DHS
Oregon Department of Human Services

Employee Education About False Claims Recoveries

DHS recommended tools for compliance with Section 6032 of the Deficit Reduction Act (DRA)

- ✓ Affected entities
- ✓ Written standards of conduct
- ✓ Descriptions of pertinent law
- ✓ Compliance checklist

June 6, 2008

Oregon HEALTH PLAN

Contents

Introduction

The Oregon Department of Human Services (DHS) is pleased to provide information and guidance to providers of Medicaid services on the implementation of Section 6032 of the Deficit Reduction Act (DRA) of 2005. This provision is found in section 1902(a)(68) of the Social Security Act, and relates to Employee Education About False Claims Recovery.

It is the goal of DHS to provide recommendations and a tool that all affected providers can use. In providing this information, DHS does not intend for it to be a detailed account of all the legal requirements relevant to compliance with Section 6032.

DHS encourages all providers subject to Section 6032 to consult with their legal counsel, Board of Directors or other business advisors about the development and implementation of their own fraud and abuse policies for purposes of Section 6032.

DRA Section 6032 requirements

As of January 1, 2007, all providers and entities who receive or pay at least $5 million in Medicaid funds annually (based on the federal fiscal year) must inform their employees and contractors in writing about:

1. The federal False Claims Act.
2. Any related civil or criminal state laws related to Medicaid fraud.

In addition, affected providers and entities must establish and distribute written policies on fraud, waste and abuse so that those policies are:

1. Distributed to all employees;
2. Readily available to all employees, contractors, or agents; and
3. Adopted by its contractors or agents.

The statute requires the provider/entity establish written standards of conduct, policies, procedures and protocols. These written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. Additionally, Section 6032 refers to “any employee handbook,” yet there is no requirement on an entity to create an employee handbook if none already exists.

Affected entities

For the 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 of Medicaid funds totaling at least $5 million annually under a State Title XIX Plan, State Plan waiver, or Title XIX demonstration. For further definition of affected entities, refer to the Centers for Medicare and Medicaid Services (CMS)

guidance on DRA Section 6032 implementation, starting on page 21 of this document.

Entities or contractors performing administrative functions (*e.g.*, enrollment, outreach and research) for Oregon Medicaid would neither be an entity nor a contractor for purposes of Section 6032 compliance. Only entities or contractors that furnish Medicaid health care items or services, in addition to meeting the $5 million threshold, would be subject to Section 6032.

DHS fraud and abuse requirements

To comply with the requirements outlined in Section 6032 of the DRA, DHS now requires managed care plan contractors and health care providers who earn at least $5 million per federal fiscal year to do the following:

- Establish fraud and abuse policies
- Review those policies annually
- Educate employees and subcontractors on these policies

This guide focuses on the third requirement– How affected entities must educate their employees and subcontractors about fraud and abuse policies to meet DRA requirements.

Recommendations on meeting state and federal requirements

- Use the information in this packet as well as other pertinent information as a basis for developing and implementing a program of Employee Education about False Claims Recoveries and to assist in assessing compliance with Section 6032.
- Complete an overview of your compliance plan regarding these new requirements.
- Ensure your policies and procedures for detecting fraud, waste and abuse are updated with this information and are in compliance with Section 6032.
- Ensure you have an effective and comprehensive employee education plan that is in compliance with this information.
- Identify and make known to all employees key personnel in the compliance and reporting arena.
- Publicize ways an employee can report fraud, waste and abuse.
- Ensure your entity has a non-retaliation policy and it is available to all employees.

Combating fraud, waste and abuse in the Medicaid program is a partnership between the state and its providers of health care items or services. DHS seeks to continue this partnership in the implementation of the requirements of Section 6032 of the DRA. DHS welcomes comments and questions regarding the implementation of these new requirements.

Requirements for affected entities

Requirements for managed care contractors

FCHPs, DCOs, PCO and CDO requirements are outlined in Exhibit J ("Prevention and Detection of Fraud and Abuse") of the OHP model contracts. These contracts are available on the OHP Web site at www.oregon.gov/DHS/healthplan/data_pubs/contracts/main.shtml.

