STATE OF MICHIGAN
IN THE SUPREME COURT

STATE OF MICHIGAN ex rel.
MARCIA GURGANUS,

Plaintiff-Appellee,

v

CVS CAREMARK CORPORATION; CVS PHARMACY INC, CAREMARK, LLC; CAREMARK MICHIGAN SPECIALTY PHARMACY, LLC; CAREMARK MICHIGAN SPECIALTY PHARMACY HOLDING, LLC; CVS PHARMACY HOLDING, LLC; CVS MICHIGAN, LLC; WOODWARD DETROIT CVS, LLC; REVCO DISCOUNT DRUG CENTERS, INC.; KMART HOLDING CORPORATION; SEARS HOLDINGS CORPORATION; SEARS HOLDINGS MANAGEMENT CORPORATION; SEARS, ROEBUCK AND CO.; RITE AID OF MICHIGAN INC.; PERRY DRUG STORES, INC.; TARGET CORPORATION; THE KROGER CO, OF MICHIGAN; THE KROGER CO.; WALGREEN CO. and WAL-MART STORES INC.,

Defendants-Appellants.

Supreme Court Case No. 146791

Court of Appeals No. 299997

Circuit Court Case No.: 09-03411-CZ
Honorable James R. Redford

CITY OF LANSING and DICKINSON PRESS INC., individually and on behalf of all others similarly situated,

Plaintiffs-Appellees,
Cross-Appellants,

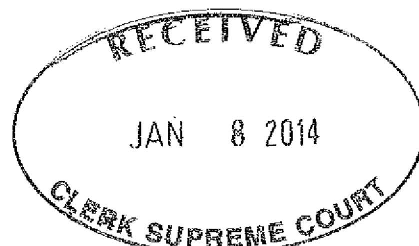
v

RITE AID OF MICHIGAN, INC. and PERRY DRUG STORES, INC.

Defendants-Appellants,
Cross-Appellees,

Supreme Court Case No. 146792

Circuit Court Case No. 09-07827-CZ
Honorable James R. Redford



CITY OF LANSING; DICKINSON PRESS INC.; and SCOTT MURPHY, individually and on behalf of all others similarly situated,

Plaintiffs-Appellees,
Cross-Appellants,

Supreme Court Case No. 146793

Court of Appeals No. 299999

Circuit Court Case No. 10-00619-CZ
Hon. James R. Redford

v

CVS CAREMARK CORPORATION; CVS PHARMACY INC.; CAREMARK, LLC; CAREMARK MICHIGAN SPECIALTY PHARMACY, LLC; CAREMARK MICHIGAN SPECIALTY PHARMACY HOLDING, LLC; CVS MICHIGAN, LLC; WOODWARD DETROIT CVS, LLC; REVCO DISCOUNT DRUG CENTERS, INC.; KMART HOLDING CORPORATION; SEARS HOLDINGS CORPORATION; SEARS HOLDINGS MANAGEMENT CORPORATION; SEARS, ROEBUCK AND CO.; TARGET CORPORATION; THE KROGER CO. OF MICHIGAN; THE KROGER CO.; WALGREEN CO. and WAL-MART STORES INC.,

Defendants-Appellants,
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BRIEF ON APPEAL OF THE STATE OF MICHIGAN AS AMICUS CURIAE

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STATEMENT OF JURISDICTION

The Attorney General agrees with the Plaintiffs' statement of appellate jurisdiction.

STATEMENT OF QUESTIONS PRESENTED

In an order dated September 18, 2013, this Court granted the Defendants' application for leave to appeal and the Plaintiffs' application for cross appeal, though limiting the cross appeal to one issue. The Attorney General will address the fourth and fifth issues identified by the Court:

4. Whether claims for payment by Medicaid that violate the pricing requirements of MCL 333.17755(2) are "false claims" under the Medicaid False claims Act (MFCA), MCL 400.601 *et seq.*?

5. Whether use of the remedies under the MFCA is available when a pharmacy has violated part 177 of the Public Health Code, MCL 333.17701 *et seq.*, by falsely certifying to the Medicaid program that the pharmacist has complied with the pricing requirements of that section?

