Employee Education About False Claims Recoveries.

Any Medicaid provider, including any Medicaid managed care organization, that receives or makes $5 million or more in Medicaid payments in a year, is required to comply with Section 6032 of the Federal Deficit Reduction Act of 2005 (DRA) (P.L. 109-171, S 1932, Feb. 8, 2006); as a condition of receiving payment under the Medicaid program. To comply with Section 6032, the provider must ensure that it has met all of the following requirements:

(1) The provider must establish written policies that provide detailed information about the Federal laws identified in section 6032 (A) and any Wisconsin laws imposing civil or criminal penalties for false claims and statements, or providing whistleblower protections under such laws, including .s. 146.997, Wis. Stats., "Health care worker protection."

(2) In addition to detailed information regarding the Federal and State laws, the provider's written policies must contain detailed information regarding the provider's own policies and procedures to detect and prevent fraud, waste and abuse in Federal health care programs, including the Medicare and Medicaid programs, and any waivers of Medicaid regulations.

(3) The provider must provide a copy of its written policies to all of its employees, contractors and agents of the vendor.

(4) If the provider maintains an employee handbook, the provider must include in its employee handbook a specific discussion of the Federal and State laws described in its written policies, the provider's policies and procedures for detecting and preventing fraud, waste and abuse and the right of its employees to be protected from discharge, demotion, suspension, threat, harassment, discrimination, or retaliation in the event the employee files a claim pursuant to the Federal False Claims Act or otherwise makes a good faith report alleging fraud, waste or abuse in a federal health care program, including the Medicare and Medicaid programs, and any waivers of Medicaid regulations, to the provider or to the appropriate authorities.

Any Medicaid provider that receives or makes annual payments of $5 million or more under the Medicaid program must certify that it complies with Section 6032 of the DRA. Specifically, each year providers must complete and submit a form to be prepared by the Department attesting compliance with section 6032 of the DRA. Providers must submit their initial attestation form no later than December 31, 2007. That form will attest to the provider's compliance with the provisions of the Act for calendar year 2007 and that the provider will be in compliance for calendar year 2008.

At the completion of each Federal Fiscal Year the Department will identify providers who met the $5 million threshold and will provide them with the attestation form and instructions for completion of the form for the upcoming calendar year.

The Department will issue a Medicaid Provider Update no later than September 2007 containing information related to compliance with these provisions.

The Update will also contain:

- A copy of the attestation form, along with directions for its completion.
- A listing of the information that is required to be included in the information provider by the entity to its employees, agents and contractors.
- Timeframes for completion and submission of attestation forms.
- Notification that, effective January 1, 2008 the scope of comprehensive audits conducted by the Bureau of Health Care Program Integrity will be expanded to include reviews of documentation to determine compliance with this section.