



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

JENNIFER M. GRANHOLM  
GOVERNOR

JANET OLSZEWSKI  
DIRECTOR

April 5, 2007

Dear Medicaid Provider:

On February 8, 2006, Public Law 109-171, otherwise known as the Deficit Reduction Act (DRA) of 2005 was passed. One of the provisions of the DRA is Section 6032, "Employee Education About False Claims Recovery", which established Section 1902 (a) (68) (A) of the Social Security Act. It will affect certain entities that receive or make Medicaid payments as follows:

- (68) provides that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall:
  - Establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about 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, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f))
  - Include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and
  - Include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

An entity has been defined as, "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."

The effective date of this provision was January 1, 2007, and applies to the entities referenced above, as well as their employees, contractors, and/or agents. These entities are mandated to do the following:

- Establish and disseminate written policies which must also be adopted by its contractors or agents. The policies may be in electronic or paper format, but must be readily available to all employees, contractors, or agents. It is not necessary to create an employee handbook if none already exists.
- 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.

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The State has incorporated these requirements into its provider enrollment agreements and will determine the manner by which it will ensure an entity's compliance with the requirements.

Enclosed are two Dear State Medicaid Director letters, dated December 13, 2006 and March 22, 2007, which were issued by the Centers for Medicare and Medicaid Services specifically on this subject. If you have any questions concerning this information, please contact Penny Dipple at (517) 241-5159 or [dipplep@michigan.gov](mailto:dipplep@michigan.gov).

Sincerely,

A handwritten signature in black ink that reads "Paul Reinhart". The signature is written in a cursive style with a large, prominent initial "P".

Paul Reinhart, Director  
Medical Services Administration

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

DEC 13 2006

SMDL #06-025

Dear State Medicaid Director:

We are writing to offer guidance to State Medicaid agencies on the implementation of section 6032 of the Deficit Reduction Act of 2005. This provision establishes section 1902(a)(68) of the Social Security Act (the Act), and relates to “Employee Education About False Claims Recovery.”

The following definitions are included in the accompanying State Plan Preprint, although additional guidance in this letter further clarifies the Preprint:

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 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.

An “employee” includes any officer or employee of the entity.

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 monitoring of health care provided by the entity.

It is the responsibility of each entity to 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. Although section 1902(a)(68)(C) refers to “any employee handbook,” there is no requirement that an entity create an employee handbook if none already exists.

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. The Centers for Medicare & Medicaid Services (CMS) is not providing model language, though States may elect to do so.

The provisions of section 1902(a)(68) of the Act must be implemented no later than January 1, 2007, except as provided in the section 6034(e) delayed effective date of the Deficit Reduction Act of 2005. To the extent a State determines that it requires legislation to implement this section and wishes to avail itself of the section 6034(e) delayed effective date, it must request through CMS that the Secretary concur with the determination that legislation is required.

The requirements of this law should be incorporated into each State’s provider enrollment agreements. Each State must also determine the manner by which it will ensure an entity’s compliance with section 1902(a)(68), which information each State must include in its State Plan along with a description of the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis. Each State shall so amend its State Plan not later than March 31, 2007, or by the end of the quarter in which the effective date of delayed implementation occurs, as described in section 6034(e). CMS may, at its discretion, independently determine compliance through audits of entities or other means. CMS may also review a State’s procedures through its routine oversight of States.

If you have any questions on this guidance, please direct them in writing to: Mr. Robb Miller, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Medicaid Integrity Group, 7500 Security Boulevard, Mailstop B2-15-24, Baltimore, MD 21244 or Ms. Claudia Simonson, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Medicaid Integrity Group, Division of Field Operations, 233 North Michigan Avenue, Suite 600, Chicago, IL 60601 or [robb.miller@cms.hhs.gov](mailto:robb.miller@cms.hhs.gov) or [claudia.simonson@cms.hhs.gov](mailto:claudia.simonson@cms.hhs.gov).

