PART VI-A. MEDICAL ASSISTANCE
PROGRAMS INTEGRITY LAW
SUBPART A. GENERAL PROVISIONS

§437.1. Short title

This Part may be cited as the "Medical Assistance Programs Integrity Law".
Acts 1997, No. 1373, §1.

§437.2. Legislative intent and purpose

A. This Part is enacted to combat and prevent fraud and abuse committed by some health care providers participating in the medical assistance programs and by other persons and to negate the adverse effects such activities have on fiscal and programmatic integrity.

B. The legislature intends the secretary of the Department of Health and Hospitals, the attorney general, and private citizens of Louisiana to be agents of this state with the ability, authority, and resources to pursue civil monetary penalties, liquidated damages, or other remedies to protect the fiscal and programmatic integrity of the medical assistance programs from health care providers and other persons who engage in fraud, misrepresentation, abuse, or other ill practices, as set forth in this Part, to obtain payments to which these health care providers or persons are not entitled.

Acts 1997, No. 1373, §1.

§437.3. Definitions

As used in this Part the following terms shall have the following meanings:

(1) "Administrative adjudication" means adjudication and the adjudication process contained in the Administrative Procedure Act.

(2) "Agent" means a person who is employed by or has a contractual relationship with a health care provider or who acts on behalf of the health care provider.

(3) "Billing agent" means an agent who performs any or all of the health care provider's billing functions.

(4) "Billing" or "bills" means submitting, or attempting to submit, a claim for goods, services, or supplies.

(5) "Claim" means any request or demand, whether under a contract or otherwise, for money or property, whether or not the state or department has title to the money or property, that is drawn in whole or in part on medical assistance programs funds that are either of the following:

(a) Presented to an officer, employee, or agent of the state or department.

(b) Made to a contractor, grantee, or other recipient, if the money or property is to be spent or used in any manner in any program administered by the department under the authority of federal or state law, rule, or regulation, and if the state or department does either of the following:

(i) Provides or has provided any portion of the money or property requested or demanded.

(ii) Reimburses the contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

A claim may be based on costs or projected costs and includes any entry or omission in a cost report or similar document, book of account, or any other document which supports, or attempts to support, the claim. A claim may be made through electronic means if authorized by the department. Each claim may be treated as a separate claim or several claims may be combined to form one claim.

(6) "Department" means the Department of Health and Hospitals.

(7) "False or fraudulent claim" means a claim which the health care provider or his billing agent submits knowing the claim to be false, fictitious, untrue, or misleading in regard to any material information. "False or fraudulent claim" shall include a claim which is part of a pattern of incorrect submissions in regard to material information or which is otherwise part of a pattern in violation of applicable federal or state law or rule.

(8) "Good, service, or supply" means any good, item, device, supply, or service for which a claim is made, or is attempted to be made, in whole or part.

(9) "Health care provider" means any person furnishing or claiming to furnish a good, service, or supply under the medical assistance programs, any other person defined as a health care provider by federal or state law or by rule, and a provider-in-fact.

(10) "Ineligible recipient" means an individual who is not eligible to receive health care through the medical assistance programs.

(11) "Knowing" or "knowingly" means that the person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information.

(12) "Managing employee" means a person who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of a health care provider. "Managing employee" shall include but is not limited to a chief executive officer, president, general manager, business manager, administrator, or director.

(13) "Material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(14) "Medical assistance programs" means the Medical Assistance Program (Title XIX of the Social Security Act), commonly referred to as "Medicaid", and other programs operated by and funded in the department which provide payment to health care providers.

(15) "Misrepresentation" means the knowing failure to truthfully or fully disclose any and all information required, or the concealment of any and all information required on a claim or a provider agreement or the making of a false or misleading statement to the department relative to the medical assistance programs.

(16) "Obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor, grantee, or licensor-licensee relationship, from a free-based or similar relationship, from statute or regulation, or from the retention of any overpayment.

(17) "Order" means a final order imposed pursuant to an administrative adjudication.

(18) "Ownership interest" means the possession, directly or indirectly, of equity in the capital or the stock, or the right to share in the profits, of a health care provider.

(19) "Payment" means the payment to a health care provider from medical assistance programs funds pursuant to a claim, or the attempt to seek payment for a claim.

(20) "Property" means any and all property, movable and immovable, corporeal and incorporeal.

(21) "Provider agreement" means a document which is required as a condition of enrollment or participation as a health care provider under the medical assistance programs.

(22) "Provider-in-fact" means an agent who directly or indirectly participates in management decisions, has an ownership interest in the health care provider, or other persons defined as a provider-in-fact by federal or state law or by rule.

(23) "Recipient" means an individual who is eligible to receive health care through the medical assistance programs.

(24) "Recoupment" means recovery through the reduction, in whole or in part, of payment to a health care provider.

(25) "Recovery" means the recovery of overpayments, damages, fines, penalties, costs, expenses, restitution, attorney fees, or interest or settlement amounts.

(26) "Rule" means any rule or regulation promulgated by the department in accordance with the Administrative Procedure Act and any federal rule or regulation promulgated by the federal government in accordance with federal law.

(27) "Sanction" shall include but is not limited to any or all of the following:

(a) Recoupment.

(b) Posting of bond, other security, or a combination thereof.

(c) Exclusion as a health care provider.

(d) A monetary penalty.

(28) "Secretary" means the secretary of the Department of Health and Hospitals, or his authorized designee.

(29) "Secretary or attorney general" means that either party is authorized to institute a proceeding or take other authorized action as provided in this Part pursuant to a memorandum of understanding between the two so as to notify the public as to whether the secretary or the attorney general is the deciding or controlling party in the proceeding or other authorized matter.

(30) "Withhold payment" means to reduce or adjust the amount, in whole or in part, to be paid to a health care provider for a pending or future claim during the time of a criminal, civil, or departmental investigation or proceeding or claims review of the health care provider.

Acts 1997, No. 1373, §1; Acts 2011, No. 185, §§1, 3.

§437.4. Claims review and administrative sanctions

A.(1) Pursuant to rules and regulations promulgated in accordance with the Administrative Procedure Act, the secretary shall establish a process to review a claim made by a health care provider to determine if the claim should be or should have been paid as required by federal or state law or by rule.

(2) Claims review may occur prior to or after payment is made to a health care provider.

(3) The secretary may withhold payment to a health care provider during claims review if necessary to protect the fiscal integrity of the medical assistance programs.

B. The secretary may establish various types of administrative sanctions pursuant to rules and regulations promulgated in accordance with the Administrative Procedure Act which may be imposed on a health care provider or other person who violates any provision of this Part or any other applicable federal or state law or rule related to the medical assistance programs.

C.(1) The department shall conduct a hearing in compliance with the Administrative Procedure Act at the request of a person who wishes to contest an administrative sanction imposed on him by the secretary.

(2) A party aggrieved of an order may seek judicial review only in the Nineteenth Judicial District Court for the parish of East Baton Rouge.

(3) Judicial review of the order shall be conducted in compliance with the Administrative Procedure Act.