MHO requirements are outlined in Exhibit J of the MHO Agreement, available on the Addictions and Mental Health Web site at www.oregon.gov/DHS/mentalhealth/tools-providers.shtml.

Requirements for affected health care providers

In keeping with requirements for managed care plans, fraud and abuse policies of providers should include, at a minimum, the following elements:

Written policies

The provider should develop and distribute to employees and subcontractors, written standards of conduct, as well as written policies and procedures, that:

- Promote the provider's commitment to compliance.
- Address specific areas of potential fraud, such as the claims submission process, and financial relationships with its subcontractors.
- Provide detailed information about the False Claims Act and related laws as listed in the table on page 5. This list does not limit the authority of DMAP or any health oversight agency or law enforcement entity from fully exercising its legal authority to pursue legal recourse to the full extent of the law.
- Detailed provisions regarding policies and procedures for detecting and preventing fraud, waste and abuse.

Employee handbook (or other written format)

In addition to the requirements for written policies, providers should provide employees and contractors an employee handbook (or other written format) that:

- Provides the description of the laws listed in the table on page 5, and specific discussion of these laws.
- Provides specific discussion about the rights of employees to be protected as whistleblowers, and the provider's policies and procedures for detecting and preventing fraud, waste and abuse.

Fraud and abuse laws required in policy/procedure and employee handbook (or other written format)

31 USC 3729-3733	The False Claims Act
31 USC Chapter 38	Administrative remedies for false claims and statements
42 USC 1320a-7b	Definition of fraud, waste and abuse
Any Oregon 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 42 USC 1320a-7b). Such Oregon laws include the following:	
ORS 411.670 to 411.690	Submitting wrongful claim or payment prohibited; liability of person wrongfully receiving payment; amount of recovery
ORS 646.605 to 646.656	Unlawful trade practices
ORS chapter 162	Crimes related to perjury, false swearing and unsworn falsification
ORS chapter 164	Crimes related to theft
ORS chapter 165	Crimes involving fraud or deception, including but not limited to ORS 165.080 (falsification of business records) and ORS 165.690 to 165.698 (false claims for health care payments
ORS 166.715 to 166.735	Racketeering – civil or criminal
ORS 659A.200 to 659A.224	Whistleblowing
ORS 659A.230 to 659A.233	Whistleblowing
OAR 410-120-1395 to 410-120-1510	Program integrity, sanctions, fraud and abuse; common law claims founded in fraud, including Fraud, Money Paid by Mistake and Money Paid by False Pretenses.

Education and training

Providers should also develop and implement regular, effective education and training programs for all affected employees and subcontractors. Although Section 6032 does not specifically include a training requirement for compliance, it is believed this element is critical to implementing with all due diligence. A regular and effective education and training program for all employees (including new employees), is a front line method for combating fraud, waste and abuse.

Administration of the fraud and abuse program

The operation of the fraud and abuse program should include the following elements:

- The designation of a chief compliance officer and other appropriate bodies charged with the responsibility of operating and monitoring the fraud and abuse program and who report directly to the CEO and the governing body;
- The creation and maintenance of a process to receive complaints and the adoption of procedures to protect the anonymity of complainants and to protect complainants from retaliation;
- The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees or subcontractors, who have violated internal fraud and abuse policies, applicable statutes, regulations, federal or state health care program requirements;
- The use of risk evaluation techniques to monitor compliance and assist in the reduction of identified problem areas;
- The investigation and correction of identified systemic problems and the development of policies addressing the non-employment of sanctioned individuals by the provider and its Subcontractors;
- A well publicized and accessible referral process;
- Enforcement of standards through well-publicized disciplinary guidelines;
- Provision for internal monitoring and auditing;
- Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract; and
- Effective lines of communication between the Department’s compliance office and Contractor’s employees.