Sincerely,



Dennis G. Smith  
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators  
for Medicaid and State Operations

Martha Roherty  
Director, Health Policy Unit  
American Public Human Services Association

Joy Wilson  
Director, Health Committee  
National Conference of State Legislatures

Matt Salo  
Director of Health Legislation  
National Governors Association

Jacalyn Bryan Carden  
Director of Policy and Programs  
Association of State and Territorial Health Officials

Christie Raniszewski Herrera  
Director, Health and Human Services Task Force  
American Legislative Exchange Council

Lynne Flynn  
Director for Health Policy  
Council of State Governments

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



**Center for Medicaid and State Operations**

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**MAR 22 2007**

SMDL #07-003

Dear State Medicaid Director:

We are writing to offer additional guidance to State Medicaid agencies on the implementation of section 6032 of the Deficit Reduction Act of 2005. This provision establishes section 1902(a)(68) of the Social Security Act (the Act), and relates to "Employee Education About False Claims Recovery."

The enclosed Frequently Asked Questions will supplement the guidance the Centers for Medicare & Medicaid Services (CMS) provided in State Medicaid Director Letter #06-024, issued on December 13, 2006. States had also requested an official description of the Federal False Claims Act for purposes of uniformity. The Department of Justice has provided that description and it is also enclosed.

We hope this information is helpful to you. CMS considers this final guidance effective immediately. Please feel free to contact Robb Miller, Director, Medicaid Integrity Group, at 410-786-8705, if there are questions.

Sincerely,

A handwritten signature in cursive script that reads "Dennis G. Smith".

Dennis G. Smith  
Director

Enclosures

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cc:

CMS Regional Administrators

CMS Associate Regional Administrators,  
Division of Medicaid and Children's Health

Martha Roherty  
Director, Health Policy Unit  
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Lynne Flynn  
Director for Health Policy  
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<b>DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions</b>			
<b>Subject</b>	<b>FAQ #</b>	<b>Question</b>	<b>Answer</b>
<b>Definitions</b>			
<b>Entity</b>			
	1	Are the State agencies that administer the Medicaid program entities required to provide education to their employees under section 6032?	No. Neither the State Medicaid agency nor an agency that is an administrative arm of the Medicaid program would be entities for purposes of section 6032.
	2	If a State Medicaid Agency pays claims on behalf of contracted Medicaid managed care organizations (MCOs) through the State Agency's claims processing system, does that qualify the State Medicaid Agency as an entity?	No. The state Medicaid Agency is performing an administrative function for the Medicaid program, and would not be an entity or a contractor for purposes of section 6032.
	3	Are the State Medicaid Agency's administrative contractors—for example, for enrollment, research, and outreach—entities or contractors under section 6032?	Whether a State Medicaid Agency's administrative contractors are entities or contractors for purposes of section 6032 depends on the function the contractor is performing. If the contractor is performing administrative functions for the State Medicaid Agency, the contractor would be neither an entity nor a contractor for purposes of section 6032 compliance. If the contractor is furnishing Medicaid health care items or services, the contractor would be an entity if it met the \$5 million threshold.
	4	Does the definition of entity include individuals and group practice arrangements, or does it only refer to institutional providers?	For purposes of section 6032 compliance, an entity includes organizational units (a governmental agency, organization, unit, corporation, partnership, or other business arrangement) and individuals, as long as the organizational unit or individual receives or makes payments totaling at least \$5 million annually under a Title XIX State Plan, State Plan waiver, or Title XIX demonstration.
	5	Is the parent corporation an entity if its subsidiary or subsidiaries are entities?	For purposes of section 6032 compliance, the entity is the largest separate organizational unit that furnishes Medicaid health care items or services, and includes all sub-units of that organizational unit that furnish Medicaid health care items or services, even if the