D. All state rules and regulations issued on or before August 15, 1997, shall be deemed to have been issued in compliance with and under the authority of this Section.

Acts 1997, No. 1373, §1.

§437.5. Settlement

A. The secretary or the attorney general may agree to settle a matter for which recovery may be sought on behalf of the medical assistance programs or for a violation of this Part. The terms of the settlement shall be reduced to writing and signed by the parties to the agreement. The terms of the settlement shall be public record.

B. At a minimum, the settlement shall ensure that the recovery agreed to by the parties covers the estimated loss sustained by the medical assistance programs. The settlement shall include the method and means of payment for recovery, including but not limited to adequate security for the full amount of the settlement.

Acts 1997, No. 1373, §1.

§437.6. Injunctive relief; lis pendens; disclosure of property and liabilities

A.(1) Concurrently with a withholding of payment, a sanction being imposed, or the institution of a criminal, civil, or departmental proceeding against a health care provider or other person, the secretary or the attorney general may bring an action for a temporary restraining order or injunction under Code of Civil Procedure Articles 3601 through 3613 to prevent a health care provider or other person from whom recovery may be sought from transferring property or to protect the business.

(2) To obtain such relief, the secretary or the attorney general shall demonstrate all necessary requirements for the relief to be granted.

(3) If an injunction is granted, the court may appoint a receiver to protect the property and business of the health care provider or other person from whom recovery may be sought. The court shall assess the cost of the receiver to the nonprevailing party.

B. Pursuant to Code of Civil Procedure Articles 3751 through 3753, the secretary or the attorney general may place a notice of pendency of action, lis pendens, on the property of a health care provider or other person during the pendency of a criminal, civil, or departmental proceeding.

C. When requested by the court, the secretary, or the attorney general, a health care provider or other person from whom recovery may be sought shall have an affirmative duty to fully disclose all property and liabilities to the requester.

Acts 1997, No. 1373, §1.

§437.7. Forfeiture of property for payment of recovery

A. In accordance with the provisions of Subsection B of this Section, the court may order the forfeiture of property to satisfy recovery under the following circumstances:

(1) The court may order the health care provider or other person from whom recovery is due to forfeit property which constitutes or was derived directly or indirectly from gross proceeds traceable to the violation which forms the basis for the recovery.

(2) If the secretary or the attorney general shows that property was transferred to a third party to avoid paying of recovery, or in an attempt to protect the property from forfeiture, the court may order the third party to forfeit the transferred property.

B. Prior to the forfeiture of property, a contradictory hearing shall be held during which the secretary or the attorney general shall prove, by clear and convincing evidence, that the property in question is subject to forfeiture pursuant to Subsection A of this Section. No such contradictory hearing shall be required if the owner of the property in question agrees to the forfeiture.

C. If property is transferred to another person within six months prior to the occurrence or after the occurrence of the violation for which recovery is due or within six months prior to or after the institution of a criminal, civil, or departmental investigation or proceeding, it shall be prima facie evidence that the transfer was to avoid paying recovery or was an attempt to protect the property from forfeiture.

D. The health care provider or other person from whom recovery is due shall have an affirmative duty to fully disclose all property and liabilities, and all transfers of property which meet the criteria of Subsection C of this Section, to the court, the secretary and the attorney general.

Acts 1997, No. 1373, §1.

§437.8. Venue

An action instituted pursuant to R.S. 46:437.6 or 437.7 may be brought in any of the following courts:

(1) The Nineteenth Judicial District Court for the parish of East Baton Rouge.

(2) A district court in the parish in which a health care provider or other person from whom recovery may be sought has its principal place of business or is domiciled.

Acts 1997, No. 1373, §1.

§437.9. Privilege; nondischargeability

A. Recovery shall be granted a privilege under state law as to all property owned by the health care provider or other person from whom recovery is due and shall be effective as to third parties only if notice of pendency, lis pendens, is placed on the property , if recorded and reinscribed in accordance with Civil Code Articles 3320 through 3327, or if the conditions of Subsection C of this Section are applicable.

B. As to the property owned by the health provider, the privilege provided in Subsection A of this Section shall rank ahead of any other privilege, mortgage, or secured interest possessed by the health care provider, his agent, or his managing employee except the first mortgage executed upon the property.

C. If property is transferred to a third party to avoid paying of recovery, or in an attempt to protect the property from forfeiture, the privilege provided in Subsection A of this Section shall rank ahead of any other privilege, mortgage, or secured interest on the transferred property obtained or possessed by the person who obtains an ownership interest in the transferred property.

D. Recovery for a violation of R.S. 46:438.2 or R.S. 46:438.3 shall be considered a nondischargeable liability under the provisions of Title 11, U.S.C. Chapters 7, 11, and 13.

Acts 1997, No. 1373, §1.

§437.10. Continuing liability; assumption of liability

A. A health care provider or person from whom recovery is due shall remain liable for the recovery regardless of any sale, merger, consolidation, dissolution, or other disposition of the health care provider or person, provided the obligation is recorded and reinscribed in accordance with Civil Code Articles 3320 through 3337.

B. Any person who obtains an ownership interest, whether by sale, merger, consolidation, or other disposition, in a health care provider or other person from whom recovery is due shall assume the liability and be responsible for paying the amount of any outstanding recovery. Such person shall remain liable, provided the obligation is recorded and reinscribed in accordance with Civil Code Articles 3320 through 3337.

Acts 1997, No. 1373, §1.

§437.11. Provider agreements

A. The department shall make payments from medical assistance programs funds for goods, services, or supplies rendered to recipients to any person who has a provider agreement in effect with the department, who is complying with all federal and state laws and rules pertaining to the medical assistance programs, and who agrees that no person shall be subjected to discrimination under the medical assistance programs because of race, creed, ethnic origin, sex, age, or physical condition.

B. Each provider agreement shall require the health care provider to comply fully with all federal and state laws and rules pertaining to the medical assistance programs, to licensure, if required, and the practice of medicine, osteopathy, surgery, and midwifery. The provider agreement shall require the health care provider to provide goods, services, or supplies only if medically necessary and that are within the scope and quality of standard care.

C. Each provider agreement shall be a voluntary contract between the department and the health care provider in which the health care provider agrees to comply with federal and state laws and rules pertaining to the medical assistance programs when furnishing goods, services, or supplies to a recipient and the department agrees to pay a sum, determined by fee schedule, payment methodology, or other method, for the goods, services, or supplies provided to the recipient. However, a provider agreement shall not be construed to be a contract for the purposes of R.S. 42:1113(D).

D.(1) Unless the provider agreement is terminated by the secretary for cause as provided in Paragraph (2) of this Subsection, a health care provider agreement shall be effective for a stipulated period of time, shall be terminable by either party thirty days after receipt of written notice, and shall be renewable by mutual agreement.

(2) The secretary may terminate a provider agreement immediately and without written notice if a health care provider is the subject of a sanction or of a criminal, civil, or departmental proceeding.

