THE TOPIC:

Section 6033 of the Deficit Reduction Act of 2005 (“DRA”) requires entities that make or receive annual Medicaid payments of $5 million or more (“covered entities”) to provide detailed information in written policies applicable to employees, contractors, and agents about the federal False Claims Act and any state laws that pertain to civil or criminal penalties for making false claims and statements to the Government or its agents. This section of the DRA also requires such entities to provide detailed information about whistleblower protection under such laws, along with the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs. These written policies must also include detailed information about the entity’s policies and procedures for detecting and preventing fraud, waste and abuse. Finally, the DRA requires that each entity’s employee handbook, if the covered entity has one, include a specific discussion of the laws, the right of employees to be protected as whistleblowers, and the entity’s compliance policies. Medicaid providers that are covered entities, including nursing and assisted living facilities and facilities for the mentally retarded and developmentally disabled (MR/DD), must have the policies in place by January 1, 2007.

THIS DISCUSSION AND ACCOMPANYING MATERIALS:

As a guide to its members who participate as Medicaid providers and who are entities (or part of an entity) that meet the annual $5 million payment threshold of the DRA, the American Health Care Association (“AHCA”) Legal Committee has prepared this discussion of the federal False Claims Act and sample policy and employee handbook insert. This information and accompanying materials must be reviewed with the following in mind:

- The Center for Medicare & Medicaid Services (“CMS”) has not formally published guidance to state Medicaid agencies regarding implementation of Section 6033. There are some ambiguities in the statutory provision and CMS may address these uncertainties in program memoranda to the states concerning what will need to be included in revision of their state plans (e.g., whether the term “entity” refers to a single provider facility

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1 Section 6033 of the DRA only requires employee “education” of the laws not “training.” Therefore, while training may be a good idea, and providers doing compliance training likely will want to include some of this information in their annual or periodic training, it is not technically required.
or may include several provider facilities structured under one legal entity). When any guidance is provided by CMS, AHCA will make it available to its members.

- Education related to a state’s Medicaid fraud statute is required. Not all states have enacted Medicaid fraud statutes similar to the federal False Claims Act. Irrespective of the status of each state’s Medicaid fraud statute, the DRA requires employers of covered entities to educate their employees on the provisions of any state law that has criminal or civil sanctions for making false claims to the Government or its agents. These may be included in other laws, such as those involving government contracts or public employers and the like. As a practical matter, the information and materials provided here are not intended to cover each state’s laws that may address criminal or civil sanctions for making false claims. You are encouraged to consult with the Association’s state affiliate organization and its legal counsel, or your personal legal counsel, for information pertaining to the DRA state law component.

- The accompanying materials are not intended to provide legal advice and you should consult your compliance officer or legal counsel for assistance if needed. This is particularly important should you or your employees have any specific concerns as to matters pertaining to fraud, abuse or waste involving your entity. The Association clearly disclaims that in producing these materials, neither it nor its Legal Committee or any individual member of that Committee is engaged in the rendering of legal services.

MODEL POLICY AND HANDBOOK INSERT:

The attached model policy and handbook insert is intended to assist nursing, assisted living and MR/DD providers in complying with the DRA’s policy requirement. Because the DRA requires the policy to provide “detailed” information about the required law, the attachments are somewhat lengthy. The document is being made available as a template in developing a provider’s own policies. Each provider should establish new state specific policies in consultation with its compliance staff, legal counsel, and other appropriate individuals.

DISSEMINATION OF NEW POLICIES:

The DRA requires that the covered entity establish the new policies for all employees of the entity (including management) and all contractors and agents. There is no guidance in the DRA, however, about how the new policy should be disseminated in a facility, other than inclusion in an employee handbook (if one exists).
INCLUSION IN EMPLOYEE HANDBOOK:

The DRA requires that the discussion of federal and state false claims laws and entity’s policies and procedures be included in “any employee handbook for the entity.” Thus, to the extent that a provider has an employee handbook, it will need to prepare an insert (such as the model insert attached to this letter) and include it in the handbook. If the nursing facility does not have an employee handbook already, the DRA does not mandate the creation of one.

