

# Key compliance and regulatory requirements for providers

### Federal and state false claims acts

- [Summary of Federal False Claims Act and Federal Program Fraud Civil Remedies Act Provisions](#)
- [Summary of Massachusetts False Claims Act Provision](#)

### Excluded entities

### MassHealth and federally required disclosures

FEDERAL AND STATE FALSE CLAIMS ACTS

**Policy**

<p><b>Purpose:</b></p>	<p>This Policy sets forth the manner in which FCHP complies with the requirements of the Deficit Reduction Act of 2005 ("DRA"), provides an overview of the federal and the Commonwealth of Massachusetts false claims acts, the federal Program Fraud Civil Remedies Act of 1986 and FCHP's internal mechanisms to help prevent and detect fraud, waste and abuse in the federal and Massachusetts health care programs.</p> <p>Under the DRA, any entity who receives or makes annual Medicaid payments of more than \$5 million is required to provide information to its employees, contractors and agents about the federal and applicable state false claims acts, the rights of employees to be protected as whistleblowers, and the organization's policies and procedures for detecting and preventing fraud, waste and abuse. This Policy covers both FCHP's PACE Program and FCHP's Medicaid managed care program, which are subject to these DRA requirements.</p>
<p><b>Policy:</b></p>	<p>FCHP is committed to complying with all applicable laws, including, but not limited to, the federal and Commonwealth of Massachusetts false claims acts and the federal Program Fraud Civil Remedies Act of 1986 described in this Policy and Attachments 1 and 2.</p>
<p><b>Compliance Checklist:</b></p>	<p>DRA, P.L. 109-171, § 6031 (Feb. 8, 2006); federal False Claims Act, 31 U.S.C. § 3729 <i>et seq.</i>; federal Program Fraud Civil Remedies Act, 31 U.S.C. § 3801 <i>et seq.</i>; Massachusetts False Claims Act, M.G.L. c. 12, §§ 5B-5O.</p>
<p><b>Application:</b></p>	<p>All FCHP Employees, Contractors and Agents</p>
<p><b>Approvals:</b></p>	<p>Approved by:</p> <p>Signed: _____ Date: _____          Anne Doyle, Senior Vice President and Chief Compliance Officer,          FCHP</p> <p>Signed: _____ Date: _____          Eric H. Schultz, President, FCHP</p> <p>Effective Date: June 1, 2007          Revision Date(s):          Review Date(s):</p>

## Overview

This Policy summarizes the procedures and mechanisms FCHP has implemented to comply with the DRA and to prevent violations of the federal False Claims Act, 31 U.S.C. § 3729 et seq., and the federal Program Fraud Civil Remedies Act of 1986, 31 U.S.C. § 3801 et seq., federal laws designed to prevent fraud, waste and abuse, which are summarized in [Attachment 1](#), and the Commonwealth of Massachusetts False Claims Act, M.G.L. c. 12, §§5B-5O, a state law designed in a similar manner as the federal False Claims Act, which is summarized in [Attachment 2](#).

## Definitions

1. "Employee" includes an officer or employee of FCHP.
2. 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 FCHP.
3. A "Relator" is an individual who files an action under the federal False Claims Act or a state false claims act (including the Massachusetts False Claims Act) on behalf of the government and him or herself based on knowledge of wrongdoing, and, in return, he or she is entitled to a percentage of any damages awarded to the federal or state government.
4. "Knowingly" means that a person (1) has actual knowledge of the false claim; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information.

## Procedures

### Accurate Billing

FCHP is committed to ensuring accurate billing and coding of all services. Physicians, healthcare facilities and all health care providers and subcontracted providers that are contracted with FCHP who participate in FCHP's Medicaid HMO or Summit ElderCare PACE program are expected to submit claims appropriately and to bill as required by FCHP, all applicable statutes, regulations and program instructions and consistent with industry standards for services rendered.

FCHP and its Employees, Contractors and Agents shall not knowingly make or submit any false or misleading entries or statements on any bills, claim forms or other requests for

reimbursement. No FCHP Employee, Contractor or Agent shall engage or participate in such an arrangement at the direction of another person, including any supervisor or manager, that results in such prohibited acts.

### **Reporting Non-Compliance**

If a FCHP Employee, Contractor or Agent has any reason to believe that anyone is engaging in practices that could lead to a false or misleading request for reimbursement, that individual shall immediately report the practice to his/her supervisor or manager, the Corporate Compliance Officer, any member of the Corporate Compliance department, or the Compliance Hotline in accordance with FCHP's Compliance Program. The Compliance Hotline telephone number is 888-203-5285.