E. Each health care provider who has a provider agreement with the department shall receive at least one provider number but may receive more than one provider number.

Acts 1997, No. 1142, §2.

§437.12. Provider agreement requirements

A. In addition to the requirements specified in R.S. 46:437.11, the provider agreement developed by the department shall require the health care provider to comply with the following:

(1) At the time of signing the provider agreement, have in his possession a valid professional or facility license or certificate pertinent to the goods, services, or supplies being provided, as required by applicable federal and state laws and rules, and maintain such license or certificate in good standing with the department throughout the effective period of the provider agreement.

(2) Maintain medical assistance programs-related records in a systematic and orderly manner that the department requires and determines are relevant to the goods, services, or supplies being provided.

(3) Retain medical assistance programs-related records for a period of five years to satisfy all necessary inquiries by the department.

(4) Safeguard the use and disclosure of information pertaining to current or former recipients and comply with federal and state laws and rules pertaining to confidentiality of patient information.

(5) Permit the department, the attorney general, the federal government, and any authorized agent of each of these entities access to all medical assistance programs-related records pertaining to goods, services, or supplies billed to the medical assistance programs, including access to all patient records and other health care provider information if the health care provider cannot easily separate records for recipients from other records.

(6) Bill other insurers and third parties, including the Medicare program, before billing the medical assistance programs, if after reasonable inquiry it is known that the recipient is eligible for payment for health care or related services from another insurer or person, and comply with all applicable federal and state laws and rules in regard to this billing.

(7) Report and refund any monies received in error or in excess of the amount to which the health care provider is entitled from the medical assistance programs.

(8) Be liable for and indemnify, defend, and hold the department harmless from any cause of action or recovery arising out of the negligence or omission of the health care provider in the course of providing goods, services, or supplies to a recipient or a person believed to be a recipient.

(9) At the option of the department, provide proof of liability insurance and maintain such insurance in effect for any period of time during which goods, services, or supplies are furnished to recipients.

(10)(a) Accept payment from the medical assistance programs as payment in full, and prohibit the health care provider from billing or collecting any additional amount from the recipient or the recipient's responsible party except, and only to the extent the department permits or requires, a co-payment, coinsurance, or a deductible to be paid by the recipient for the goods, services, or supplies provided.

(b) The payment-in-full policy shall not apply to goods, services, or supplies provided to a recipient if the goods, services, or supplies are not covered by the medical assistance programs or the recipient is determined not to be covered by medical assistance programs.

(11) Agree to be subject to claims review.

B. A provider agreement shall provide that, if the health care provider sells or transfers a business interest or practice that substantially constitutes the entity named as the health care

provider in the provider agreement, or sells or transfers a facility that is of substantial importance to the entity named as the health care provider in the provider agreement, the health care provider shall maintain and make available to the department medical assistance programs-related records that relate to the sale or transfer of the business interest, practice, or facility in the same manner as though the sale or transaction had not taken place, unless the health care provider enters into an agreement with the purchaser of the business interest, practice, or facility to fulfill this requirement and provides a copy of this agreement to the department.

C. A provider agreement shall provide that any sale, merger, consolidation, or other disposition of a health care provider shall be subject to any and all outstanding debts and liabilities owed or which may be owed to the medical assistance programs.

D. A provider agreement shall provide that, if the department withholds payment or is entitled to recovery, such withholding or assessment of recovery may be imposed on any and all provider numbers in which the health care provider has an interest or in which he may have an interest.

Acts 1997, No. 1142, §2.

§437.13. Powers and duties of the department

A. The department shall:

(1) Make payment timely at the established rate for goods, services, or supplies furnished to a recipient by the health care provider upon receipt of a properly completed and properly supported claim.

(2) Require certification on the claim form that the goods, services, or supplies have been completely furnished to a recipient eligible to receive the goods, services, or supplies and that, with the exception of those goods, services, or supplies specified by the department, the amount billed does not exceed the health care provider's usual and customary charge for the same goods, services, or supplies.

(3) Not demand repayment from the health care provider in any instance in which the medical assistance programs overpayment is attributable to error of the department in the determination of eligibility of a recipient.

B. The department may:

(1) Adopt, and include in the provider agreement, such other requirements and stipulations on either party as the department finds necessary to properly and efficiently administer the medical assistance programs.

(2)(a) Revoke any provider agreement as the result of a change of ownership in the named health care provider.

(b) Require a health care provider to give the department sixty days written notice before making any change in ownership of the person named in the provider agreement as the health care provider.

(3) Require, as a condition of participating in the medical assistance programs and before entering into the provider agreement, the following:

(a) An on-site inspection of the health care provider's service location by department representatives or other personnel designated by the secretary to assist in this function.

(b) A letter of credit, a surety bond, or a combination thereof, from the health care provider not to exceed fifty thousand dollars. The letter of credit, surety bond, or combination thereof may be required only if either of the following conditions is met:

(i) A letter of credit, surety bond, or any combination thereof is required for each health care provider in that category of health care provider.

(ii) The health care provider is the subject of a sanction or of a criminal, civil, or departmental proceeding.

(c) The submission of information concerning the professional, business, and personal background of the health care provider, any person having an ownership interest in the health care provider, and any agent of the health care provider. Such information shall include:

(i) Proof of holding a valid license or operating certificate, as applicable, if required by federal or state law or by rule or by a local jurisdiction in which the health care provider is located.

(ii) Any prior violation, fine, suspension, termination, or other administrative action taken under federal or state law or rule or the laws or rules of any other state relative to medical assistance programs, Medicare, or a regulatory body.

(iii) Any prior violation of the rules or regulations of any other public or private insurer.

(iv) Full and accurate disclosure of any financial or ownership interest that the health care provider, or a person with an ownership interest in that health care provider, may hold in any other health care provider or health care related entity or any other entity that is licensed by the state to provide health or residential care and treatment to persons.

(v) If a group health care provider, identification of all members of the group and attestation that all members of the group are enrolled in or have applied to enroll in the medical assistance programs.

C. Upon receipt of a completed, signed, and dated application, and after any necessary investigation by the department, which may include the Department of Public Safety and Corrections,

office of state police background checks, the department shall either:

(1) Enroll the applicant as a Medicaid provider.

(2) Deny the application if, based on the grounds listed in R.S. 46:437.14, the secretary determines that it is in the best interest of the medical assistance programs to do so, specifying the reasons for denial.

D. In accordance with the provisions of 42 CFR 433.318(d)(2)(ii), the department is hereby granted the authority to certify that a provider enrolled in the Medical Assistance Program is out of business and that any overpayments made to the provider cannot be collected under state law.

Acts 1997, No. 1142, §2; Acts 2008, No. 139, §1.

§437.14. Grounds for denial or revocation of enrollment

A. The department may deny or revoke enrollment in the medical assistance programs to a health care provider if any of the following are found to be applicable to the health care provider, his agent, a managing employee, or any person having an ownership interest equal to five percent or greater in the health care provider:

(1) Misrepresentation.