INTRODUCTION

Michigan's Medicaid program is a crucial safety net for residents who are unable to afford health care. The program provides essential care for the State's indigent population. Indeed, Michigan Medicaid provides health care services to more than 1.9 million people (approximately 19% of Michigan's population), and it paid approximately $800 million in pharmacy claims in the fiscal year ending September 2012. With Medicaid funds stretched to their limit, Michigan cannot afford to pay falsely inflated prices for health care services.

The Attorney General's primary tool to combat fraud against these funds needed to care for the State's neediest citizens is the Medicaid False Claims Act, MCL 400.600 *et seq*. The MFCA empowers the Attorney General to investigate and take civil or criminal action against persons who commit Medicaid fraud. The MFCA also permits private citizens, as in this case, to bring actions on behalf of the State. The Attorney General may then choose to intervene in those actions and take over prosecution on behalf of the State, or, as here, to decline to intervene for a number of reasons unrelated to the merits of the allegations. Failing to uphold the Court of Appeals' decision in this case may impair the effective use of the Medicaid False Claims Act to prevent fraud and waste of Medicaid funds. The Defendants argue that overcharging Medicaid for prescription drugs does not result in a false claim under the Medicaid False Claims Act, and that providers do not certify their claims by submitting them to Medicaid. Both of these arguments are wrong.

As to the first, Michigan law—specifically, MCL 333.17755(2)—requires pharmacists to pass on the savings from generic prescription drugs. Claims that seek reimbursement for a generic drug, based on the falsely reported difference in acquisition costs between the brand name drug and the generic drug and that fail to pass on the pharmacy's actual savings, are deceptive and support a claim under the Act. And as to the second, by submitting claims for reimbursement by Medicaid, providers expressly certify that the claims are true and accurate, and that the services and products were dispensed and priced in accordance with Michigan law.

The mandate of the Attorney General is to fight fraud by enforcing the Medicaid False Claims Act. This mandate is distinct from that of the Department of Licensing and Regulatory Affairs or of the Board of Pharmacy; their mandate is to "regulate, control, and inspect the character and standard of pharmacy practice" and to discipline licensees who have adversely affected the public's health, safety, and welfare. MCL 333.17722. Nothing in the Public Health Code provides a mechanism for the Attorney General to recover Medicaid dollars fraudulently obtained by pharmacists. Conversely, the remedies available under the Act are not available through the Board. In short, different state entities have different roles to play, and the fact that certain state agencies exert regulatory authority in no way diminishes the Attorney General's separate authority and responsibility to enforce Michigan's anti-fraud laws. The existence of administrative remedies to address public health concerns does not displace laws against fraud.

ARGUMENT

I. Reimbursement claims for improperly priced drugs are false claims.

MCL 333.17755(2) requires a pharmacy to pass along its generic drug savings to Medicaid. The language of the statute is clear and unambiguous:

> If a pharmacist dispenses a generically equivalent drug product, the pharmacist shall pass on the savings in cost to the purchaser or to the third party payment source if the prescription purchase is covered by a third party pay contract. The savings in cost is the difference between the wholesale cost to the pharmacist of the 2 drug products.

A pharmacy that fails to comply with this law and instead presents inflated claims for payment by Medicaid is making false claims. Consider a concrete example. If a pharmacy dispenses a generically equivalent drug with an acquisition cost of $20.00 and the pharmacy's acquisition cost for the brand name version of that drug is $70.00, the pharmacy must pass on to the purchaser this $50.00 difference by selling the generic drug for at least $50.00 less than the pharmacy would have sold the brand name drug to that purchaser. If the pharmacy fails to pass on the savings, that pharmacy may be held liable under the Medicaid False Claims Act.

The Medicaid False Claims Act provides that persons shall not submit claims for reimbursement by Medicaid that are false. MCL 400.607. "False" means wholly or partially untrue or deceptive. MCL 400.602(d). "Deceptive" means "making a claim or causing a claim to be made under the social welfare act *that contains a statement of fact or that fails to reveal a fact*, which statement or failure leads the department to believe the represented or suggested state of affair to be other than it actually is. (Emphasis added) MCL 400.602(c). MCL 400.602(c) (emphasis added).

Inflated claims—i.e. claims that do not accurately reflect the provider's true costs—are, for that reason, "false" claims. One need not resort to theories of certification to determine whether a claim is "false."