If an Employee, Contractor or Agent does not believe that FCHP responds appropriately when given notification of a potential violation, that individual may have rights as a Relator under the federal and state false claims acts, as described in more detail in Attachment 1 and Attachment 2.

### **Internal Reporting Mechanisms**

To assist in its efforts to detect and prevent fraud, waste and abuse, FCHP has a compliance program that includes the following internal reporting mechanisms: open door policy and anonymous hotline.

### **Auditing & Monitoring Procedures**

FCHP conducts regular and periodic audit and monitoring procedures as determined by FCHP's Internal Audit department to ensure that compliant procedures are being followed and to ensure that if such procedures were not followed, proper steps are taken.

### **Non-Retaliation**

As described in FCHP's Corporate Compliance Policy Reporting of Potential Issues or Areas of Noncompliance, it is FCHP's policy to protect its Employees from retaliation of any kind for, among other things, reporting in good faith any concerns regarding fraud, waste and abuse. Retaliation against such Employees will result in disciplinary action.

### **Contractors and Agents**

FCHP shall provide a copy of this Policy to its Contractors and Agents, as defined above.

### **Questions**

If you have any questions regarding this policy, please contact the FCHP Compliance Department at ext. 69414.

**Attachment 1: Summary of Federal False Claims Act and Federal Program Fraud Civil Remedies Act Provisions**

**I. FEDERAL FALSE CLAIMS ACT**

**A. Overview**

The federal False Claims Act is one of the laws the Government uses to prevent and detect fraud, waste and abuse in federal health care programs. The federal False Claims Act provides that anyone who “knowingly” submits false claims to the Government is liable for damages up to three times the amount of the erroneous payment, mandatory penalties between \$5,500 and \$11,000 for each false claim submitted, and potential administrative remedies, such as exclusion from future participation in government health care programs.

The federal False Claims Act defines “knowingly” to mean that a person (1) has actual knowledge of the false claim; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information.

Specifically, there are seven (7) actions that may form the basis for liability under the federal False Claims Act including, by way of example:

- Knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval by the federal Government;
- Knowingly making or using, or causing to be made or used, a false record or statement to get a false claim paid or approved;
- Conspiring to defraud the Government by getting a false or fraudulent claim allowed or paid; or
- Knowingly making, using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the Government.

**B. Applicability**

Among other things, the federal False Claims Act applies to claims submitted for payment by federal health care programs, including Medicare and Medicaid.

**C. Methods of Enforcement/Whistleblower Provisions**

The Government or a Whistleblower/Relator can bring actions under the Federal False Claims Act. If a Relator brings an action under the Federal False

Claims Act, the Government has a period of time to investigate the allegations and decide whether to join the lawsuit. If the Government elects to join the lawsuit, the Relator is entitled to 15-25% of any recovery. If the Government declines to join the lawsuit, the Relator may still proceed with the action and is entitled to 25-30% of any recovery.

**D. Employee Protection**

The federal False Claims Act prohibits discrimination by FCHP against an employee for taking lawful actions in furtherance of an action under the Federal False Claims Act. Under the Federal False Claims Act, any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the federal False Claims Act is entitled to all relief necessary to make the employee whole. Such relief may include reinstatement, double back pay, and compensation for any special damages, including litigation costs and reasonable attorneys' fees.

**E. Procedural & Other Requirements**

The federal False Claims Act contains a number of procedural and other requirements. For example, in order to be a Relator, the person must be the "original source" of the information reported to the government. Specifically, the Relator must have direct and independent knowledge of the false claims activities and voluntarily provide this information to the government. If the matter disclosed is already the subject of a federal investigation, or if the health care provider or supplier has previously disclosed the problem to a federal agency, the Relator may be barred from obtaining recovery under the Federal False Claims Act.

**II. FEDERAL PROGRAM FRAUD CIVIL REMEDIES ACT OF 1986**

**A. Overview.**

The Program Fraud Civil Remedies Act of 1986, 31 U.S.C. § 3801 et seq. is similar to the Federal False Claims Act, establishing an administrative remedy against any person who present or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious or fraudulent to certain Federal agencies, including the Department of Health and Human Services ("DHHS"), which includes Medicare and Medicaid claims.