(2) Previous or current exclusion, suspension, termination from, or the involuntary withdrawing from participation in, the medical assistance programs, any other state's Medicaid program, Medicare, or any other public or private health or health insurance program.

(3) Conviction under federal or state law of a criminal offense relating to the delivery of any goods, services, or supplies, including the performance of management or administrative services relating to the delivery of the goods, services, or supplies, under the medical assistance programs, any other state's Medicaid program, Medicare, or any other public or private health or health insurance program.

(4) Conviction under federal or state law of a criminal offense relating to the neglect or abuse of a patient in connection with the delivery of any goods, services, or supplies.

(5) Conviction under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(6) Conviction under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

(7) Conviction under federal or state law of a criminal offense punishable by imprisonment of a year or more which involves moral turpitude, or acts against the elderly, children, or infirmed.

(8) Conviction under federal or state law of a criminal offense in connection with the interference or obstruction of any investigation into any criminal offense listed in Paragraphs (3) through (9) of this Subsection.

(9) Sanction pursuant to a violation of federal or state laws or rules relative to the medical assistance programs, any other state's Medicaid program, Medicare, or any other public health care or health insurance program.

(10) Violation of licensing or certification conditions or professional standards relating to the licensure or certification of health care providers or the required quality of goods, services, or supplies provided.

(11) Failure to pay recovery properly assessed or pursuant to an approved repayment schedule under the medical assistance programs.

(12) Failure to meet any condition of enrollment.

B. Before signing a provider agreement and at the discretion of the department, a person may become eligible to receive payment from the medical assistance programs from the time the goods, services, or supplies were furnished, if:

(1) The goods, services, or supplies provided were otherwise compensable.

(2) The person met all other requirements of a health care provider at the time the goods, services, or supplies were provided.

(3) The person agrees to abide by the provisions of the provider agreement to be effective from the date the goods, services, or supplies were provided.

Acts 1997, No. 1142, §2.

SUBPART B. CIVIL CAUSES OF ACTION

§438.1. Civil actions authorized

A. The secretary or the attorney general may institute a civil action in the courts of this state to seek recovery from persons who violate the provisions of this Part.

B. An action to recover costs, expenses, fees, and attorney fees shall be ancillary to, and shall be brought and heard in the same court as, the civil action brought under the provision of Subsection A of this Section.

C.(1) A prevailing defendant may only seek recovery for costs, expenses, fees, and attorney fees if the court finds, following a contradictory hearing, that either of the following apply:

(a) The action was instituted by the secretary or attorney general pursuant to Subsection A of this Section after it should have been determined by the secretary or attorney general to be frivolous, vexatious, or brought primarily for the purpose of harassment.

(b) The secretary or attorney general proceeded with the action instituted pursuant to Subsection A of this Section after it should have been determined by the secretary or attorney general that proceeding would be frivolous, vexatious, or for the purpose of harassment.

(2) Recovery awarded to a prevailing defendant shall be awarded only for those reasonable, necessary, and proper costs, expenses, fees, and attorney fees actually incurred by the prevailing defendant.

D. An action to recover costs, expenses, fees, and attorney fees may be brought no later than sixty days after the rendering of judgment by the district court, unless the district court decision is appealed. If the district court decision is appealed, such action may be brought no later than sixty days after the rendering of the final opinion on appeal by the court of appeal or, if applicable, by the supreme court.

Acts 1997, No. 1373, §1.

§438.2. Illegal remuneration

A. No person shall solicit, receive, offer, or pay any remuneration, including but not limited to kickbacks, bribes, rebates, or bed hold payments, directly or indirectly, overtly or covertly, in cash or in kind, for the following:

(1) In return for referring an individual to a health care provider, or for referring an individual to another person for the purpose of referring an individual to a health care provider, for the furnishing or arranging to furnish any good, supply, or service for which payment may be made, in whole or in part, under the medical assistance programs.

(2) In return for purchasing, leasing, or ordering, or for arranging for or recommending purchasing, leasing, or ordering, any good, supply, or service, or facility for which payment may be made, in whole or in part, under the medical assistance programs.

(3) To a recipient of goods, services, or supplies, or his representative, for which payment may be made, in whole or in part, under the medical assistance programs.

(4) To obtain a recipient list, number, name, or any other identifying information.

B. An action brought pursuant to the provisions of this Section shall be instituted within one year of when the department knew that the prohibited conduct occurred. Such prohibited conduct shall be referred to in this Part as "illegal remuneration".

C. By rules and regulations promulgated in accordance with the Administrative Procedure Act, the secretary may provide for additional "safe harbor" exceptions to which the provisions of this Section shall not apply.

D. The following are "safe harbor" exceptions to which the provisions of this Section shall not apply:

(1) A discount or other reduction in price obtained by a health care provider under the medical assistance programs if the reduction in price is properly disclosed to the department and is reflected in the claim made by the health care provider.

(2) Any amount paid by an employer to an employee, who has a bona fide employment relationship with such employer, for the provision of covered goods, services, or supplies.

(3) Any discount amount paid by a vendor of goods, services, or supplies to a person authorized to act as a purchasing agent for a group of health care providers who are furnishing goods, services, or supplies paid or reimbursed under the medical assistance programs provided the following criteria are met:

(a) The person acting as the purchasing agent has a written contract with each health care provider specifying the amount to be paid to the purchasing agent, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such health care provider under the contract, or a combination of both.

(b) The health care provider discloses the information contained in the required written contract to the secretary in such form or manner as required under rules and regulations promulgated by the secretary in accordance with the Administrative Procedure Act.

(4) Any other "safe harbor" exception created by federal or state law or by rule.

Acts 1997, No. 1373, §1.

§438.3. False or fraudulent claim; misrepresentation

A. No person shall knowingly present or cause to be presented a false or fraudulent claim.

B. No person shall knowingly engage in misrepresentation or make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim.

C. No person shall knowingly make, use, or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the medical assistance programs, or to knowingly conceal, avoid, or decrease an obligation to pay or transmit money or property to the medical assistance programs.

D. No person shall conspire to defraud, or attempt to defraud, the medical assistance programs through misrepresentation or by obtaining, or attempting to obtain, payment for a false or fraudulent claim.

E.(1) No person shall knowingly submit a claim for goods, services, or supplies which were medically unnecessary or which were of substandard quality or quantity.

(2) If a managed care health care provider or a health care provider operating under a voucher system under the medical assistance programs fails to provide medically necessary goods, services, or supplies or goods, services, or supplies which are of substandard quality or quantity to a recipient, and those goods, services, or supplies are covered under the managed care contract or voucher contract with the medical assistance programs, such failure shall constitute a violation of Paragraph (1) of this Subsection.

(3) "Substandard quality" in reference to services applicable to medical care as used in this Subsection shall mean substandard as to the appropriate standard of care as used to determine medical malpractice, including but not limited to the standard of care provided in R.S. 9:2794.

F. Each violation of this Section may be treated as a separate violation or may be combined into one violation at the option of the secretary or the attorney general.

G. No action shall be brought under this Section unless the amount of alleged actual damages is one thousand dollars or more.