<b>DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions</b>			
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			<p>components are separately incorporated or located in different States. Unless the organizational unit is part of a health system (see FAQ 6), each organizational unit is viewed separately for purposes of determining whether the \$5 million threshold has been met, and the other requirements of section 6032 are applicable.</p>
	6	<p>Where a health system includes hospitals that individually do not receive \$5 million in Medicaid payments and other hospitals that individually do receive \$5 million in Medicaid payments, is the health system the entity or are the individual hospitals entities?</p>	<p>For purposes of section 6032 compliance, an entity is an organizational unit that furnishes Medicaid health care items or services, and includes all sub-units of that organizational unit that furnish Medicaid health care items or services, even if the components are separately incorporated or located in different States. Unless the organizational unit is part of a health system, as described below, each organizational unit is separate for purposes of determining whether the \$5 million threshold has been met.</p> <p>With respect to a health system, for purposes of section 6032 compliance, the parent corporation, partnership, government agency or other owner, and its sub-units, are all integrally involved in furnishing Medicaid items or services. In that instance, the entire organization is the entity for purposes of determining the requirements of section 6032.</p>
	7	<p>Where there are subsidiaries of a corporate parent, and the subsidiaries have separate Federal employer identification numbers (FEINs) or provider numbers, are the subsidiaries aggregated or are they separate entities?</p>	<p>For purposes of section 6032 compliance, the number of FEINs or provider numbers is not indicative of whether an organization is an entity. An organization may have multiple subsidiaries, locations and FEINs or provider numbers and still be combined for purposes of meeting the definition of an entity. Whether the subsidiaries would be aggregated or viewed as separate entities depends upon the corporate structure and assessment of the largest separate organizational unit that furnishes Medicaid health care items or services.</p>

<b>DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions</b>			
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	8	If an agency, organization, or component of State, county, or municipal government operates a facility that furnishes Medicaid health care items and services and meets the definition of “entity”, will the State, county, or municipal government as a whole be the entity or will the facility be the entity?	For purposes of section 6032 compliance, the entity is the largest separate organizational unit that furnishes Medicaid health care items or services, and includes all sub-units of that organizational unit that furnish Medicaid health care items or services.
	9	Where a university has a health sciences center campus and a separate non-healthcare academic campus, is the entire university or only the health services campus the entity?	For purposes of section 6032 compliance, the entity is the largest separate organizational unit that furnishes Medicaid health care items or services, and includes all sub-units of that organizational unit that furnish Medicaid health care items or services.
	10	Does an individual investor in nursing homes that in the aggregate are paid \$5 million under a State’s Medicaid program qualify as an entity?	No. For purposes of section 6032 compliance, an individual investor or shareholder would not become an entity solely by virtue of holding stock in entities.
	11	Are pharmaceutical manufacturers that make payments to States under the Medicaid drug rebate program entities?	For purposes of section 6032 compliance, pharmaceutical manufacturers are not entities solely by virtue of making Medicaid drug rebate payments to States.
	12	If a provider or organization would not be subject to audit under OMB Circular A-133 and the President’s Council on Integrity and Efficiency Position Statement Number 6 (1992), would it be an entity required to comply under DRA section 6032?	For purposes of section 6032 compliance, a provider or organization that is considered to be an entity under section 6032 is required to comply even if it would not be subject to audit under OMB Circular A-133. According to the Policy statement in OMB Circular A-133, to the extent there are subsequent statutes that specifically prescribe policies that conflict with the standards of OMB Circular A-133, the provisions of the subsequent statute would govern. The DRA is an example of such a statute.
<b>\$5M</b>			
	13	What is the period used for calculating the \$5 million in annual payments?	For purposes of determining whether an entity must comply with section 6032: If an entity receives or makes payments totaling \$5 million during a Federal fiscal year (October 1 to September 30), then the

<b>DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions</b>			
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			entity must comply as of January 1 of the next calendar year. With respect to compliance as of January 1, 2007, look to payments received or made between October 1, 2005 and September 30, 2006. Similarly, for compliance as of January 1, 2008, look to the period October 1, 2006 through September 30, 2007.
	14	If a Medicaid MCO receives \$3 million in payments and pays out \$2 million, will its receipts and payments be aggregated to reach the \$5 million annual threshold?	For purposes of determining whether an organization must comply with section 6032, the payments that a Medicaid MCO receives under a State's Title XIX State Plan, State Plan waivers, or Title XIX demonstrations are not aggregated with payments the Medicaid MCO makes to providers. The \$5 million annual threshold is met by either receiving \$5 million in payments from the State or making \$5 million in payments to the Medicaid MCO's providers.
	15	When calculating the \$5 million in annual payments, does an individual or organization aggregate payments received directly from the State Medicaid Agency and from Medicaid MCOs for its MCO patients?	Solely for purposes of determining whether an individual or organization must comply with section 6032, only the amounts received from a State Medicaid Agency should be counted when calculating the \$5 million in payments. The amounts an individual or organization may receive through its contract with a Medicaid MCO should not be counted when calculating the \$5 million in payments.
	16	When calculating the \$5 million in annual payments, are those payments based on date of payment or date of service?	For purposes of determining whether an organization must comply with section 6032, CMS has no preference whether a State uses the date of service or the date of payment, as long as a State applies the criterion uniformly.
	17	When calculating the \$5 million in annual payments, are those payments based on the amount billed or the amount received?	Whether an entity meets the \$5 million annual payment threshold for purposes of section 6032 compliance is based on the amount actually received in a Federal fiscal year.
	18	Are payments from multiple States aggregated to reach the \$5 million annual threshold?	No, payments from multiple States are not aggregated to reach the \$5 million threshold. For