Similar to the Federal False Claims Act, a person who "knows or has reason to know" is defined as one who (1) has actual knowledge of the information; (2)

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## FEDERAL AND STATE FALSE CLAIMS ACTS

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acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information.

### **B. Applicability**

The Federal Program Fraud Civil Remedies Act applies to claims submitted to certain Federal agencies, including DHHS, which would include Medicare and Medicaid claims.

### **C. Penalties**

A violation of the Federal Program Fraud Civil Remedies Act can result in a civil monetary penalty of up to \$5,500 per false claim and an assessment of twice the amount of the false claim. The penalty can be imposed through an administrative hearing after investigation by DHHS and approval by the U.S. Attorney General.

## Attachment 2: Summary of Massachusetts False Claims Act Provisions

### A. Overview

The Massachusetts False Claims Act ("Massachusetts FCA") defines, "knowing and knowingly," as "possessing actual knowledge of relevant information, acting with deliberate ignorance of the truth or falsity of the information or acting in reckless disregard of the truth or falsity of the information and no proof of specific intent to defraud is required." M.G.L. c. 12, § 5A.

The Massachusetts FCA provides for liability when a person:

1. Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
2. Knowingly makes, uses, or causes to be made or used, a false record or statement to obtain payment or approval of a claim by the commonwealth or any political subdivision thereof;
3. Conspires to defraud the commonwealth or any political subdivision thereof through the allowance or payment of a fraudulent claim;
4. Has possession, custody, or control of property or money used, or to be used, by the commonwealth or any political subdivision thereof and knowingly delivers, or causes to be delivered to the commonwealth, less property than the amount for which the person receives a certificate or receipt with the intent to willfully conceal the property;
5. Is authorized to make or deliver a document certifying receipt of property used, or to be used, by the commonwealth or any political subdivision thereof and with the intent of defrauding the commonwealth or any political subdivision thereof, makes or delivers the receipt without completely knowing that the information on the receipt is true;
6. Buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the commonwealth or any political subdivision thereof, knowing that said officer or employee may not lawfully sell or pledge the property;
7. Enters into an agreement, contract or understanding with one or more officials of the commonwealth or any political subdivision thereof knowing the information contained therein is false;

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8. Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or to transmit money or property to the commonwealth or political subdivision thereof; or
9. Is a beneficiary of an inadvertent submission of a false claim to the commonwealth or political subdivision thereof, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the commonwealth or political subdivision within a reasonable time after discovery of the false claim...

M.G.L. c. 12, § 5B.

A person who violates the Massachusetts FCA is liable for a civil penalty of not less than \$5,000 and not more than \$10,000 per violation. M.G.L. c. 12, § 5B(10). The Massachusetts FCA provides for treble damages, including consequential damages, that the Commonwealth or political subdivision sustains because of the act of that person. M.G.L. c. 12, § 5B(9).

### *Voluntary Disclosure*

However, damages may be reduced to the amount of damages sustained where the court finds that the person committing the Massachusetts FCA violation:

- Informed the attorney general with all information known to the person within 30 days after discovering the information;
- Fully cooperated with any commonwealth investigation of such violation; and
- No criminal prosecution, civil or administrative action had commenced with respect to the violation, and person did not have actual knowledge of an investigation into such violation.

M.G.L. c. 12, § 5B(10).

### **B. Applicability**

The Massachusetts FCA defines "Claim," as "any request or demand, whether pursuant to a contract or otherwise, for money or property which is made to an officer, employee, agent or other representative of the commonwealth, political subdivision thereof or to a contractor, subcontractor, grantee, or other person if the commonwealth or any political subdivision thereof provides any portion of the money or property which is requested or demanded, or if the commonwealth or any political subdivision thereof will reimburse directly or indirectly such

contractor, subcontractor, grantee, or other person for any portion of the money or property which is requested or demanded." M.G.L. c. 12, § 5A. Thus, the Massachusetts FCA applies to the Medicaid program.

The Massachusetts FCA defines "political subdivision" as "any city, town, county or other governmental entity authorized or created by state law, including public corporations and authorities." M.G.L. c. 12, § 5A.

The Massachusetts FCA defines "person" as "any natural person, corporation, partnership, association, trust or other business or legal entity." M.G.L. c. 12, § 5A.

### **C. Methods of Enforcement/Whistleblower Provisions.**

#### **a. Responsibilities of the Attorney General**

The attorney general is required to investigate violations of the Massachusetts FCA, and if a violation has occurred, may bring a civil action in superior court. M.G.L. c. 12, § 5C(1).