Defendants' focus on certification is not only misplaced, but it mischaracterizes Plaintiffs' argument as focusing on an "implied certification" theory. Indeed, pharmacy providers, who are required to comply with applicable state and federal laws, rules, regulations, and policies, *expressly* certify that their claims are true and accurate. Before billing Medicaid, a pharmacy provider must enter into a Pharmacy Provider Enrollment & Trading Partner Agreement. (Exhibit A). This form requires pharmacy providers to read and comply with: 1) the Michigan Medicaid Provider Manual and the Claims Processing Manual and 2) Michigan Department of Community Health's policies and procedures for the Medical Assistance Program contained in the manual, manual updates, provider bulletins, and other program notifications. The Michigan Medicaid Provider Manual expressly states that applicable state and federal laws, rules, regulations, and policies must be observed by participating pharmacies.

Consequently, compliance with pricing laws, rules, regulations, and policies is highly relevant to whether a claim for Medicaid payment is false. Section 13 of the Pharmacy Chapter of the Medicaid Manual describes reimbursement limits, including usual and customary charges, product cost payment limits, and maximum allowable costs. Pricing involves determination and verification of average wholesale price (AWP), maximum allowable cost (MAC), and other factors. It is

noteworthy that the Pharmacy Provider Enrollment & Trading Partner Agreement includes, in paragraph 10, a condition that a provider must include a clause in all of its contracts allowing authorized state or federal government agents access to the subcontractor's accounting records and other documents needed to verify the *nature and extent of costs* and services furnished under the contract.

A. Pharmacy providers expressly certify Medicaid claims.

Pharmacy providers *expressly* certify, as a condition of payment, that their claims are true, accurate, and do not contain untrue, misleading, or deceptive information. The MDCH must ensure that claims against the program are timely, substantiated, and not false, misleading, or deceptive and that the state is a prudent buyer. MCL 400.111a(3). A "prudent buyer" is defined in the statute as "a purchaser who . . . [s]eeks to economize by minimizing cost." MCL 400.111a(4)(c). To effectuate this mandate, MCL 400.111b(17) makes it a "condition of payment for services rendered to a medically indigent individual" that the provider "shall certify that a claim for payment is true, accurate, prepared with the knowledge and consent of the provider, and does not contain untrue, misleading, or deceptive information." This provision further states that the provider's certification "shall be *prima facie* evidence that the provider knows that the claim or claims are *true, accurate, prepared with his or her knowledge and consent, do not contain misleading or deceptive information, and are filed in compliance with the policies, procedures, and instructions, and on the forms established or developed under this act* . . . ." *Id.* (emphasis added).

This certification is mandated by federal regulation. Specifically, 42 CFR 455.18 requires "all provider claim forms" to include, in bold, the following statements (or alternate wording specifically approved by the Regional HCFA Administrator):

> (1) "This is to certify that the foregoing information is true, accurate, and complete."
>
> (2) "I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws."

The regulation requires this language (or a reference to it if they appear on the back of the form) to appear "immediately preceding the claimant's signature." 42 CFR 455.18.

This condition of payment, a critical component of the State's efforts to ensure Medicaid's cost containment and continued viability, is reinforced in the Medicaid Provider Manual, Chapter on General Information for Providers, Section 10.7, titled "Claim Certification": "Providers certify by signature that a claim is true, accurate, and contains no false or erroneous information."

That is not the only place pharmacies are required to certify the accuracy of claims. Pharmacy providers must enroll with First Health Services Corporation (a fiscal intermediary for the Michigan Department of Community Health) in order to submit claims for payment by Medicaid. Pharmacy Provider Enrollment & Trading Partner Agreement, a copy of which is attached hereto in Exhibit A. (See also, https://michigan.fhsc.com/Downloads/RxEnrollment_MSA1626-201210.pdf.) The first paragraph of the Conditions and Provisions of the Agreement they must sign to

enroll states: "I represent and *certify* as follows:. . . ." *Id.* (emphasis added). The pharmacy provider certifies that before billing for any pharmacy services rendered, the provider will read the Michigan Medicaid Provider Manual and the First Health Claims Processing Manual. The provider also agrees to *comply* with the terms and conditions of participation set forth in the Manuals and MDCH's own policies and procedures for the Medical Assistance Program contained in the Manual, updates, provider bulletins, and other program notifications. ("Pharmacy Provider Enrollment & Trading Partner Agreement," paragraphs 6, 13.) The application form emphasizes in bold type:

> **BY SIGNING THIS AGREEMENT, I ASSERT THAT I HAVE READ AND AGREE TO THE PHARMACY PROVIDER ENROLLMENT & TRADING PARTNER AGREEMENT – CONDITIONS AND PROVISIONS.**

Furthermore, a Medicaid provider is required promptly to notify the director of the Medicaid program of a payment it is not entitled to receive, or if the payment exceeds the proper amount. Prompt notification is required and the provider must repay the overpayment. MCL 400.111b(16).