EXISTING COMPLIANCE PLANS AND SYSTEMS:

With increasing attention focused on Medicaid enforcement and state and federal false claims laws, each provider may want to review its existing compliance plans and systems to determine its overall effectiveness in preventing and detecting fraud and abuse and to determine the availability and utility of internal reporting mechanisms. A model of a general corporate compliance checklist has been provided for those providers who do not have a formal compliance program and may want to consider developing such a program.

CONTRACTORS AND AGENTS:

The DRA education provisions apply to “any contractor or agent of the entity.” Draft communications from CMS indicates that this will include anyone “which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, the delivery 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.” Each provider will need to consider how it will disseminate the information to its contractors and agents, similar to the model letter which is attached. Also, providers should consider requiring all new or renewing contractors to agree to comply with the DRA requirements as well.

INTENDED AUDIENCE:

AHCA has produced this information and these materials as a guide for those responsible for developing, implementing and overseeing a provider’s compliance with the Education requirements at Section 6033 of the DRA. This information and accompanying materials should be used to educate about the issues concerning the federal False Claims Act and to customize the sample policies and handbook inserts to the unique circumstances of the provider’s needs. Local legal counsel should be utilized in completing the state law component and possibly in the actual education of
your employees. Moreover, CMS guidance could modify the requirements over the next several months, and, thus, providers should be prepared to make changes to their policy from time-to-time.
SUMMARY OF THE FEDERAL FALSE CLAIMS ACT:
(31 USC §3279-3730)

The False Claims Act, 31 U.S.C. §3279 (the "Act") is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare, Medicaid and other government programs. The Act was first enacted to counter Civil War profiteering by military contractors. The Act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

As used in the Act, "knowingly" means that a person:

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

The Act does not require proof that a person specifically intended to defraud the United States government. Instead, health care providers can be prosecuted for conduct that leads to the submission of fraudulent claims. These could include knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished, or otherwise causing a false claim to be submitted.

For purposes of the Act, a "claim" includes any request or demand for money that is submitted to the U.S. government or its contractors. In long-term care, such claims would include those made by both electronic and paper submission to seek payment for nursing care and other ancillary services from the Medicare, Medicaid and other government programs. Anyone who violates the Act is liable for a civil penalty of not less than $5,500 and not more than $11,000 per claim, plus three times the amount of the damages the government sustains. In addition, the government can exclude violators from participating in Medicare, Medicaid, and other government programs in the future. A violator can also be liable to the government for costs associated with any civil action which seeks to recover penalties or damages. There are also criminal consequences under federal law for intentional participation in the submission of a false claim.
The Act also permits employees and other knowledgeable persons to bring suits on behalf of the government as *qui tam* relators. These provisions allow those with evidence of fraud against federal programs or contracts to sue the wrongdoer on behalf of the government. A *qui tam* relator (sometimes called a private attorneys general or whistleblower) is the one who originally brings the information to the court as a plaintiff. In return, the relator may receive a percentage of any recovery or settlement.

If the government believes the case brought by the *qui tam* relator has merit, the government will pursue the matter by investigating and prosecuting the entity and recovering damages under the Act. The *qui tam* relator can be entitled to anywhere between 10% and 25% of the final settlement or judgment. Even if the government decides not to get involved in the case (also known as intervention), the relator can privately pursue the action and, if successful, receive up to 30% of the settlement.

In addition to a financial award, the Act also provides that a *qui tam* relator can obtain additional remedies against his or her employer, if justified, including employment reinstatement, back pay, and any other compensation arising from any retaliation against that person for filing the action under the Act or committing other permissible activities, such as investigating a false claim or providing testimony for, or assistance in, an action under the Act.

**OTHER ISSUES THAT NEED TO BE UNDERSTOOD:**

Every provider who is a covered entity, has a number of obligations. Although ACHA has produced this memo to assist members to comply with the DRA requirements, there are a number of notable aspects to the requirements, beyond the summary of the information that should be understood. Those aspects include:

1. **State Implementation:**

   The DRA requirement is a part of federal law. Notably though, the DRA provision is really a requirement on states through their voluntary participation in the Medicaid program.\(^2\) There remains a question about whether the provisions of the act are “self-executing” (i.e., go into effect without any other action), or if a state would need to pass laws or rules to implement the requirement as they are required to do.