#### **b. Scope of who can be a Relator**

When a Relator brings an FCA action, only the attorney general may intervene or bring a related action based on the underlying pending action. M.G.L. c. 12, § 5C(6).

An individual who is or was employed by the Commonwealth or any political subdivision as an auditor, investigator, attorney, financial officer, or contracting officer, who otherwise performed such functions for the Commonwealth or who discovered or learned of the allegations or the underlying facts from such persons, may not bring an action based upon allegations or transactions that the Relator discovered or learned of within the scope of such person's duties or job description. M.G.L. c. 12, § 5G(4).

#### **c. Standing for Relators**

An individual may bring a civil action in superior court for a violation of the Massachusetts FCA. The action shall be brought in the name of the Commonwealth or the political subdivision thereof. M.G.L. c. 12, § 5C(2).

#### **d. Relator's Rights if Government Intervenes**

If the attorney general proceeds with the action, he shall have primary responsibility for prosecuting the action and is not be bound by any act of the Relator; however, Relator continues as a party to the action, subject to certain limitations. M.G.L. c. 12, § 5D(1). The attorney general may dismiss the action

notwithstanding Relator's objections, provided Relator has an opportunity for a hearing on the motion to dismiss. M.G.L. c. 12, § 5D(2). The attorney general may settle the case notwithstanding Relator's objections if the court determines, after a hearing, that the proposed settlement is fair, adequate and reasonable. M.G.L. c. 12, § 5D(3).

**e. Limiting Relator's Role**

If unrestricted participation by the Relator would interfere with or unduly delay the state attorney general's prosecution, or would be repetitious or irrelevant or for purposes of harassment, the court may impose limitations on the Relator's participation in the case, such as limiting the number of witnesses, limiting the length of testimony, limiting the person's cross-examination, or otherwise limiting the person's participation in the litigation. M.G.L. c. 12, § 5D(4).

If the defendant shows that unrestricted participation by the Relator would be for harassment or would be an undue burden to the defendant or would cause unnecessary expense, the court may limit the Relator's participation in the litigation. M.G.L. c. 12, § 5D(5).

Whether or not the attorney general proceeds with the action, upon a showing by the attorney general that certain acts of discovery by the Relator initiating the action would interfere with the attorney general's investigation or prosecution of a criminal or civil matter arising out of the same or similar facts, the court may stay such discovery. M.G.L. c. 12, § 5D(7).

**f. Relator's Rights if Government Declines**

If the attorney general elects not to proceed with the action, the Relator has the right to conduct the action. M.G.L. c. 12, § 5D(6). The court may permit the attorney general to intervene at a later date upon showing of good cause. M.G.L. c. 12, § 5D(6).

**g. Government's Election of Other Proceeding**

The attorney general may elect to pursue its claim through any alternative remedy available to it, including any administrative proceeding to determine a civil penalty. M.G.L. c. 12, § 5E. During such proceeding, the Relator has the same rights in the proceeding as such person would have had if the original action had continued. Any finding of fact or conclusion of law made in such other proceeding that has become final is conclusive on all parties to the Massachusetts FCA. M.G.L. c. 12, § 5E.

**h. Relator's Share of Recovery**

Successful Relators entitled to 15-25% of the judgment when the attorney general intervenes; 25-30% if the attorney general does not intervene. M.G.L. c. 12, §5F. Also, Relator is entitled to reasonable expenses necessarily incurred, plus reasonable attorney's fees and costs. All such expenses, fees and costs shall be awarded against the defendant.

Where action is based on certain disclosures of specific information in a criminal, civil or administrative hearing, or legislative, administrative, auditor or inspector general hearing, audit, investigation or from the news media, the court may award sums it finds appropriate up to 10% of the proceeds. M.G.L. c. 12, § 5F(2). If a court finds that Relator planned and initiated the FCA violation, the court may reduce or eliminate the Relator's share of proceeds. If a Relator is convicted of criminal conduct arising from his/her role in the violation, the Relator shall be dismissed from the civil action and not receive any share of proceeds. M.G.L. c. 12, § 5F(5).

**C. Employee Protection**

The Massachusetts FCA prohibits employers from making, adopting or enforcing "any rule, regulation, or policy preventing an employee from disclosing information to a government or law enforcement agency or from acting to further a false claims action." It further indicates that any such agreement that limits or denies the employee's right to bring an action is void. M.G.L. c. 12, § 5J(1).