In short, these statutory, policy, and contractual conditions all mandate that claims submitted for payment by Medicaid are expressly certified as being true and accurate, and not based on false or misleading information. There is no need to resort to an "implied" certification theory in this case. The case law cited by Defendants is unpersuasive and inconsistent with a significant body of case law holding that violations in the chain of causation render a claim non-payable and

therefore false under the federal false claims act.[1] Most of the "implied certification" cases decided by the federal courts have involved kickbacks. Kickbacks are not alleged in this case, and it is the pricing practices of the Defendants that render their Medicaid claims false and untrue.

Deflecting attention from the pricing requirements, the Defendants focus on the first section of MCL 333.17755, which addresses the pharmacists' substitution of generic drugs. But the allegations of the Relator's complaint and the crux of her arguments both focus on the Defendants' violation of the second section, which address the pricing of generic drugs and the cost to third party payers, including the Michigan Medicaid program. The second section states:

> (2) If a pharmacist dispenses a generically equivalent drug product, the pharmacist *shall pass on the savings in cost* to the purchaser or *to the third party payment source if the prescription purchase is covered by a third party pay contract.* The savings in cost is the difference between the wholesale cost to the pharmacist of the 2 drug products. [MCL 333.17755(2) (emphasis added).]

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[1] See, *United States ex rel Duxbury v Ortho Biotech Products, LP*, 2009 WL 2450716 (CA 1, 2009) (false claims/kickback case where defendant did not itself submit false claims but through defendant's illegal kickbacks false claims were submitted by medical providers for reimbursement of defendant's drug products); *United States v Rogan*, 517 F3d 449, 452 (CA 7, 2008) (upholding False Claims Act liability of defendant based on knowing violation of anti-kickback provisions and submission of Medicare claims); *In re Pharmaceutical Industry Average Wholesale Price Litigation*, 491 F Supp2d 12, 18 (D Mass, 2007); *United States ex rel McNutt v Haleyville Medical Supplies*, 423 F3d 1256 (CA 11, 2005); *United States ex rel Kneepkins v Gambro Healthcare Inc*, 115 F Supp2d 35 (D Mass, 2000); *United States ex rel Barrett v Columbia/HCA Healthcare Corp*, 251 F Supp2d 28 (DDC, 2003); *United States ex rel Pogue v Diabetes Treatment Centers of America*, 238 F Supp2d 258, 264 (DDC, 2002); *United States ex rel Augustine v Century Health Serv*, 289 F3d 409 (CA 6, 2002).

A pharmacy cannot make a greater gross profit on the sale of a generically equivalent drug product than it does on the brand name version of the drug.[2] Consequently, compliance with MCL 333.17755(2) goes to the essence of the pharmacy provider's right to receive payment from the Medicaid program. By submitting a claim for payment for dispensing generic drugs, the pharmacist is expressly certifying that it has complied with MCL 333.17755(2), and is indeed passing on to Medicaid any savings in cost when the generic drugs are dispensed. If Defendants are not passing along the savings in cost, then they are concealing material facts regarding their profits and overcharging Medicaid. Therefore, the express certification that accompanies the submission of their claims is false. MCL 400.602(c) and (d).

B. Even if the provider's representation is deemed to be implied, such a false representation constitutes a false claim.

The Court of Appeals did not adopt an "implied certification" theory; rather, the Court stated that the "defendants' presentation of claims for payment impliedly represents to purchasers and payees that defendants are passing the savings in cost, if any, when generic drugs are dispensed." COA Op 20. But even if the

[2] Nothing in the language of section 17755(2) supports Defendants' argument that a substitution transaction occurs within the meaning of the statute only in those situations in which a pharmacist dispenses a generic drug when a brand name was prescribed. The plain language of the section makes clear that the legislature intended the section to apply when a generic drug is dispensed regardless of whether a brand name drug was prescribed. There would be no logical or policy reason for the State to be entitled to savings on generic drugs only in those situations where the physician prescribes a brand drug.

provider's representation is deemed to be implied, not express, the State urges the Court to uphold the Court of Appeals' decision, which is in line with the decisions of many jurisdictions holding that valid pricing is an implied condition of payment. COA Op 20.