H. No action brought pursuant to this Section shall be instituted later than ten years after the date upon which the alleged violation occurred.

Acts 1997, No. 1373, §1; Acts 2007, No. 14, §1, eff. June 18, 2007; Acts 2009, No. 426, §1; Acts 2011, No. 185, §1.

§438.4. Illegal acts regarding eligibility and recipient lists

A. No person shall knowingly make, use, or cause to be made or used a false, fictitious, or misleading statement on any form used for the purpose of certifying or qualifying any person for eligibility for the medical assistance programs or to receive any good, service, or supply under the medical assistance programs which that person is not eligible to receive.

B. No unauthorized person, or no authorized person for an unauthorized purpose, shall obtain a recipient list, number, name, or any other identifying information, nor shall that person use, possess, or distribute such information.

C. An action brought pursuant to the provisions of this Section shall be instituted within one year of when the department knew that the prohibited conduct occurred.

Acts 1997, No. 1373, §1.

§438.5. Civil monetary penalty

A. In a civil action instituted in the courts of this state pursuant to the provisions of this Part, the secretary or the attorney general may seek a civil monetary penalty provided in R.S. 46:438.6(C) from any of the following:

(1) A health care provider or other person sanctioned by order pursuant to an administrative adjudication.

(2) A health care provider or other person determined by a court to have violated any provision of this Part.

(3) A health care provider or other person who has violated a settlement agreement entered into pursuant to this Part.

(4) A health care provider or other person who has been charged with a violation of R.S. 14:70.1, R.S. 14:133, or R.S. 46:114.2.

(5) A health care provider or other person who has been found liable in a civil action filed in federal court pursuant to 18 U.S.C. 1347, et seq., 42 U.S.C. 1359nn(h)(6), or 42 U.S.C. 1320a-7(b).

(6) A health care provider or other person who has pled guilty to, pled nolo contendere to, or has been convicted in federal court of criminal conduct arising out of circumstances which would constitute a violation of this Part.

B.(1) If a health care provider is sanctioned by order pursuant to an administrative adjudication and if judicial review of the order is sought, a civil suit may be filed for imposition and recovery of the civil monetary penalty during the pendency of such judicial review. The reviewing court may consolidate both actions and hear them concurrently.

(2) If judicial review of an order is sought, the secretary or the attorney general shall file the action for recovery of the civil monetary penalty within one year of service on the secretary of the petition seeking judicial review of the order.

(3) If no judicial review of an order is sought, the secretary or the attorney general may file the action for recovery of the civil monetary penalty within one year of the date of the order.

(4) Any action brought under the provisions of this Subsection shall be filed in the Nineteenth Judicial District Court for the parish of East Baton Rouge.

C. In the instance of a state criminal action, the action for recovery of the civil monetary penalty may be brought as part of the criminal action or shall be brought within one year of the date of the criminal conviction or final plea.

D.(1) In the case of a civil judgment rendered in federal court, the action for recovery of the civil monetary penalty may be brought once the judgment becomes enforceable and no later than one year after written notification to the secretary of the enforceable judgment.

(2) In the case of a criminal conviction or plea in federal court, the action under this Section may be brought once the conviction or plea is final and no later than one year after written notification to the secretary of the rendering of the conviction or final plea.

(3) Any action brought under the provisions of this Subsection shall be filed in the Nineteenth Judicial District Court for the parish of East Baton Rouge.

E. If an action is brought pursuant to this Part, the request for the imposition of a civil monetary penalty shall only be considered if made part of the original or amended petition.

Acts 1997, No. 1373, §1.

§438.6. Recovery

A. Actual damages. (1) Actual damages incurred as a result of a violation of the provisions of this Part shall be recovered only once by the medical assistance programs and shall not be waived by the court.

(2) Except as provided by Paragraph (3) of this Subsection, actual damages shall equal the difference between what the medical assistance programs paid, or would have paid, and the amount that should have been paid had not a violation of this Part occurred plus interest at the maximum rate of legal interest provided by R.S. 13:4202 from the date the damage occurred to the date of repayment.

(3) If the violator is a managed care health care provider or a health care provider under a voucher program, actual damages shall be determined in accordance with the violator's provider agreement.

B. Civil fine. (1) Any person who is found to have violated R.S. 46:438.2 shall be subject to a civil fine in an amount not to exceed ten thousand dollars per violation, or an amount equal to three times the value of the illegal remuneration, whichever is greater.

(2) Except as limited by this Section, any person who is found to have violated R.S. 46:438.3 shall be subject to a civil fine in an amount not to exceed three times the amount of actual damages sustained by the medical assistance programs as a result of the violation.

C. Civil monetary penalty. (1) In addition to the actual damages provided in Subsection A of this Section and the civil fine imposed pursuant to Subsection B of this Section, the following civil monetary penalties shall be imposed on the violator:

(a) Not less than five thousand five hundred dollars but not more than eleven thousand dollars for each false or fraudulent claim, misrepresentation, illegal remuneration, or other prohibited act as contained in R.S. 46:438.2, 438.3, or 438.4.

(b) Payment of interest on the amount of the civil fine imposed pursuant to Subsection B of this Section at the maximum rate of legal interest provided by R.S. 13:4202 from the date the damage occurred to the date of repayment.

(2) Prior to the imposition of a civil monetary penalty, the court shall consider if there are extenuating circumstances as provided in R.S. 46:438.7.

(3) The penalties provided in this Subsection shall be adjusted according to the Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. 2461.

D. Costs, expenses, fees, and attorney fees. (1) Any person who is found to have violated this Subpart shall be liable for all costs, expenses, and fees related to investigations and proceedings associated with the violation, including attorney fees.

(2) All awards of costs, expenses, fees, and attorney fees are subject to review by the court using a reasonable, necessary, and proper standard of review.

(3) The secretary or attorney general shall promptly remit awards for those costs, expenses, and fees incurred by the various clerks of court or sheriffs involved in the investigations or proceedings to the appropriate clerk or sheriff.

E. Damages. (1) If recovery is due from a health care provider under the provisions of Subsections A and B of this Section, such recovery shall constitute civil liquidated damages for breach of the conditions and requirements of participation in the medical assistance programs which are and shall be construed by the courts to be remedial, but not retroactive, in nature.

(2) Any award of civil liquidated damages, costs, expenses, and attorney fees shall be in addition to criminal penalties and to the civil monetary penalty provided in Subsection C of this Section.

Acts 1997, No. 1373, §1; Acts 2007, No. 14, §1, eff. June 18, 2007; Acts 2011, No. 185, §1.

§438.7. Reduced damages

If requested by the secretary or the attorney general, the court may reduce to not less than twice the actual damages or any recovery required to be imposed under the provisions of this Subpart if all of the following extenuating circumstances are found to be applicable:

(1) The violator furnished all the information known to him about the specific allegation to the secretary or attorney general no later than thirty days after the violator first obtained the information.

(2) The violator cooperated fully with all federal or state investigations concerning the specific allegation.