In addition, the Massachusetts FCA prohibits an employer from discharging, demoting, suspending, threatening, harassing, denying promotion to, or in any other manner discriminating against an employee for disclosing information to a government or law enforcement agency or in furthering a false claims action, including investigation, initiation of, testimony for or assistance in the action filed or to be filed under the Massachusetts FCA. M.G.L. c. 12, § 5J(2). Any employer who violates Section 5J(2) shall be liable for such damages or equitable relief as a court shall deem appropriate, including reinstatement with same seniority status, two (2) times the amount of back pay, interest on the back pay, and compensation for any special damage sustained as a result of the employer's violation plus litigation costs and reasonable attorney's fees. M.G.L. c. 12, § 5J(3).

In order for an employee to be entitled to damages or equitable relief under § 5J(3) (described above), both of the following must have occurred:

- i. the employee has been harassed, threatened with termination or demotion, or otherwise coerced by the employer or its management into engaging in the fraudulent activity in the first place; and
- ii. the employee voluntarily disclosed information prior to being dismissed to a government or law enforcement agency or acts in furtherance of a false claims action, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed. M.G.L. c. 12, § 5J(4).

#### **D. Procedural & Other Requirements**

##### **a. Burden of Proof**

Under the Massachusetts FCA, all essential elements including damages must be proved by a preponderance of the evidence. M.G.L. c. 12, § 5L.

##### **b. Public Disclosure/Original Source**

No court jurisdiction over Massachusetts FCA actions based on public disclosure of the allegations or transactions in a criminal, civil or administrative hearing; in a legislative, administrative, auditor's or inspector general's report, hearing, audit or investigation; or from the news media, unless the action is brought by the attorney general, or by the Relator who is an "original source" of the information. M.G.L. c. 12, § 5G(3). "Original source" means an "individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the state attorney general, without public disclosure, before the filing of an action under this section which is based on such information." M.G.L. c. 12, § 5A.

##### **c. Statute of Limitations**

A civil action may not be brought under the Massachusetts FCA (1) more than six years after the date on which the violation occurred, or (2) more than three years after the date when material facts are known or should have been known by the attorney general, but in no event more than ten years after the date on which the violation is committed, whichever occurs last. M.G.L. c. 12, § 5K(1).

##### **d. Collateral Estoppel**

A final judgment rendered in favor of the Commonwealth in any criminal proceeding charging fraud or false statements, whether upon a verdict after trial or upon a plea of guilty or nolo contendere, shall estop the defendant from denying the essential elements of the offense in any action which involves the same act, transaction or occurrence which is brought under the Massachusetts FCA. M.G.L. c. 12, § 5K.

## EXCLUDED ENTITY CHECKS

### Overview

The identification of excluded individuals and entities is an area that has been identified by the Office of the Inspector General (OIG) and the Centers for Medicare and Medicaid Services (CMS) as requiring further attention based on audits conducted in 2010 on both health plans and health providers. In an effort to combat fraud, waste, and abuse, the OIG and CMS have increased their oversight in this arena and clarified the expectations surrounding the regulations governing excluded entities and their employment in the health care sector.

Although much of the guidance available “strongly suggests” conducting these checks on a monthly basis by providers, and suppliers, a provision in the Patient Protection and Affordable Care Act has increased the scope of liability should a provider or supplier not identify an excluded entity timely, thus, increasing the chances for Civil Monetary Penalties (CMPs) for employing or doing business with an excluded entity. By increasing this standard of liability, CMS has solidified its position that monthly checks are required of all databases as updated information is available on a monthly basis from both the OIG and the GSA.

In addition, as part of this increased oversight and as a condition of their participation, CMS is requiring that health plans monitor all first tier, downstream, and related entities to ensure that monthly checks of the appropriate databases are being conducted for their organizations. In addition, the Massachusetts Executive Office of Health and Human Services has incorporated this requirement into all Medicaid contracts effective July 1, 2011, thereby, further enforcing this requirement at the State level.

### Background

The HHS Office of the Inspector General (OIG) excludes individuals and entities from participation in Medicare, Medicaid, and the State Children’s Health Insurance (SCHIP) and all Federal health care programs (as defined in section 1128 B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156.