DHS measures for monitoring compliance

CMS places much of the responsibility for ensuring provider compliance with Section 6032 of the DRA with the state. On an annual basis DHS will identify affected entities and ensure compliance. Once compliance is established, DHS will use the following measures for monitoring compliance with Section 6032:

1. ***Audits:*** Audits of affected Medicaid providers will include a review for compliance in the normal course of their audit work
2. ***QI:*** Through regular and systematic reviews of program integrity and quality improvement
3. ***On-site visitation:*** When DHS program, policy or other staff perform an on-site visit
4. ***Licensing:*** As part of the initial or renewal of licensing of an affected entity
5. ***Contracting and contract desk reviews:*** As contracts are requested or are up for renewal
6. ***Submission of policies*** by affected entities

Providers subject to Section 6032 will be required to submit any changes or updates in their fraud, waste and abuse policies to DHS for review.

DHS sample checklist for monitoring compliance

#	Element for Review	Comments/Action Items
1	Is the provider subject to Section 6032 of the Deficit Reduction Act: Employee Education about False Claim Recoveries?	
2	Does the provider have written standards of conduct, policies and procedures that promote commitment to compliance and address specific areas of potential fraud, waste and abuse?	
3	Does the provider have written policies and procedures for educating employees on the False Claims Act?	
4	Does the policy discuss the roles of the individual and provider in preventing fraud, waste and abuse?	
5	Does the written material include a detailed description of the Federal False Claims Act?	
6	Does the written material include a detailed discussion on the federal non-retaliation/ whistleblower protections?	

#	Element for Review	Comments/Action Items
7	Does the provider have an employee handbook or other written document where information is readily accessible to the employee about the False Claims Act?	
8	Is there a systematic, effective education and training for all employees and subcontractors of the provider subject to Section 6032?	
9	Is there a Chief Compliance Officer designated who reports directly to the CEO and governing body?	
10	Does the provider have a well publicized process for receiving complaints, for protecting the anonymity of the complainant and for protecting the complainant from retaliation?	
11	Does the provider have a system to respond to allegations of fraud, waste and abuse?	
12	Does the provider have a written process to investigate and correct identified systemic problems?	
13	Does the provider have well publicized disciplinary guidelines and a process for the enforcement of disciplinary action?	
14	Does the provider employ the use of evaluation and fraud and abuse detection techniques to monitor compliance and assist in the reduction of problem areas or behavior?	
15	Is there a written process to promptly refer all suspected cases of fraud, waste and abuse to the Medicaid Fraud Control Group (MFCU), or the DHS Provider Audit Unit?	
16	Does the provider have a process and provision for internal auditing, monitoring and controls as related to fraud, waste and abuse?	
17	Does the provider have a system to track detected offenses and corrective actions taken?	
18	Are there available and effective lines of communication between the compliance officer and all employees?	

Frequently asked questions about fraud and abuse

Why should I care about program integrity and fraud, waste and abuse?

Program integrity is critical to ensure those in need of the services from the programs DHS administers are receiving those services in the most efficient and cost-effective manner possible. When there is fraud, waste or abuse present, it threatens the ability of DHS and providers to make available those important services when needed.

What is the difference between fraud and abuse?

Fraud is defined as intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse is defined as practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

What are some examples of fraud?

- A Medicaid provider submits a claim for services or supplies that were not provided.
- An employee falsifies client medical records in order to gain reimbursement for services.
- A person when applying for Medicaid benefits reports their household income as $500.00 per month when their income is actually $6.000.00 per month.

What are some examples of abuse?

- A provider orders diagnostics that are not medically necessary.
- A provider provides and bills for a power wheelchair for a client who only met the coverage criteria for a manual wheelchair.

What are the requirements of providers related to fraud, waste and abuse?

For providers subject to Section 6032 of the DRA, they must come into compliance with all legal requirements found in statute and guidance, including educating all employees on the False Claims Act and their rights under the whistleblower protections.

For providers not subject to Section 6032 of the DRA, all other applicable federal and state laws are still in force. It is strongly recommended for these providers to recognize the value of the provisions of Section 6032 and comply as reasonably possible.

How serious is fraud and abuse?

Fraud is a crime and abuse violates other applicable laws and administrative rules. Both undermine the integrity of the Medicaid program. Some applicable Oregon laws include:

- ORS 411.670 to 411.690: Submitting wrongful claim or payment prohibited.
- ORS 646.605 to 646.656: Unlawful trade practices.
- ORS 162: Crimes related to perjury, false swearing and unsworn falsification.
- ORS 164: Crimes related to theft.
- ORS 165: Crimes involving fraud or deception.
- ORS 165.690 through 165.698: False claims for health care payments.
- ORS 166.715 to 166.735: Racketeering.