(3) At the time the violator furnished the information concerning the specific allegation to the department or the attorney general, no criminal, civil, or departmental investigation or proceeding had been commenced as to the alleged violation.

Acts 1997, No. 1373, §1; Acts 2011, No. 185, §1.

§438.8. Burden of proof; prima facie evidence; standard of review

A. The burden of proof in an action instituted pursuant to this Part shall be on the medical assistance programs and by a preponderance of the evidence, except that the defendant shall carry the burden of proving that goods, services, or supplies were actually provided to an eligible recipient in the quantity and quality submitted on a claim. In all other aspects, the burden of proof shall be as set forth in the Code of Civil Procedure and other applicable laws.

B. Proof by a preponderance of the evidence of a false or fraudulent claim or illegal remuneration shall be deemed to exist under the following circumstances:

(1) If the defendant has pled guilty to, been convicted of, or entered a nolo contendere plea to a criminal charge in any federal or state court to charges arising out of the same circumstances as would be a violation of this Subpart.

(2) If an order has been rendered against a defendant finding the defendant to have violated this Subpart.

C.(1) The submission of a certified or true copy of an order, civil judgment, or criminal conviction or plea shall be prima facie evidence of the same.

(2) The submission of the bill of information or of the indictment and the minutes of the court shall be prima facie evidence as to the circumstances underlying a criminal conviction or plea.

D.(1) In determining whether a pattern of incorrect submissions exists in regard to an alleged false or fraudulent claim, the court shall give consideration as to whether the total amount of the incorrect submissions by a health care provider is material in relation to the total claims submitted by the health care provider.

(2) "Material" as used in this Subsection shall have the same meaning as defined by rules and regulation promulgated by the secretary in accordance with the Administrative Procedure Act which incorporate the same definition of "material" as recognized by the American Institute of Certified Public Accountants.

Acts 1997, No. 1373, §1.

SUBPART C. QUI TAM ACTION

§439.1. Qui tam action, civil action filed by private person

A. A private person may institute a civil action in the courts of this state on behalf of the medical assistance programs and himself to seek recovery for a violation of R.S. 46:438.2, 438.3, or 438.4 pursuant to the provisions of this Subpart. The institutor shall be known as a "qui tam plaintiff" and the civil action shall be known as a "qui tam action".

B. No qui tam action shall be instituted more than six years after the date on which the violation of the Louisiana Medical Assistance Programs Integrity Law is committed or more than three years after the date the facts material to the right of action are known or reasonably should have been known by the official of the state of Louisiana charged with the responsibility to act in the circumstances, but no more than ten years after the date on which the violation is committed, whichever occurs last.

C. The burden of proof in a qui tam action instituted pursuant to this Subpart shall be the same as that set forth in R.S. 46:438.8.

D.(1) The court shall dismiss an action or claim in accordance with this Section, unless opposed by the government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed in any of the following:

(a) A criminal, civil, or administrative hearing in which the government or its agent is a party.

(b) A congressional or government accountability office or other federal report, hearing, audit, or investigation.

(c) The news media, unless the action is brought by the attorney general or the person bringing the action is an original source of the information.

(2) For the purposes of this Subsection, "original source" means an individual who, prior to a public disclosure in accordance with this Subsection, has voluntarily disclosed to the government the information on which allegations or transactions in a claim are based or who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the government before filing an action in accordance with this Subpart.

E. Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if the employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent, or associated others in furtherance of an action in accordance with this Part or other efforts to stop one or more violations of this Part.

(1) Relief in accordance with this Subsection shall include reinstatement with the same seniority status the employee, contractor, or agent would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney fees. An action in accordance with this Section may be brought in the appropriate district court of competent jurisdiction for the relief provided in this Section.

(2) A civil action in accordance with this Section may not be brought more than three years after the date the retaliation occurred.

F. The court shall allow the secretary or the attorney general to intervene and proceed with the qui tam action in the district court at any time during the qui tam action proceedings.

G. Notwithstanding any other law to the contrary, a qui tam complaint and information filed with the secretary or attorney general shall not be subject to discovery or become public record until judicial service of the qui tam action is made on any of the defendants, except that the information contained therein may be given to other governmental entities or their authorized agents for review and investigation. The entities and their authorized agents shall maintain the confidentiality of the

information provided to them under this Subsection.
H, I. Repealed by Acts 2011, No. 185, §2.
Acts 1997, No. 1373, §1; Acts 2009, No. 426, §1; Acts 2011, No. 185, §§1, 2.

§439.2. Qui tam action procedures

A. The following procedures shall be applicable to a qui tam action:

(1) The complaint shall be captioned: "Medical Assistance Programs Ex Rel.: [insert name of qui tam plaintiff(s)] v. [insert name of defendant(s)]". The qui tam complaint shall be filed with the appropriate state or federal district court.

(2) A copy of the qui tam complaint and written disclosure of substantially all material evidence and information each qui tam plaintiff possesses shall be served upon the secretary or the attorney general in accordance with the applicable rules of civil procedure.

(3) When a person brings an action in accordance with this Subpart, no person other than the secretary or attorney general may intervene or bring a related action based on the same facts underlying the pending action.

(4)(a) The complaint and information filed with the court shall be made under seal, shall remain under seal for at least ninety days from the date of filing, and shall be served on the defendant when the seal is removed.

(b) For good cause shown, the secretary or the attorney general may move the court for extensions of time during which the petition remains under seal. Any such motions may be supported by affidavits or other submissions in camera and under seal.

B.(1) If the secretary or the attorney general elects to intervene in the action, the secretary or the attorney general shall not be bound by any act of a qui tam plaintiff. The secretary or the attorney general shall control the qui tam action proceedings on behalf of the state and the qui tam plaintiff may continue as a party to the action. For prescription purposes, any government complaint in intervention, whether filed separately or as an amendment to the relator's complaint, shall relate back to the filing date of the complaint, to the extent that the claim of the government arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the relator's complaint.

(2) The qui tam plaintiff and his counsel shall cooperate fully with the secretary or the attorney during the pendency of the qui tam action.

(3) If requested by the secretary or the attorney general and notwithstanding the objection of the qui tam plaintiff, the court may dismiss the qui tam action provided the qui tam plaintiff has been notified by the secretary or the attorney general of the filing of the motion to dismiss and the court has provided the qui tam plaintiff a contradictory hearing on the motion.

(4)(a) If the secretary or the attorney general does not intervene, the qui tam plaintiff may proceed with the qui tam action unless the secretary or the attorney general shows that proceeding would adversely affect the prosecution of any pending criminal actions or criminal investigations into the activities of the defendant. Such a showing shall be made to the court in camera and neither the qui tam plaintiff or the defendant shall be informed of the information revealed in camera. In which case, the qui tam action shall be stayed for no more than one year.

(b) When a qui tam plaintiff proceeds with the action, the court, without limiting the status and rights of the qui tam plaintiff, may nevertheless permit the secretary or the attorney general to intervene at a later date upon a showing of good cause.