When the HHS-OIG has excluded a provider, Federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. (Section 1903(i)(2) of the Act; and 42 CFR section 1001.1901(b)) This payment ban applies to any items or services reimbursable under a Federal health program that are furnished by an excluded individual or entity, and extends to:

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## EXCLUDED ENTITY CHECKS

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1. all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;
2. payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and
3. payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the payment itself is made to another provider, practitioner or supplier that is not excluded. (42 CFR section 1001.1901(b))

### **Effects of Exclusion**

The effect of an OIG exclusion from Federal health care programs is that no Federal health care program payment may be made for any items or services (1) furnished by an excluded individual or entity, or (2) directed or prescribed by an excluded physician (42 CFR 1001.1901). This payment ban applies to all methods of Federal program reimbursement, whether payment results from itemized claims, cost reports, fee schedules or a prospective payment system (PPS). Any items and services furnished by an excluded individual or entity are not reimbursable under Federal health care programs. In addition, any items and services furnished at the medical direction or prescription of an excluded physician are not reimbursable when the individual or entity furnishing the services either knows or should know of the exclusion. This prohibition applies even when the Federal payment itself is made to another provider, practitioner or supplier that is not excluded.

The prohibition against Federal program payment for items or services furnished by excluded individuals or entities also extends to payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Federal program beneficiaries. This prohibition continues to apply to an individual even if he or she changes from one health care profession to another while excluded. In addition, no Federal program payment may be made to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct

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patient care.

Set forth below is a listing of some of the types of items or services that are reimbursed by Federal health care programs which, when provided by excluded parties, violate an OIG exclusion. These examples also demonstrate the kinds of items and services that excluded parties may be furnishing which will subject their employer or contractor to possible CMP liability.

- Services performed by excluded nurses, technicians or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or indirectly (such as through a PPS or a bundled payment) by a Federal health care program, even if the individuals do not furnish direct care to Federal program beneficiaries;
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by any Federal health care program;
- Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation reimbursed by a Federal health care program, to hospital patients or nursing home residents;
- Services performed for program beneficiaries by excluded individuals who sell, deliver or refill orders for medical devices or equipment being reimbursed by a Federal health care program;
- Services performed by excluded social workers who are employed by health care entities to provide services to Federal program beneficiaries, and whose services are reimbursed, directly or indirectly, by a Federal health care program;
- Administrative services, including the processing of claims for payment, performed for a Medicare intermediary or carrier, or a Medicaid fiscal agent, by an excluded individual;
- Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Federal health care program;

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- Items or services provided to a program beneficiary by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Federal health care program; and
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of beneficiaries and reimbursed, directly or indirectly, by a Federal health care program.

### **Violation of an OIG Exclusion By an Excluded Individual or Entity**

An excluded party is in violation of its exclusion if it furnishes to Federal program beneficiaries items or services for which Federal health care program payment is sought. An excluded individual or entity that submits a claim for reimbursement to a Federal health care program, or causes such a claim to be submitted, may be subject to a CMP of \$10,000 for each item or service furnished during the period that the person or entity was excluded (section 1128A(a)(1)(D) of the Act). The individual or entity may also be subject to treble damages for the amount claimed for each item or service. In addition, since reinstatement into the programs is not automatic, the excluded individual may jeopardize future reinstatement into Federal health care programs (42 CFR 1001.3002).

### **Employing an Excluded Individual or Entity**

As indicated above, BBA authorizes the imposition of CMPs against health care providers and entities that employ or enter into contracts with excluded individuals or entities to provide items or services to Federal program beneficiaries (section 1128A(a)(6) of the Act; 42 CFR 1003.102(a)(2)). This authority parallels the CMP for health maintenance organizations that employ or contract with excluded individuals (section 1857(g)(1)(G) of the Act). Under the CMP authority, providers such as hospitals, nursing homes, hospices and group medical practices may face CMP exposure if they submit claims to a Federal health care program for health care items or services provided, directly or indirectly, by excluded individuals or entities.

Thus, a provider or entity that receives Federal health care funding may only employ an excluded individual in limited situations. Those situations would include instances where the provider is both able to pay the individual exclusively with private funds or from other non-federal funding sources, and where the services furnished by the excluded individual relate solely to non-federal program patients.

In many instances, the practical effect of an OIG exclusion is to preclude employment of an excluded individual in any capacity by a health care provider that receives reimbursement, indirectly or directly, from any Federal health care program.

