records, double-billing for items or services, or submitting bills for services or items never furnished.

- **Whistleblower**- An individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government before filing an action under Sections 31 USC 3729 through 3733 which is based on the information.
- **Claim**- A "claim" includes any request or demand for money that is submitted to the Division or its fiscal agent.

Appeals

Refer to Provider Policy Manual Section 7.06 for Administrative Hearings for Providers policy. To obtain additional information regarding the False Claims Act, refer to the following websites:

- www.gpoaccess.gov/plaws/index.html
- www.gpoaccess.gov/uscode/index.html