Federal laws such as the federal False Claims Act can also apply.

What are the expectations on providers and employees when they become aware or suspect potential or actual fraud, waste and abuse?

It is expected when an individual becomes aware of actual or suspected fraud and abuse they will immediately report it to the appropriate entity.

How can an individual report actual or suspected fraud and abuse?

There are several ways:

- Telephone: Fraud Reporting Hotline: 800-FRAUD01 (800-372-8301)
- Internet: Fraud Reporting Web page: www.oregon.gov/DHS/aboutdhs/fraud/
- Fax: Send to 503-373-1525 (ATTN: HOTLINE)
- Reporting to the entity's assigned individual or contact
- Reporting to the Human Resources department of the entity or organization

Can an individual remain anonymous when reporting suspected fraud and abuse?

Yes, both the fraud reporting hotline and the fraud reporting Web page include options to remain anonymous.

Is staff protected from retaliation when reporting suspected fraud and abuse?

Yes, state and federal law protect those who report against retaliation (discharge, demotion, suspension, threats, harassment, or other manner of discrimination) because of the lawful acts of the employee in reporting under the False Claims Act.

State Plan Amendment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX-43
Seattle, Washington 98121

JUN 19 2007

Bruce Goldberg, MD, Director
Department of Human Services
Human Resources Building
500 Summer Street NE
Suite E-15
Salem, Oregon 97301-1097

RE: TN 07-002

Dear Dr. Goldberg:

The Office of Medical Assistance Programs (OMAP) submitted State Plan Transmittal Number 07-002 to the Region 10 office of the Centers for Medicare & Medicaid Services (CMS) for review. This amendment establishes policies and procedures for the education of employees of entities covered by Section 1902(a)(68) of the Social Security Act regarding false claims recoveries.

CMS has completed our review of the amendment. The State Plan Amendment is approved effective January 1, 2007 as requested by the State.

If you have additional questions or require further assistance, please contact Liz Trias at (206) 615-2400 or via email at Elizabeth.Trias@cms.hhs.gov.

Sincerely,

Karen O'Connor
Associate Regional Administrator
Division of Medicaid and Children's Health

CC: James Edge, Acting Administrator, OMAP
Jesse Anderson, State Plan Coordinator
Carole Van-Eck, Title XIX Specialist

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

1. TRANSMITTAL NUMBER: 07-02

2. STATE: Oregon

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Medical Assistance

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2007

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902(a)(68) of the Social Security Act.

7. FEDERAL BUDGET IMPACT:
a. FFY $ -0-
b. FFY $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Pages 79y ,79z and 79z-1 and Attachment 4.42-A, page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT: This transmittal is being submitted to establish policies and procedures for the education of employees of entities covered by Section 1902(a)(68) of the Social Security Act regarding false claims recoveries.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Tim Edgar Bruce Goldberg, MD

14. TITLE: Interim Admin, OMAP Director, DHS

15. DATE SUBMITTED: 3-22-07

16. RETURN TO:
Office of Medical Assistance Programs
Department of Human Services
500 Summer Street NE, 3rd Floor, E35
Salem, OR 97301

ATTN: Carole Van Eck

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MAR 22 2007

18. DATE APPROVED: JUN 19 2007

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 1 2007

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM HCFA-179 (01-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

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 1 902(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 1 902(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 1 902 (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.

(3) 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.

Transmittal #07-02

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

(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 1 902(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 January 1, 2007.

(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.

TN No. 07-02 Approval Date JUN 19 2007 Effective Date January 1, 2007
Supersedes TN No. _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _Oregon_____

Employee Education Regarding False Claims Recovery
Methodology of Compliance Oversight

State will oversee compliance through existing and other methodologies found to comply with requirements of Section 6032 of The Deficit Reduction Act, 2005. Methods include but are not limited to contract and intergovernmental agreement approval and management; systematic quality assurance/quality improvement reviews; provider/entity enrollment procedures; provider/entity education and training; auditing. The State began to disseminate information regarding the requirements for compliance across all affected providers/entities January 9, 2007 and will follow with additional guidance through regular communication and training channels. The State will provide to all affected providers/entities basic information outlining what is necessary for compliance and material that may be used for compliance purposes. The State will continue its use of effective mechanisms available to prevent, detect and report fraud, waste and abuse in federal health care programs.