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## EXCLUDED ENTITY CHECKS

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### **CMP Liability for Employing or Contracting with an Excluded Individual or Entity**

CMS and the OIG state that monthly updates are available for the OIG List of Excluded Individuals and Entities (LEIE) and the GSA Excluded Parties List System (EPLS). This guidance indicates that monthly checks of these databases are necessary to ensure that an organization is not employing or contracting with an excluded entity and to mitigate the risk of employing or contracting with an entity. In addition, the Patient Protection and Affordable Care Act (PPACA) provides clarification that a health care organization that contracts (through employment or otherwise) with an excluded or terminated individual or entity....is subject to civil fines and penalties and the standard for liability is whether the organization "knew or should have known" of the exclusion or termination.

If a health care provider arranges or contracts (by employment or otherwise) with an individual or entity who is excluded by the OIG from program participation for the provision of items or services reimbursable under such a Federal program, the provider may be subject to CMP liability if they render services reimbursed, directly or indirectly, by such a program. CMPs of up to \$10,000 for each item or service furnished by the excluded individual or entity and listed on a claim submitted for Federal program reimbursement, as well as an assessment of up to three times the amount claimed and program exclusion may be imposed. For liability to be imposed, the statute requires that the provider submitting the claims for health care items or services furnished by an excluded individual or entity "knows or should know" that the person was excluded from participation in the Federal health care programs (section 1128A(a)(6) of the Act; 42 CFR 1003.102(a)(2)). Providers and contracting entities have an affirmative duty to check the program exclusion status of individuals and entities prior to entering into employment or contractual relationships, or run the risk of CMP liability if they fail to do so.

### **How to Determine If an Individual or Entity is Excluded**

#### OIG List of Excluded Individuals and Entities (OIG LEIE)

In order to avoid potential CMP liability, health care providers and entities must check the OIG List of Excluded Individuals/Entities on the OIG web site ([www.hhs.gov/oig](http://www.hhs.gov/oig)) prior to hiring or contracting with individuals or entities. In addition, if they have not already done so, health care providers must check the OIG web site for determining the participation/exclusion status of current employees and contractors. The web site contains OIG program exclusion information and is updated in both on-line searchable and downloadable formats. This information is updated on a regular basis. The OIG web site sorts the exclusion of individuals and entities by: (1) the legal basis for the exclusion, (2) the types of individuals and entities that have been excluded, and (3) the State where the excluded individual resided at the time they were excluded or the State where the entity was

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## EXCLUDED ENTITY CHECKS

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doing business. In addition, the entire exclusion file may be downloaded for persons who wish to set up their own database. Monthly updates are posted to the downloadable information on the web site and must be checked for exclusions.

The OIG LEIE database can be found here: <http://oig.hhs.gov/exclusions/index.asp>

### General Service Administration Excluded Parties List System (GSA EPLS)

The EPLS is an electronic, web-based system that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits. The EPLS keeps its user community aware of administrative and statutory exclusions across the entire government, and individuals barred from entering the United States. The user is able to search, view, and download both current and archived exclusions. The files can be downloaded and reviewed in various formats including Excel and ASCII formats.

The GSA EPLS database can be found: <http://www.epls.gov>.

### **Plan Notification Requirements and Right to Audit**

All providers and/or suppliers of care are required to notify Fallon Community Health Plan (FCHP) immediately should they identify any excluded individuals or entities during the monthly, required searches of the OIG LEIE or the GSA EPLS databases. Notification should be made to the Provider Relations Department at:

1-866-ASK-FCHP (866-275-3247)

[askfchp@fchp.org](mailto:askfchp@fchp.org)

Providers must maintain a record of their searches and of any findings. These records can be as simple as a Word document or Excel spreadsheet that include the date of the search, the person that conducted the search (or a description of an automated process), and the results of the search. FCHP reserves the right to audit the provider or supplier as needed to ensure compliance with this requirement.

*\* Information in this section has been taken from various sources including the following: OIG (1999). The Effect of Exclusion From Participation in Federal Health Care Programs: Special Advisory Bulletin.*

## MASSHEALTH AND FEDERALLY REQUIRED DISCLOSURES

The Executive Office of Health and Human Services (EOHHS)/MassHealth requires Fallon Community Health Plan (FCHP), as a MassHealth contracted Managed Care Organization (MCO), to obtain certain information from its contracted providers. Providers are required to check the HHS-OIG List of Excluded Entities and Individuals and Entities (LEIE) and the General Service Administration (GSA) Excluded Parties List System (EPLS) on a monthly basis to ensure that they are not employing or contracting with an excluded entity programs discussed in the provider manual section titled: Key Compliance and Regulatory Requirements for Providers. Providers must also disclose the following information as required by federal law, 42 CFR §§ 455.100-106:

- Individuals with business ownership and control interests
- Business transactions/managing employee information
- Criminal convictions of the provider and other parties associated with the provider's entity

To meet these MassHealth disclosure requirements, FCHP must obtain a completed Federally Required Disclosure Form from providers and other disclosing entities, whenever one of the following conditions exists:

- upon submission of a provider application;
- upon execution of the provider agreement;
- upon revalidation of enrollment (and
- within 35 days after any change in ownership of the entity required to disclose.