(5) If the qui tam plaintiff objects to a settlement of the qui tam action proposed by the secretary or the attorney general, the court may authorize the settlement only after a hearing to determine whether the proposed settlement is fair, adequate, and reasonable under the circumstances.

C. Repealed by Acts 2011, No. 185, §2.

D. A defendant shall have thirty days from the time a qui tam complaint is served on him to file a responsive pleading.

E. The qui tam plaintiff and the defendant shall serve all pleadings and papers filed, as well as discovery, in the qui tam action on the secretary and the attorney general.

F.(1) Whether or not the secretary or the attorney general proceeds with the action, upon

showing by the secretary or the attorney general that certain actions of discovery by the qui tam plaintiff or defendant would interfere with a criminal, civil, or departmental investigation or proceeding arising out of the same facts, the court shall stay the discovery for a period of not more than ninety days.

(2) Upon a further showing that federal or state authorities have pursued the criminal, civil, or departmental investigation or proceeding with reasonable diligence and any proposed discovery in the qui tam action would unduly interfere with the criminal, civil, or departmental investigation or proceeding, the court may stay the discovery for an additional period, not to exceed one year.

(3) Such showings shall be conducted in camera and neither the defendant nor the qui tam plaintiff shall be informed of the information presented to the court.

(4) If discovery is stayed pursuant to this Subsection, the trial and any motion for summary judgment in the qui tam action shall likewise be stayed.

Acts 1997, No. 1373, §1; Acts 2007, No. 14, §1, eff. June 18, 2007; Acts 2009, No. 426, §1; Acts 2011, No. 185, §§1, 2.

§439.3. Qui tam action procedures; alternative remedies

Notwithstanding any other provision of this Subpart, the secretary or the attorney general may elect to pursue an administrative or civil action against a qui tam defendant through any alternative remedy available to the secretary or the attorney general. If an alternate remedy is pursued in another proceeding, the person initiating the action shall have the same rights he would have had if the action had continued in accordance with this Subpart. Any finding of fact or conclusion of law made in the other proceeding that has become final shall be conclusive on all parties to an action in accordance with this Subpart. A finding or conclusion is final if it has been finally determined on appeal, if all delays for the filing of an appeal regarding the finding or conclusion have expired, or if the finding or conclusion is not subject to judicial review.

Acts 1997, No. 1373, §1; Acts 2009, No. 426, §1.

§439.4. Recovery awarded to a qui tam plaintiff

A.(1) Except as provided by Subsection D of this Section and Paragraph (3) of this Subsection, if the secretary or the attorney general intervenes in the action brought by a qui tam plaintiff, the qui tam plaintiff shall receive at least fifteen percent, but not more than twenty-five percent, of recovery.

(2) In making a determination of award to the qui tam plaintiff, the court shall consider the extent to which the qui tam plaintiff substantially contributed to the prosecution of the action.

(3) If the court finds the allegations in the qui tam action to be based primarily on disclosures of specific information, other than information provided by the qui tam plaintiff, relating to allegations or transactions in criminal, civil, or administrative hearings, or from the news media, the court may award such sum it considers appropriate, but in no case may the court award more than ten percent of the proceeds, considering the significance of the information and the role of the person bringing the action in advancing the case to litigation. Any payment to a person in accordance with this Subsection shall be made from the proceeds recovered.

B. Except as provided by Subsection D of this Section, if the secretary or the attorney general does not intervene in the qui tam action, the qui tam plaintiff shall receive an amount, not less than twenty-five but not more than thirty percent of recovery, which the court decides is reasonable for the qui tam plaintiff pursuing the action to judgment or settlement.

C.(1) In addition to all other recovery to which he is entitled and if he prevails in the qui tam action through litigation or settlement, the qui tam plaintiff shall be entitled to an award against the defendant for costs, expenses, fees, and attorney fees, subject to review by the court using a reasonable, necessary, and proper standard of review.

(2) If the secretary or the attorney general does not intervene and the qui tam plaintiff conducts the action, the court shall award costs, expenses, fees, and attorney fees to a prevailing defendant if the court finds that the allegations made by the qui tam plaintiff were meritless or brought primarily for the purposes of harassment. A finding by the court that qui tam allegations were meritless or brought primarily for the purposes of harassment may be used by the prevailing defendant in the qui tam action or any other civil proceeding to recover losses or damages sustained as a result of the qui tam plaintiff filing and pursuing such a qui tam action.

D. Whether or not the secretary or the attorney general intervenes, if the court finds that the action was brought by a person who planned and initiated the violation which is the subject of the action, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action which the qui tam plaintiff would otherwise receive under Subsection A or B of this Section, taking into account the role the qui tam plaintiff played in advancing the case to judgment or settlement and any relevant circumstances pertaining to the qui tam plaintiff's participation in the violation.

E. When more than one party serves as a qui tam plaintiff, the share of recovery each receives shall be determined by the court. In no case, however, shall the total award to multiple qui tam plaintiffs be greater than the total award allowed to a single qui tam plaintiff under Subsection A or B of this Section.

F. In no instance shall the secretary, the medical assistance programs, the attorney general, or the state be liable for any costs, expenses, fees, or attorney fees incurred by the qui tam plaintiff or for any award entered against the qui tam plaintiff.

G. The percentage of the share awarded to or settled for by the qui tam plaintiff shall be determined using the total amount of the award or settlement.

Acts 1997, No. 1373, §1; Acts 2007, No. 14, §1, eff. June 18, 2007; Acts 2009, No. 426, §1; Acts 2011, No. 185, §1.

SUBPART D. FRAUD AND ABUSE DETECTION AND PREVENTION

§440.1. Medical Assistance Programs Fraud Detection Fund

A. The Medical Assistance Programs Fraud Detection Fund, hereafter referred to as the "fund", is created in the state treasury as a special fund. The monies in the fund shall be invested by the state treasurer in the same manner as monies in the state general fund and interest earned on the investment of monies in the fund shall be credited to the fund. All unexpended and unencumbered monies in the fund at the end of each fiscal year shall remain in the fund.

B. After compliance with the requirements of Article VII, Section 9(B) of the Constitution of Louisiana relative to the Bond Security and Redemption Fund, and prior to monies being placed in the state general fund, all monies received by the state pursuant to a civil award granted or settlement under the provisions of this Part, except for the amount to make the medical assistance programs whole, shall be deposited into the fund.

C. Fifty percent of the monies collected and deposited into the fund shall be allocated to the Medicaid Fraud Control Unit within the office of the attorney general.

D. Fifty percent of the monies collected and deposited into the fund shall be allocated to the Department of Health and Hospitals to be used solely for Medicaid fraud detection and for the purposes specified in Subsection E of this Section.

E. The monies in the fund shall not be used to replace, displace, or supplant state general funds appropriated for the daily operation of the department or the medical assistance programs and may be appropriated by the legislature for the following purposes only:

(1) To pay costs or expenses incurred by the department or the attorney general relative to an action instituted pursuant to this Part.

(2) To enhance fraud and abuse detection and prevention activities related to the medical assistance programs.