In CY 2007 affected providers/entities will be identified and provided with the information described above. Thereafter and on an annual basis, the State will obtain information on additional affected providers/entities and follow the process described above. Non MCO contracts and FFS providers/entities will be notified of the obligation to comply with state and federal regulations, contracts or agreements will be amended on the next renewal, and that the Departments oversight and compliance will begin upon receipt of notification or by September 30, 2007 which ever is first. The Department will audit provider/entities for compliance during the audit unit's regular schedule.

Managed Care contracts were amended for the term that began January 1, 2007 in order to require compliance with section 6032 referenced above. The Department reviews the MCO contractors on an annual basis for contract compliance which will also include compliance with this section.

CMS guidance on DRA Section 6032 implementation

State Medicaid Directors Letter (SMDL) 07-003

The first enclosure to this letter ("Frequently Asked Questions") starts on page 24; the second enclosure (federal DOJ description of False Claims Act) starts on page 43.

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

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,

Dennis G. Smith

Dennis G. Smith
Director

Enclosures

cc:

CMS Regional Administrators

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

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

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

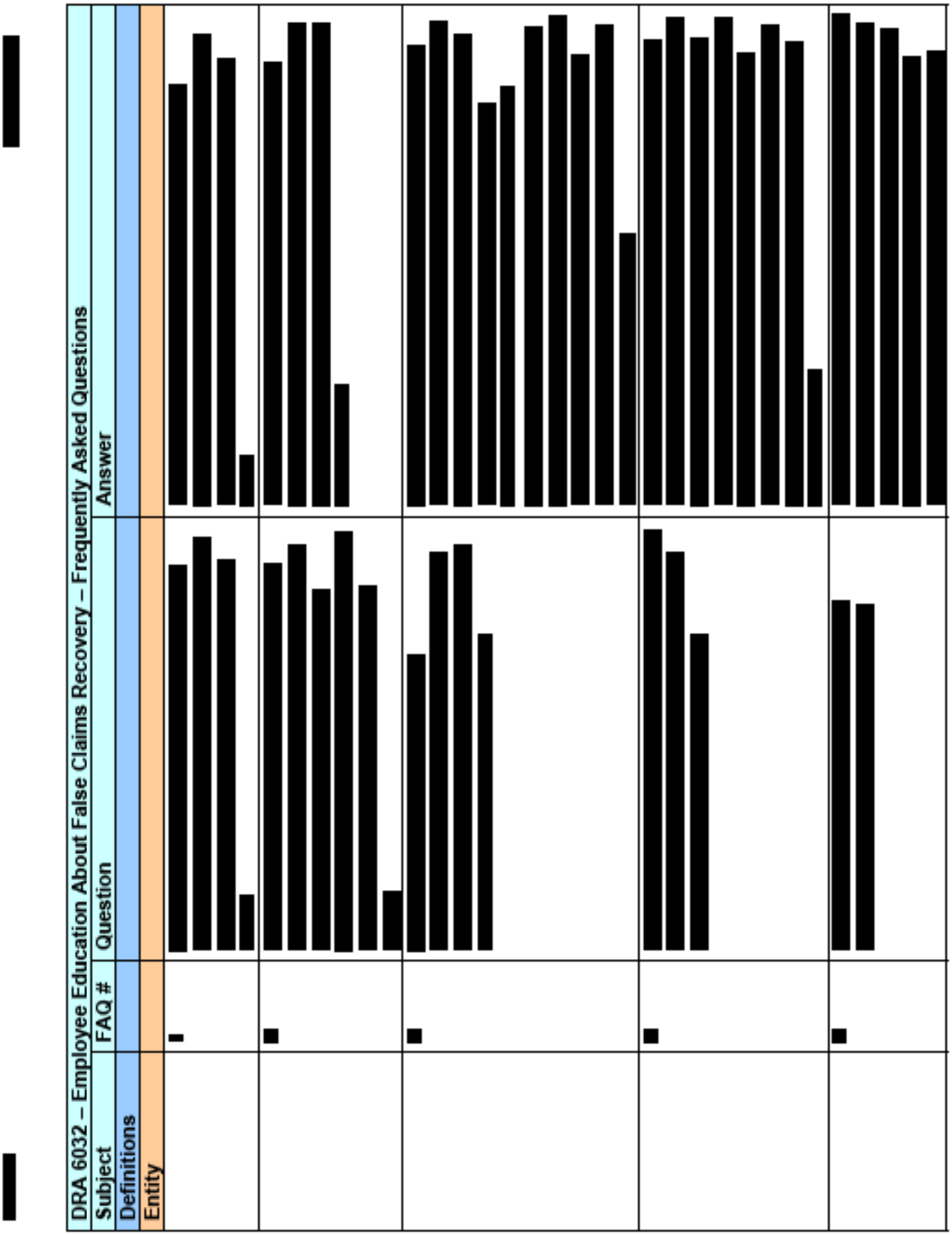
Matt Salo
Director of Health Legislation
National Governors Association