For your convenience, all data will be collected electronically utilizing the MassHealth required Federally Required Disclosure form which may be accessed through our secure electronic form. IPA/PHO groups please contact your Contract Manager or Provider Services Representative to expedite this requirement.

Please note providers are required to update this information when changes occur. In the future, this information will be requested at the time of recontracting/recredentialing for existing providers and credentialing/contracting for new providers.

Below is a *Frequently asked questions* section that will provide further information regarding this request. For questions, please call 1-866-ASK-FCHP, option 4, or email us at [askfchp@fchp.org](mailto:askfchp@fchp.org) and include the following as your email subject: "Provider Disclosure Request".

## Frequently asked questions - MassHealth and federally required disclosures

### Who must provide this information?

The Federal/State requirement applies to any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, any Medicare intermediary or carrier, and an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health related services for which it claims payment under any plan or program established under Title V or Title XX of the Social Security Act. It also applies to subcontractors which means (a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or (b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Definitions are provided on the Federally Required Disclosure Form.

### Why must providers submit this information to FCHP?

FCHP is contracted with the State of Massachusetts as a MassHealth Managed Care Organization (MCO) providing health insurance to Medicaid recipients. Under that contract, MCOs are required to obtain this information from its providers. FCHP is required to obtain this information prior to the execution and renewal of the provider contract and when ownership of the provider's business changes. Federal regulation requires termination of the contract if the provider fails to comply with Federal disclosure mandates. The following information from the *MassHealth Provider Billing and Services Updates & Upcoming Initiatives Massachusetts Health Care Training Forum July 2011, page 3* states:

#### Provider Disclosure Statement

- All provider organizations are required to comply with Federal, State and local laws and regulations (42 CFR sections 431.107, 447.10 and 455.100 through 455.106; and section 1902(a)(9) of the Social Security Act).

Subsequently, entities must disclose to EOHHS the identity of any person who:

- Has ownership or control interest in the provider organization, or is an agent or managing employee of the provider, and of those people; and Those who have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs (42 CFR 455.106 paragraph (a))

**I am a health system employed practitioner. Should I provide this information to FCHP?**

As a health system employed practitioner, there is no need for you to provide this information directly to FCHP. FCHP is requesting information for health system employed practitioners from the hospital systems and/or PHOs.

**As a MassHealth contracted provider, I am required to provide and update this information to the State. Why must I also disclose the same information to FCHP?**

As directed by the Centers of Medicare & Medicaid Services, the State of Massachusetts is required to direct its MCOs to obtain this information from their providers.

**How will FCHP use this information?**

FCHP is required to conduct criminal and other background checks on its providers, its providers managing employees, and other related entities. FCHP cannot pay claims to providers if they or their managing employees/related entities have been convicted of a crime involving Medicare or Medicaid or if they have been suspended, debarred, or excluded from participating in a federal program.

**Why are the full name, address, and social security number being requested?**

MassHealth requires FCHP to obtain from providers their tax identification number (TIN), social security number (SSN), or employer identification number (EIN) for purposes necessary to properly administer this federal requirement. This is the same information providers are required to submit with their Medicaid provider contracts. This information is the minimum data required in order to perform an accurate background check.

**How will FCHP maintain the confidentiality and security of this information?**

FCHP will comply with all federal and state privacy & security rules and regulations, including the Health Insurance Portability and Accountability Act (HIPAA). All information obtained shall be kept confidential and used only for the purposes of conducting criminal and other background checks. Data will be maintained only for a period of time as either required by the State of Massachusetts, or until FCHP receives notification from the provider that the information is obsolete.

**How do we submit the data?**

For your convenience, you can submit your data using our [secure electronic form](#). It is strongly suggested that you gather all information prior to entering your data. The form cannot be saved prior to submitting the information