   Unofficial communications from CMS appear to indicate that CMS believes a state must take action to ensure that the requirements are binding on providers in its Medicaid program. CMS likely will advise each Medicaid agency to file a state plan amendment that includes

\(^2\) Soc. Sec. Act §1902(a)(68) states, “A state plan for medical assistance must …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…”
evidence of a state law, regulatory provision, or binding Medicaid policy that places this DRA requirement on affected Medicaid providers. A state likely could also put this requirement in place by including the state Medicaid provider contract to include this requirement.

How the provision is implemented will vary from state to state based upon what is required under state law for laws, rules or state contracts to be amended. Regardless of the mechanism the state uses, it seems clear that CMS intends to hold states accountable for putting these requirements in place for Medicaid providers as of January 1, 2007.

2. Defining an “Entity” Covered by the Requirement:

As discussed above, the DRA requirement covers any “entity” that receives $5 million dollars or more in Medicaid payments, whether received from a single or multiple states. For the purposes of determining whether an entity is covered, CMS will look at whatever Medicaid payments are received and aggregate their amount. Obviously, this results in the broadest possible interpretation of who is covered. Facilities likely will not be able to rely on an argument that “X facility” only received $2 million, if the total Medicaid reimbursement to the “entity” (i.e., the corporation as a whole) is more than the $5 million threshold. CMS is likely not to confirm its accounting of the $5 million amount to a single facility, location of business, or provider number. For the purposes of determining whether the $5 million is met in a given year, CMS has also indicated that an annual cut-off date (for example, December 31) will be established. Any entity meeting the threshold in a previous year would have to comply for the following year.

A provider that routinely accepts and approaches the $5 million threshold should consider implementing the education requirements of the DRA even though it may not technically meet the dollar threshold.

3. Penalties for not complying:

CMS has indicated that it will determine if a state has put the requirement in place through audit or other means. For providers, compliance becomes a de facto condition of Medicaid participation. While there are no specific penalty provisions in Section 6033 of the DRA, failure to comply with the requirements could be enforceable by a state agency withholding Medicaid payments for the time a provider was not in compliance with the requirement. Moreover, if a provider does not implement the education provisions, and is then the subject of some type of false claims investigation, that provider is more likely to face harsher federal enforcement than if it implemented such an education program in good faith.
4. Are Compliance Programs Now Mandatory?

Technically, the DRA provision does not require anything more than the elements from the law outlined above. However, the provisions require informing employees and contractors about the “entity’s policies and procedures for detecting fraud, waste, and abuse.” At least at some basic level, an entity is therefore going to have to develop and put in place such policies and procedures if it does not already have them. Therefore, basic elements of a fraud and abuse compliance plan (e.g., a reporting hotline, internal investigation of reports, etc.) need to be in place for every covered entity.

5. Contractors:

The education provisions of the DRA apply to all employees, including management and officers. They also apply to “any contractor or agent of the entity.” Neither the term “contractor” nor the term “agent” is defined in the DRA. Draft communications from CMS indicate that they will define “contractor or agent” to include “any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, the delivery 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.”

Entities should presume that anyone who is being paid to perform or provide services for it is covered under the new law. While formal education of these entities may not be required, a covered entity will likely need evidence that contractors or agents have been provided the information about the entity’s policies and procedures on fraud and abuse prevention, and that those contractors adopt and agree to adhere to those policies. Covered entities should consider incorporating such language into their contracts as they come up for renewal.

6. Balancing The Approach To Disseminating Information:

Entities will have to balance the details contained in their policies, procedures, educational materials, and employee handbooks against the risk of unjustifiably creating whistleblowers in their ranks. As this may involve the intersection of various conflicting legal provisions, that often differ from state to state, AHCA encourages providers to get legal counsel involved in drafting your policies and in helping you comply with the new requirements.

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3 Similar to what was done with business associate agreements under HIPAA, a covered entity may be able to simply provide information to its contractors and agents and have them “adopt” the policies as ones they agree to follow, rather than bringing in every contractor or agent for specific training as might be done for employees.