The crux of the "implied certification" theory is that the claim may be deemed legally false where it implicitly, but falsely, represents compliance with all conditions that are relevant to the government's decision to pay the claim. The implied certification theory begins from the fact that it is often especially difficult for the Government to detect breaches of contract or material violation of statutes or regulations by government contractors. The MFCA addresses this problem by allowing the government to contract for effective duties to cooperate, in the form of certifications of compliance backed by extra compensatory remedies. As the Court of Appeals noted, for a pharmacist to be entitled to payment for generic drugs that it dispenses, the amount charged must be in compliance with section 17755(2). COA Op 20. That is, "but for" the pharmacist's compliance with the rules and regulations regarding, among other things, generic drug pricing, the pharmacist's claims would not qualify for payment.

The Court of Appeals concluded that concealing material facts regarding the profits they are realizing from the sale of generics and omitting this material fact is deceptive. Defendants' presentation of claims for payment "impliedly represents" to purchasers and third party payers that defendants are passing on the savings in cost, if any, when generic drugs are dispenses. COA Op 20. When pharmacies

violate the terms of section 17755(2), and then submit claims to Medicaid, seeking payment for dispensing generic drugs, they are omitting a material fact—they did not pay the full cost for which they are seeking reimbursement. The omission leads Medicaid to believe the state of affair is something other than it actually is.

As the Court of Appeals noted, nothing in the MFCA requires an affirmative misrepresentation for a claim to be considered false; neither the HFCA, nor the MFCA definition of "false claim" requires an affirmative act, and none should be read into the plain statutory language. COA Op 20. As the Michigan Court of Appeals has stated, "[i]ndeed, if a defendant contractually agrees to abide by billing procedures and has access to the applicable manuals and documentation controlling those procedures, deviations from the established procedures are presumed to be intentional or provide evidence that the defendant knew the submitted claims were false." *People v Orzame*, 224 Mich App 551, 560; 570 NW2d 118 (1997).

By complying with statute, the Enrollment Agreement, the Medicaid Manual and the certifications required thereunder, enrolled Medicaid Providers commit to submitting only true and accurate claims to Medicaid. When they submit inflated claims, the accompanying representation—whether deemed express or implied—is false. See, *United States v Kmart Corp*, 2013 WL 5615747 (SD Ill Sept 18, 2013).

II. MFCA remedies are always available in a *qui tam* action based on the filing of false claims.

A. Qui tam actions exist to aid in fighting fraud.

Michigan's Medicaid False Claim Act is modeled after the Federal False Claims Act, 31 USC § 3729, *et seq*, which was originally enacted in 1863 during the Civil War, to fight rampant fraud against the federal government and Union troops. A key to its success was its "*qui tam*" provisions, which allow private citizen whistleblowers ("relators") to sue on behalf of the United States and share in its recovery. This provision is aimed at establishing a law enforcement "partnership" between federal law enforcement officials and private citizens who learn of fraud against the government. The prospect of a reward is an important means of inducing private parties who are uniquely armed with information about false claims to come forward with that information. Those states deemed to have a False Claims Act that complies with the provisions of section 1909 of the Social Security Act, and relevant amendments thereto, receive a 10% increase in their share of any amounts recovered under such law.

Under 42 USC 1396b(q), a state's "Medicaid Fraud Control Unit" is charged with "conducting a statewide program for the investigation and prosecution of violations of all applicable state laws regarding any and all aspects of fraud in connection with . . . any aspect of the provision of medical assistance and the activities of providers of such assistance under the State [Medicaid] plan . . . ." By allowing private citizens to bring an action on behalf of the State, the MFCA provides an incentive to those who are in a particularly good position to understand

how a fraud is being perpetrated by a particular provider to bring that scheme to light. MCL 400.610a.

Once the *qui tam* relator brings an action on behalf of the State, the Attorney General's Office investigates the allegations. The Attorney General may then choose to intervene in the action, in which case it then has primary control over prosecution of the case. Even where the government declines to intervene—as Michigan did here—it may choose to intervene at a later date. MCL 400.610a.