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

Frequently asked questions



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DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
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	[redacted]	[redacted]	[redacted]

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DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
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	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]
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DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
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	[redacted]	[redacted]	[redacted]
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DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
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DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
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			[redacted]
Contractor or Agent			
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	[redacted]	[redacted]	[redacted]
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DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	FAQ #	Question	Answer

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DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
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DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
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Policies and Procedures			
Content			
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Adoption of Policies			
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DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
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Dissemination			
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Employee Handbook			
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[redacted] [redacted]

DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
		[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]
Training			
	[redacted]	[redacted]	[redacted]
Implementation			
Compliance Date			
	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]

[redacted] [redacted]

DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
	[redacted]	[redacted]	[redacted]
Delayed Implementation			
	[redacted]	[redacted]	[redacted]

[redacted] [redacted]

DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

[redacted] [redacted]

DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
Enforcement			
	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]

[redacted] [redacted]

DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
		[redacted]	[redacted]
Penalties			
	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]
State Medicaid Agency Requirements			
State False Claims Act			
	[redacted]	[redacted]	[redacted]

[redacted] [redacted]

DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
		[redacted]	[redacted]
State Plan Amendment			
	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]
Provider Agreements			
	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]
Other			

[redacted] [redacted]

DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
	[redacted]	[redacted]	[redacted]

Additional references

Social Security laws pertaining to DRA Section 6032

Section 1128B – Criminal penalties for acts involving Federal health care programs

[42 U.S.C. 1320a-7b]. The full text of this law is on the Social Security Web site at www.ssa.gov/OP_Home/ssact/title11/1128B.htm

Section 1902(a)(68) – State Plans for Medical Assistance

[42 U.S.C. 1396a]. The full text of this law is on the federal Social Security Web site at www.ssa.gov/OP_Home/ssact/title19/1902.htm.

(a) A State plan for medical assistance must—

****

(68) provide 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—

(A) 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(1128(B)(f));

(B) 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

(C) 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…

Federal False Claims Act

[31 U.S.C. 3729–3731]. The full text of this law is available on the US Code Web site at http://uscode.house.gov/pdf/2005/2005usc31.pdf. The federal Department of Justice provided the following description of the False Claims Act :

> 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,
> >
> > ***
> >
> > 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.

State law pertaining to DRA Section 6032

Oregon Administrative Rule 410-120-1380(1)(c)(B) – Compliance with Federal and State Statutes.

The full text of this rule is in the General Rules administrative rulebook on the OHP Web site at www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html.

> (B) Any Provider entity that receives or makes annual payments under the Title XIX State Plan of at least $5,000,000, as a condition of receiving such payments, shall:
>
> (i) Establish written policies for all employees of the entity (including management), and of any contractor, subcontractor, 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 chapter38 of title 31, United States Code, any Oregon State laws pertaining to civil or criminal penalties for false claims and statements, and whistle-blowing 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));
>
> (ii) Include as part of written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse; and
>
> (iii) Include in any employee handbook for the entity, a specific discussion of the laws described in (i), the rights of the employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.