<b>DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions</b>			
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			purposes of section 6032 compliance, an organization would satisfy the \$5 million annual payment threshold if it received or made payments under one State’s Medicaid State Plan or State Plan waiver programs. However, once an organization meets the \$5 million annual threshold and is considered an entity, then the entity must provide education to all its employees, regardless of whether those employees are located in different States.
	19	If a State requires Medicaid recipients to contribute an amount toward their care (the “patient pay amount”), is that patient contribution included when calculating an entity’s annual payments?	No, for purposes of section 6032 compliance, the patient pay amounts are not payments under a State’s Title XIX State Plan, State Plan waiver program or Title XIX demonstration program and, therefore, would not be counted toward the \$5 million in annual payments.
	20	Where a corporate parent has several components, but none of the components individually reach the \$5 million annual threshold, are the components’ payments aggregated and counted toward the corporate parent’s annual threshold?	For purposes of determining whether an organization must comply with section 6032, if the corporate parent is either a health system or itself provides Medicaid health care items or services, it would be the entity, and the payments to those components that provide Medicaid health care items or services would be aggregated to determine whether the organization must comply in a given year.
	21	Are there any exceptions to the \$5 million annual payment threshold such that an individual or organization that received or made payments totaling less than \$5 million in a Federal fiscal year would be required to comply?	For purposes of section 6032 compliance, as long as the individual or organization does not reach the \$5 million annual payment threshold and is not a corporate subsidiary where the parent qualifies as an entity, then that individual or organization would not be required to comply with section 6032 for that year.
	22	Do Medicare payments count toward the \$5 million annual payment threshold?	In general, Medicare payments are not considered for purposes of determining whether an individual or organization must comply with section 6032. However, Medicare deductibles and co-insurance that the State Agency pays for dual-eligible individuals and Qualified Medicare Beneficiaries (QMBs) should be

<b>DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions</b>			
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			considered for purposes of determining whether an individual or organization must comply with section 6032.
<b>Contractor or Agent</b>			
	23	Are billing and coding vendors the only contractors who are required to accept an entity's policies and procedures?	No. Under CMS guidance regarding section 6032 compliance, an entity must establish policies for its contractors' and agents' employees, including, but not limited to, the employees of the entity's vendors performing billing and coding functions. Other contractors or agents include those which or who, on behalf of the entity, furnish or otherwise authorize the furnishing of Medicaid health care items or services or are involved in monitoring of health care provided by the entity.
	24	Will CMS provide guidance on what it means by "involved in monitoring of health care"?	No.
	25	What types of contractors are included in the definition of those individuals, businesses, or organizations furnishing Medicaid health care items or services?	For purposes of section 6032 compliance, contractors furnishing Medicaid health care items or services include, but are not limited to, all contract therapists, physicians (including, but not limited to, house staff, hospitalists, and independent contractors), and pharmacies.
	26	Does the definition of contractor exclude individuals, businesses, or organizations that perform functions not associated with the provision of Medicaid health care items or services, such as copy or shredding services, grounds maintenance, or hospital cafeteria or gift shop services?	For the purposes of section 6032 compliance, those contractors are excluded from the definition of "contractor".
	27	Must entities amend their contracts with contractors and agents to reflect the requirements of section 6032 or is it adequate if the contracts require contractors and agents to comply with all applicable Federal laws and	There is no requirement in section 6032 that contracts recite the language of section 6032. However, each State will determine the manner by which it will ensure an entity's compliance with the requirements of section 6032.