The MFCA does not reach all forms of deception, but only that which targets the government fisc. The Relator's allegations, that violation of MCL 333.17755(2) constitutes a false claim under the MFCA, pertain not to the pharmacist's conduct in substituting generics, but rather to their conduct in *failing to pass along the savings when submitting claims for payment by Medicaid.* The MFCA attaches liability not to the underlying activity, but to the fraudulent claim for payment.

What constitutes the MFCA offense is the knowing presentation of a claim that is either fraudulent or simply false. A broad array of scenarios can constitute MFCA violations, including up-coding by physicians, kickbacks by pharmaceutical companies or hospitals, off-label marketing, or overcharging Medicaid for any service, pharmaceutical, or item of durable medical equipment. All of these providers' health care practices are regulated in some way by other state and/or federal bodies. Notwithstanding the applicability of these other regulations to providers in their role as medical practitioners, the MFCA and the remedies

available thereunder are also applicable to the providers in their role as Medicaid claimants.

B. The administrative sanctions of the Public Health Code are not exclusive and do not displace the Attorney General's authority.

Part 161 of the Michigan's Public Health Code addresses the rules and regulations applicable to the conduct of health professions, including that of pharmacists. The Board of Pharmacy is empowered under MCL 333.17722, among other things, to regulate, control, and inspect the character and standard of pharmacy practice. To that end, the disciplinary subcommittee may under MCL 333.17768, fine, reprimand, or place on probation, deny, limit, suspend, or revoke a person's license or order restitution or community service.

Defendants argue that the remedy for violation of section 17755(2) is limited to the administrative remedies provided in section 17768. Such a statutory construction is not supported by a plain reading of the statute. Nor would it make sense, since the PHC and the MFCA address separate injuries to different parties. See, *US ex rel Augustine v Century Health Serv,* 289 F3d 409 (2002).

Unlike the MFCA, the Public Health Code is concerned with regulating activities related to the practice of health professions by a licensee—not with ferreting out and prosecuting the provider's false Medicaid claims. MCL 333.16221. LARA is empowered to investigate activities of health practitioners and to impose only certain specified sanctions, where appropriate. MCL 333.16104(2), MCL 333.17768.

There is no mechanism under LARA's statutory scheme by which the Attorney General, or an individual acting on behalf of the State, can bring an action against a provider for false claims. Neither is there a mechanism for encouraging individuals to expose fraud that they discover due to their insider knowledge or information. Consequently, to make administrative sanctions under the PHC exclusive would be to usurp the role of the Attorney General in fighting fraud through enforcement of the MFCA and would preclude it from initiating an action.

Congress envisioned prosecutions under state law for Medicaid fraud; 42 USC 1396b(q) defines the term "State Medicaid Fraud Control Unit," and sets forth numerous criteria that must be satisfied for an entity to qualify as such a unit. For an entity to be designated a state Medicaid Fraud Control Unit it must investigate and prosecute violations of all applicable state laws "regarding *any and all aspects of fraud* in connection with (A) *any aspect of the provision of medical assistance and the activities of providers of such assistance* . . . and (B) . . . *any aspect of the provision of health care services and activities of providers of such services* under any Federal health care program." 42 USC 1396b(q) (emphasis added).

The Attorney General is empowered to prosecute those committing MFCA violations, notwithstanding the fact that such providers are subject to other government regulatory provisions. For example, notwithstanding that dentists' practices are also under the regulatory authority of LARA, the State had authority to prosecute a dentist in *People v Kanaan*, 278 Mich App 594, 751 NW2d 57 (2008),

and to prosecute physicians in both *In re Rucker*, 121 Mich App 798, 329 NW2d 510 (1982), and *People v Orzame,* 224 Mich App 551, 570 NW2d 118 (1997), for submission of fraudulent Medicaid claims.