(3) To pay rewards for information concerning fraud and abuse as provided in Subpart B of this Part.

(4) To provide a source of revenue for the Medical Assistance Program in the event of a change in federal policy which results in an increase in state participation or a shortfall in state general fund due to a decrease in the official forecast, as defined in R.S. 39:2(30), during a fiscal year.

Acts 1997, No. 1373, §1; Acts 2008, No. 712, §1, eff. July 1, 2009.

§440.2. Rewards for fraud and abuse information

A. The secretary may provide a reward of up to two thousand dollars to an individual who submits information to the secretary which results in recovery pursuant to the provisions of this Part, provided such individual is not himself subject to recovery under this Part.

B. The secretary shall grant rewards only to the extent monies are appropriated for this purpose from the Medical Assistance Programs Fraud Detection Fund. The secretary shall determine the amount of a reward, not to exceed two thousand dollars per individual per action, and establish a process to grant the reward in accordance with rules and regulations promulgated in accordance with the Administrative Procedure Act.

Acts 1997, No. 1373, §1.

§440.3. Whistleblower protection and cause of action

A. No employee shall be discharged, demoted, suspended, threatened, harassed, or discriminated against in any manner in the terms and conditions of his employment because of any lawful act engaged in by the employee or on behalf of the employee in furtherance of any action taken pursuant to this Part in regard to a health care provider or other person from whom recovery is or could be sought. Such an employee may seek any and all relief for his injury to which he is entitled under state or federal law.

B. No individual shall be threatened, harassed, or discriminated against in any manner by a health care provider or other person because of any lawful act engaged in by the individual or on behalf of the individual in furtherance of any action taken pursuant to this Part in regard to a health care provider or other person from whom recovery is or could be sought except that a health care provider may arrange for a recipient to receive goods, services, or supplies from another health care provider if the recipient agrees and the arrangement is approved by the secretary. Such an individual may seek any and all relief for his injury to which he is entitled under state or federal law.

C.(1) An employee of a private entity may bring his action for relief against his employer or the health care provider in the same court as the action or actions were brought pursuant to this Part or as part of an action brought pursuant to this Part.

(2) A person aggrieved of a violation of Subsection A or B of this Section shall be entitled to exemplary damages.

D. A qui tam plaintiff shall not be entitled to recovery pursuant to this Section if the court finds that the qui tam plaintiff instituted or proceeded with an action that was frivolous, vexatious, or harassing.

Acts 1997, No. 1373, §1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: LOUISIANA

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

4.42 Employee Education About False Claims Recoveries.

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

(1) Definitions.

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

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

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

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

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

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

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

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

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

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

(5) The State will implement this State Plan amendment on 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.

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ATTACHMENT 4.42-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Louisiana
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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 reassess compliance on an ongoing basis

1. By July 1, 2007 the following language will be added to the PE-50 Addendum:

   "The Deficit Reduction Act of 2005, Section 6032 Implementation. As a condition of payment for goods, services and supplies provided to recipients of the Medicaid Program, providers and entities must comply with the False Claims Act employee training and policy requirements in 1902(a)(68) of the Social Security Act, set forth in that subsection and as the Secretary of US Department of Health and Human Services may specify. As an enrolled provider/entity, it is your obligation to inform all of your employees and affiliates of the provisions of the Federal False Claims Act, and any Louisiana laws and/or rules pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws and/or rules. When monitored or audited, you will be required to show evidence of compliance with this requirement.

   All new providers that enroll in the Louisiana Medicaid Program after July 1, 2007, must sign the PE-50 which will contain the above language.

   By July 1, 2007, the above message will be posted on the Louisiana Medicaid Provider website (www.lamedicaid.com). By September, 2007, four weekly provider remittance advice messages will contain the above notice. This language will also be placed in the July/August 2007 Provider Update.

   As part of these messages and notices, providers/entities will be informed that monitoring for this requirement will begin November 1, 2007.

2. By November 1, 2007, enrolled Medicaid providers will be monitored for compliance through already established monitoring/auditing processes, i.e. desk audits, on-site monitoring, and/or random sampling. At the time of monitoring/auditing, the Medicaid State Agency will determine if the provider/entity is obligated to comply with the requirements of the Act. If the provider/entity meets the requirements of the Act, the provider/entity must demonstrate that it has met its responsibility regarding Employee Education About False Claims Recoveries, and any Louisiana laws and/or rules pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws and/or rules. If the provider/entity fails to demonstrate compliance at time of monitoring/auditing, the provider/entity will be given a specific time period in which to demonstrate compliance. Failure to demonstrate compliance, after written notice of noncompliance, will subject the provider/entity to sanctions.

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

SMDL #06-024

December 13, 2006

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 or claudia.simonson@cms.hhs.gov.

Sincerely,

/s/

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

March 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,

/s/

Dennis G. Smith
Director

Enclosures

cc:

CMS Regional Administrators

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

Martha Roherty
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DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
Definitions			
Entity			
	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

DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
			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.
	6	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?	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. 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.
	7	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?	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.

DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
	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.
$5M			
	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

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

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

DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
			considered for purposes of determining whether an individual or organization must comply with section 6032.
Contractor or Agent			
	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.

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

DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
	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.
Policies and Procedures			
Content			
	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".
Adoption of Policies			
	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

DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
			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.
Dissemination			
	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.
Employee Handbook			
	44	If there is an employee handbook that exists,	If there is an employee handbook, the policies and

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

DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
	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)?	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. 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. 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.
Delayed Implementation			
	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?	If a State determines it needs legislation to comply with section 6032, it must submit a written request for approval of delayed implementation to: Leslie V. Norwalk, Acting Administrator Department of Health & Human Services Centers for Medicare & Medicaid Services 200 Independence Avenue, SW Mail Stop 314G Washington, DC 20201 with copies to: Dennis G. Smith, Director Center for Medicaid & State Operations

DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
			Centers for Medicare & Medicaid Services 7500 Security Blvd. Mail Stop S2-26-12 Baltimore, MD 21244 and: Claudia Simonson Centers for Medicare & Medicaid Services Medicaid Integrity Group 233 North Michigan Avenue, Suite 600 Chicago, IL 60601 The request must demonstrate that the State needs legislative authority to require entities to meet the employee education requirement. 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.
	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.

DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions			
Subject	**FAQ #**	**Question**	**Answer**
Enforcement			
	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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		subsequent State Plan Amendment imposes additional requirements, will entities be required to reissue their policies?	required to reissue its policies.
Penalties			
	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.
State Medicaid Agency Requirements			
State False Claims Act			
	65	If a State does not have a false claims act,	Yes. DRA section 6032 applies to States regardless

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		does section 6032 apply?	of whether the States have false claims acts.
State Plan Amendment			
	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.
Provider Agreements			
	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.
Other			

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	71	Where can I access the CMS guidance on section 6032?	On December 13, 2006, CMS issued the State Medicaid Director Letter (SMDL #06-025). It can be found on the CMS website at: http://www.cms.hhs.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1190449&intNumPerPage=10