<b>DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions</b>			
<b>Subject</b>	<b>FAQ #</b>	<b>Question</b>	<b>Answer</b>
		regulations?	
	28	If an entity's contracts require contractors and agents to comply with the entity's policies, may the entity distribute the policy to contractors and agents without additionally amending the contracts?	There is no requirement that contracts recite the language of section 6032. However, each State will determine the manner by which it will ensure an entity's compliance with the requirements of section 6032.
	29	Must providers who are contractors of Medicaid MCOs comply as "entities" or as "contractors"?	For purposes of determining whether an individual or organization must comply with section 6032 as an entity or as a contractor: a) if a provider is directly paid \$5 million in a Federal fiscal year from the State Medicaid Agency, the provider would qualify as an entity, and must comply as such, regardless of whether the provider also contracts with a Medicaid MCO; b) if a provider contracts with a Medicaid MCO that has met the \$5 million threshold, but the provider itself receives less than \$5 million annually directly from the State Medicaid Agency, then the provider must comply as a contractor of the Medicaid MCO, regardless of the amount it is paid by the Medicaid MCO for Medicaid patients.
	30	Must a provider that contracts with several Medicaid MCOs adopt the policies of all the Medicaid MCOs, even if the policies conflict?	For purposes of section 6032 compliance, parties that contract with multiple entities must abide by each entity's policies to the extent the policies for preventing and detecting fraud, waste and abuse are relevant to the interaction between the individual entities and their contractors and agents.
	31	Are a hospital's independent contractors treated the same as other contractors under section 6032?	Yes. For purposes of section 6032 compliance, an entity's contractors and agents, including independent contractors, must abide by the entity's policies to the extent applicable.
	32	Are supply vendors that supply products used in the furnishing of Medicaid health care services contractors for purposes of compliance with section 6032?	Yes. For purposes of section 6032 compliance, supply vendors with a contractual relationship with the entity (even if the contract has not been reduced to writing) are the entity's contractor.

<b>DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions</b>			
<b>Subject</b>	<b>FAQ #</b>	<b>Question</b>	<b>Answer</b>
	33	Is a medical supply manufacturer that sells \$5 million in medical supplies to a hospital or other medical provider an entity or a contractor?	For purposes of section 6032 compliance, a supply manufacturer would be an entity if it sells \$5 million in medical supplies for which it is paid directly by the State Medicaid Agency. The medical supply manufacturer may also be a contractor of another entity like a hospital, depending on its relationship with the entity.
	34	If an entity joins with other entities to purchase medical supplies through a group purchasing organization, is a medical supply vendor the contractor of the individual entities or of the group purchasing organization (GPO)?	Though this depends upon the particular terms of the relationships between the entities and the GPO and between the GPO and the medical supply vendor, for purposes of section 6032 compliance, in most instances the medical supply vendor will be the contractor of the GPO, not of the entities.
<b>Policies and Procedures</b>			
<b>Content</b>			
	35	Will CMS provide model policies?	No. At this time CMS will not provide any model language for policies required under section 6032.
	36	Will the U.S. Department of Justice provide a summary of the Federal False Claims Act?	Yes. CMS will make the summary available on the CMS website.
	37	Will CMS provide any guidance on the level of detail for the “detailed information” about false claims laws and regulations and other information required under this section?	At this time CMS will not provide any model language for policies required under section 6032 and is not prescribing the level of detail for the required “detailed information”.
<b>Adoption of Policies</b>			
	38	Must contractors and agents adopt the entity’s policies or is it adequate that the policies are made available to contractors and agents?	Under DRA section 6032, an entity must “establish written policies for all employees ... of any contractor or agent of the entity.” In order for the entity to establish policies for the employees of its contractor or agent, the entity must disseminate the policies to the contractor or agent, which must then abide by the policies as to the work the contractor or agent performs for the entity, in addition to making the policies available to the contractor’s and agent’s