Moreover, nothing in the plain language of the Public Health Code makes its administrative sanctions exclusive. Where, as here, the statutory language is clear and unambiguous, judicial construction is neither necessary nor permitted. *Sun Valley Foods Co v Ward*, 460 Mich 200, 236, 596 NW 2d 119 (1999). A court must "look to the object of the statute and the harm it was designed to remedy and apply a reasonable construction in order to accomplish the statute's purpose. Particular provisions should be read in the context of the entire statute to produce a harmonious whole." *ABC Supply Co v River Rouge*, 216 Mich App 396, 398, 549 NW 2d 73 (1996). If judicial construction of the Code is appropriate, it is plain that the those administrative sanctions must be viewed as furthering the mandate of the Board in protecting the public's health, safety, and welfare, not in protecting the State's fisc by detecting and prosecuting Medicaid fraud.

If the plaintiffs (including the State of Michigan as a party in interest) must look to the administrative sanctions of the Public Health Code as their exclusive means of redress, then, in effect, they are left with no redress. The sanctions available to the Board are inadequate to discourage fraud, since they do nothing to discourage providers from overcharging Medicaid, and then, if caught, simply paying the restitution or administrative fines.

In contrast, the Medicaid False Claims Act creates an incentive for insiders, such as relators, and at the same time discourages fraud by allowing for the imposition of per claim monetary penalties, and for the award of triple damages, interest, fees, and costs. MCL 400.612. In addition, the MFCA encourages the exposure of fraud by protecting anyone who files a lawsuit under the Act from being fired, demoted, threatened, or harassed by their employer as a result of filing a false claims act lawsuit.

In sum, nothing in the language of the Public Health Code restricts a private party from bringing an action under the MFCA where violations of MCL 333.17755 result in false claims being submitted for payment by the Medicaid program. And nothing in the language of the Code can be construed as making the sanctions available thereunder the exclusive means of redress when a pharmacy violates MCL 333.17755(2) by failing to pass along its generic drug savings to Medicaid and instead presenting inflated claims. Indeed, it is the mandate and function of the Department of the Attorney General to detect and fight Medicaid fraud through enforcement of the MFCA—including its *qui tam* provisions—irrespective of the fact that LARA regulates certain aspects of the pharmacist's practice.

CONCLUSION

The Attorney General urges the Court to reject Defendants' argument that overcharging Medicaid for generic drugs does not result in a false claim under the Medicaid False Claim Act. Pricing is an essential component of the Medicaid pharmacy claim and must be based on true and accurate information and reported in conformity with statute, rules, and policy. Further, pharmacy providers expressly certify their claims will be true and accurate and are not based on false information.

Where breach of section 17755(2) of the Public Health Code results in a provider submitting to Medicaid false and inflated claims for generic drugs, a claim may be brought under the Medicaid False Claims Act. Nothing in the PHC precludes the use of MFCA remedies where a provider has submitted false claims or committed Medicaid fraud. Moreover, the MFCA is precisely the appropriate mechanism for ferreting out such false claims, as it provides an incentive to industry insiders to bring such false claims to light on behalf of the State, allows for restitution to the State, and permits the imposition of per-claim monetary penalties that discourage such fraud. Regulatory breaches that result in Medicaid being overcharged are best addressed through the enforcement mechanism provided by the MFCA.

Respectfully submitted,

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517-241-6500

Dated: January 8, 2014

S:/CASES/2009-0012670/BRF.AMICUS.140108

EXHIBIT A

Michigan Department of Community Health

Pharmacy Provider Enrollment & Trading Partner Agreement

Attached is the Pharmacy Provider Enrollment & Trading Partner Agreement (MSA-1626) used by the Michigan Department of Community Health (MDCH) Pharmacy Benefits Manager (PBM), First Health Services Corporation (FHSC) to enroll pharmacies into the Fee-For-Service (FFS) Programs for Medicaid, Children's Special Health Care Services, Adult Benefits Waiver, Maternity Outpatient Medical Services, and *Plan First!*.

It is very important that you update your information with the National Council for Prescription Drug Programs (NCPDP). NCPDP is the clearinghouse that provides pharmacy contact information to FHSC and ultimately to MDCH. The web address for NCPDP is https://www.ncpdponline.org .

To receive Electronic Funds Transfer (EFT) payments you must complete the FHSC Electronic Funds Transfer (EFT) Authorization form. You must contact the FHSC Provider Enrollment Department at 804-965-7619 to obtain this form.

If you are an out-of-state/beyond borderland pharmacy requesting enrollment in the Michigan Medicaid Program, see additional enrollment information for out of state providers at www.michigan.fhsc.com >> Providers >> Provider Forms >> Out of State Billing Information.