<b>DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions</b>			
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			employees involved in performing that work.
	39	If an entity has policies and procedures for detecting and preventing fraud, waste and abuse, does an entity’s contractor or agent adopt the policies by participating in the entity’s practices to detect fraud, waste and abuse, or must the contractor or agent institute the same practices as to its activities?	For purposes of section 6032 compliance, an entity must have policies that include policies and procedures for detecting and preventing fraud, waste and abuse. To the extent that an entity’s policies provide for reviews or audits of claims or services, the contractor or agent would participate in those reviews or audits. The contractor or agent must abide by the policies insofar as they are relevant and applicable to the contractor or agent’s interaction with the entity.
<b>Dissemination</b>			
	40	To whom must an entity disseminate its policies?	Under DRA section 6032, an entity must establish policies for all of its employees and for the employees of its contractors and agents. Therefore the policies must be disseminated to all of the entity’s employees and to the entity’s contractors and agents.
	41	Must entities meet with contractors and agents to walk them through the policies, or is it adequate to send the policies to contractors and agents?	For purposes of section 6032 compliance, each entity must determine for itself how it will satisfy the dissemination requirement within the requirements of the State’s methodology for compliance oversight.
	42	How often must an entity disseminate its policies to its contractors and agents? For example, must the entity disseminate its policies to its contractors annually, or upon renewal of a contract with the same contractor?	Each State will determine the manner by which it will ensure an entity’s compliance with the requirements of section 6032, including the frequency of dissemination of policies.
	43	Must the written policies be in hard copy or may they be sent out electronically or posted on the employee website?	For purposes of section 6032 compliance, written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. Employees, contractors and agents must be made aware of their existence and location.
<b>Employee Handbook</b>			
	44	If there is an employee handbook that exists,	If there is an employee handbook, the policies and

<b>DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions</b>			
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		are entities required to include the policies and procedures in the handbook?	procedures required by section 6032 must be included in the handbook.
	45	If an entity has more than one employee handbook, must the policies required by section 6032 be included in all employee handbooks?	Section 6032 requires entities to establish and disseminate its policies to all employees. If an entity has multiple employee handbooks for the same group of employees, the policies need only be included in the handbook addressing the entity's policies regarding detecting and preventing fraud, waste, and abuse. If the entity has a separate employee handbook for each of several groups of employees, then the policies must be included in each employee handbook.
<b>Training</b>			
	46	Section 6032 is entitled "Employee Education About False Claims Recovery". Must entities provide training on the policies and procedures?	There is no training requirement for compliance with section 6032. Education refers to provision of information to employees, contractors and agents.
<b>Implementation</b>			
<b>Compliance Date</b>			
	47	What is the date by which States must comply?	The date by which each State must have imposed the requirement on entities to provide false claims education under section 6032 was January 1, 2007, unless the State has approval for delayed implementation. The date by which each State must amend its Medicaid State Plan is March 31, 2007, unless the State has approval for delayed implementation.
	48	What is the date by which entities must comply?	The date by which an entity must comply with section 6032 was January 1, 2007, the date the State must have implemented the requirements of this section, unless the Secretary has approved the State's request for delayed implementation.
	49	Will CMS defer enforcement until after it releases additional guidance on this section?	No. There is no grace period for compliance with section 6032.

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<b>Subject</b>	<b>FAQ #</b>	<b>Question</b>	<b>Answer</b>
	50	If a Medicaid-enrolled provider changed ownership during Federal fiscal year (FFY) 2006 and the new owner corporation did not receive \$5 million during FFY 2006, is the Medicaid-enrolled provider or the new parent corporation exempt from the requirements of Section 6032 until January 1, 2008 (the next compliance date)?	<p>Under 42 C.F.R. 442.14, when there is a change of ownership, the Medicaid provider agreement is automatically assigned to the new owner, subject to all applicable statutes and regulations, terms and conditions of the provider agreement, and any additional requirements imposed by the State Medicaid Agency.</p> <p>As long as the provider itself received \$5 million in payments in FFY 2006, the change of ownership would not affect its qualifying status as an entity subject to the Section 6032 requirements.</p> <p>If the parent corporation would be an entity because it furnished Medicaid health care items or services, it would be an entity for FFY 2006 because the medical provider it acquired received payments of \$5 million during FFY 2006.</p>
<b>Delayed Implementation</b>			
	51	If a State determines it needs legislation to comply with this section, how would the State request approval of delayed implementation under section 6034(e) of the DRA?	<p>If a State determines it needs legislation to comply with section 6032, it must submit a written request for approval of delayed implementation to:</p> <p>Leslie V. Norwalk, Acting Administrator Department of Health &amp; Human Services Centers for Medicare &amp; Medicaid Services 200 Independence Avenue, SW Mail Stop 314G Washington, DC 20201</p> <p>with copies to:</p> <p>Dennis G. Smith, Director Center for Medicaid &amp; State Operations</p>

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<b>Subject</b>	<b>FAQ #</b>	<b>Question</b>	<b>Answer</b>
			<p>Centers for Medicare &amp; Medicaid Services 7500 Security Blvd. Mail Stop S2-26-12 Baltimore, MD 21244</p> <p>and:</p> <p>Claudia Simonson Centers for Medicare &amp; Medicaid Services Medicaid Integrity Group 233 North Michigan Avenue, Suite 600 Chicago, IL 60601</p> <p>The request must demonstrate that the State needs legislative authority to require entities to meet the employee education requirement.</p> <p>If the State's request is approved, CMS would not find the State to be out of compliance with this section until the end of the first calendar quarter after the conclusion of the first full legislative session after the enactment of the DRA. In other words, if a State's first legislative session after February 8, 2006, begins on February 1, 2007, and concludes on July 31, 2007, the state must submit its State Plan Amendment by December 31, 2007; the effective date of the State Plan Amendment would be October 1, 2007.</p>
	52	How would a State's 2-year legislative session affect a request for approval of delayed implementation?	For purposes of section 6032 compliance, if a State has a 2-year legislative session, each year of the session will be considered to be a separate regular session of the State legislature.
	53	Does delayed implementation by the State affect the entity's implementation date?	Yes. Delayed implementation is available only to States. However, if a State has approval for delayed implementation, entities have until the effective date of the State legislation to comply with section 6032.

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<b>Subject</b>	<b>FAQ #</b>	<b>Question</b>	<b>Answer</b>
<b>Enforcement</b>			
	54	How will CMS monitor the States' compliance with Section 6032?	CMS will monitor States' compliance through its routine oversight of States.
	55	Will CMS offer any guidance to the States regarding the States' enforcement of this requirement?	No. CMS is not prescribing the manner of the States' enforcement of the requirements of section 6032. Each State must include in its State Plan Amendment a description of the methodology of compliance oversight.
	56	Is there any recommended documentation with which an entity could prove the policies were presented to employees?	No. Beyond this guidance, CMS is not prescribing the manner of entities' due diligence for compliance with Section 6032.
	57	Must entities provide CMS with a copy of their policies established in compliance with section 6032?	CMS is not requiring entities to provide their policies to CMS on a routine basis. Each State will determine the manner by which it will ensure an entity's compliance with the requirements of section 6032. CMS may, however, independently determine compliance through audits of entities or other means by which an entity may be required to produce such documents to CMS or its contractors.
	58	Between now and the point at which a State's State Plan Amendment goes into effect, what does the law prescribe as an enforcement mechanism against entities?	Unless a State has an approved request for delayed implementation of the requirements of section 6032, the State's State Plan Amendment must be submitted by March 31, 2007. The State would identify the enforcement mechanism in its State Plan Amendment.
	59	May a State impose more stringent requirements on entities and entities' contractors and agents?	Each State must determine the manner by which it will ensure an entity's compliance with the requirements of section 6032. A State may impose more stringent requirements on entities, and entities' contractors and agents, as long as those requirements do not conflict with the requirements of DRA section 6032.
	60	If an entity has complied with the requirements of section 6032 before the State Medicaid Agency amends its State Plan, if the	Each State will determine the manner by which it will ensure an entity's compliance with the requirements of section 6032, including whether an entity will be

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<b>Subject</b>	<b>FAQ #</b>	<b>Question</b>	<b>Answer</b>
		subsequent State Plan Amendment imposes additional requirements, will entities be required to reissue their policies?	required to reissue its policies.
<b>Penalties</b>			
	61	Will a State lose Federal Financial Participation (FFP) if it is not in compliance on January 1, 2007?	A State that fails to comply with the requirements of section 6032 may be at risk of losing FFP. Each State must have imposed the requirement on entities to provide false claims education as of January 1, 2007, unless the State has approval for delayed implementation. Each State must amend its Medicaid State Plan by March 31, 2007, unless the State has approval for delayed implementation.
	62	Can providers who are entities continue to participate in the Medicaid program if they fail to comply with the requirements of this section?	Each State must determine the manner by which it will ensure an entity's compliance with the requirements of section 6032, including the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis. States should follow their normal procedures for enforcement of provider enrollment agreements and managed care contracts.
	63	What should entities do if their contractors or agents fail to abide by the entities' policies?	Each entity must determine for itself the appropriate course of action.
	64	Will an entity be found out of compliance when its agent refuses to comply with its requirements under section 6032, but where the entity is not able to terminate the agency relationship due to some hardship in the delivery of Medicaid services to a population?	The DRA permits no formal waiver from the application of section 6032.
<b>State Medicaid Agency Requirements</b>			
<b>State False Claims Act</b>			
	65	If a State does not have a false claims act,	Yes. DRA section 6032 applies to States regardless

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<b>Subject</b>	<b>FAQ #</b>	<b>Question</b>	<b>Answer</b>
		does section 6032 apply?	of whether the States have false claims acts.
<b>State Plan Amendment</b>			
	66	Do States have to amend the Medicaid State Plan regarding the False Claims Act?	Under section 6032, each State must amend its Medicaid State Plan to reflect that the State has required entities that are paid or make payments totaling \$5 million in a Federal fiscal year to establish and disseminate false claims act information to the entities' employees and to the employees of the entities' contractors and agents.
	67	Will the State Plan Amendments be retroactive to January 1, 2007?	Unless a State has an approved request for delayed implementation of the requirements of section 6032, the State's State Plan Amendment must be effective January 1, 2007.
	68	Will CMS prescribe the level of detail for the State Plan Amendment methodology of compliance oversight?	No. CMS is not prescribing the level of detail for the manner of the States' enforcement under section 6032.
<b>Provider Agreements</b>			
	69	The State Medicaid Director Letter says the requirements of this law should be incorporated in each State provider enrollment agreement. Must provider enrollment agreements specifically recite the language of section 6032, or is a requirement that the provider "comply with all applicable Federal laws and regulations" adequate?	There is no requirement that provider agreements recite the language of section 6032.
	70	If States require providers to comply with all applicable Federal laws and regulations, may States also include in their provider manual or other policies and procedures for providers that providers must comply with the requirements of section 6032, rather than amending the provider agreement?	There is no requirement that provider agreements recite the language of section 6032. States may give providers additional guidance or impose additional requirements, as long as the guidance or requirements do not conflict with CMS guidance and Federal statutory mandates.
<b>Other</b>			

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<b>Subject</b>	<b>FAQ #</b>	<b>Question</b>	<b>Answer</b>
	71	Where can I access the CMS guidance on section 6032?	<p>On December 13, 2006, CMS issued the State Medicaid Director Letter (SMDL #06-024). It can be found on the CMS website at:</p> <p><a href="http://www.cms.hhs.gov/SMDL/SMD/itemdetail.asp?filterType=none&amp;filterByDID=0&amp;sortByDID=1&amp;sortOrder=descending&amp;itemID=CMS1190449&amp;intNumPerPage=10">http://www.cms.hhs.gov/SMDL/SMD/itemdetail.asp?filterType=none&amp;filterByDID=0&amp;sortByDID=1&amp;sortOrder=descending&amp;itemID=CMS1190449&amp;intNumPerPage=10</a></p>

The False Claims Act ("FCA") provides, in pertinent part, that:

(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; . . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

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is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person . . . .

(b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729. 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(b).

In sum, 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. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as "*qui tam* relators," may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a *qui tam* relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

The FCA provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.