The effective date of enrollment for a pharmacy provider is the date you sign the Agreement (license permitting) should FHSC receive the **Agreement and all required documentation** within 30 days of the signature date. Effective dates for some pharmacy providers are determined by certification requirements or other approval dates. A pharmacy may request retroactive enrollment in writing. This request must contain a valid reason for retroactive enrollment. The retroactive written request must accompany this Agreement. Approval for retroactive enrollment is not a waiver for any claim(s) not submitted within the Michigan Medicaid Program billing guidelines.

You will be notified when your Agreement has been processed/approved via a fax form "Michigan Medicaid Provider Enrollment Confirmation" which will contain your Medicaid enrollment information.

If you have questions concerning enrollment, please contact the FHSC Provider Enrollment Department at (804) 965-7619 or (804) 965-7748 or via e-mail HWTune@fhsc.com.

First Health Services Corporation
Michigan Medicaid – Provider Enrollment Department
4300 Cox Road
Glen Allen, VA 23060

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

Pharmacy Provider Enrollment & Trading Partner Agreement Conditions and Provisions

IMPORTANT

- Trading Partner Provisions apply to all electronic billers.
- Either party, upon thirty (30) days written notice, may cancel this Agreement.

In applying for enrollment as a provider or trading partner with First Health Services Corporation (FHSC) (and programs for which the Michigan Department of Community Health (MDCH) is the fiscal intermediary), I represent and certify as follows:

1. The applicant and the employer certify that the undersigned have the authority to execute this Agreement.
2. Enrollment in the Medical Assistance Program does not guarantee participation in MDCH managed care programs nor does it replace or negate the contract process between a managed care entity and its providers or subcontractors.
3. All information furnished on this Pharmacy Provider Enrollment & Trading Partner Agreement is true and complete.
4. The providers and fiscal agents of ownership and control information agree to provide proper disclosure of provider's, owner's and other person's criminal convictions related to Medicare, Medicaid or Title XX involvement. [42 CFR 455.100]
5. The applicant and the employer agree to provide proper disclosure of any criminal convictions related to Medicare (Title XVIII), Medicaid (Title XIX), and other State Health Care Programs (Title V, Title XX, and Title XXI) involvement. [42 CFR 455.106 and 42 U.S.C. § 1320a-7]
6. Before billing for any pharmacy services that I render, I will read the Michigan Medicaid Provider Manual from the Michigan Department of Community Health (MDCH) and the First Health Claims Processing Manual. I also agree to comply with: 1) the terms and conditions of participation noted in the Manuals; and 2) MDCH's policies and procedures for the Medical Assistance Program contained in the manual, manual updates, provider bulletins and other program notifications.
7. I agree to comply with the provisions of 42 CFR 455.104, 42 CFR 455.105, 42 CFR 431.107 and Act No. 280 of the Public Acts of 1939, as amended, which state the conditions and requirements under which participation with MDCH is allowed.
8. I agree to comply with the requirements of Section 6032 of the Deficit Reduction Act of 2005, codified at Section1902(a)(68) of the Social Security Act, which relates to the conditions and requirements of "Employee Education About False Claims Recovery."
9. I agree that, upon request and at a reasonable time and place, I will allow authorized state or federal government agents to inspect, copy, and/or take any records I maintain pertaining to the delivery of goods and services to, or on behalf of, a MDCH beneficiary. These records also include any service contract(s) I have with any billing agent/service or service bureau, billing consultant, or other healthcare provider.
10. I agree to include a clause in any contract I enter into which allows authorized state or federal government agents access to the subcontractor's accounting records and other documents needed to verify the nature and extent of costs and services furnished under the contract.
11. I understand that payment for services billed under my provider identification number will be made directly to me, unless Item 19 (below) applies.
12. I am not currently suspended, terminated, disbarred, or excluded from the Medical Assistance Program by any state or by the U.S. Department of Health and Human Services.
13. I agree to comply with all policies and procedures of the MDCH when billing for services rendered. I also agree that disputed claims, including overpayments, may be adjudicated in administrative proceedings convened under Act No. 280 of the Public Acts of 1939, as amended, or in a court of competent jurisdiction. I further agree to reimburse the Medical Assistance Program for all overpayments, and I acknowledge that the Medicaid Audit System, which uses random sampling, is a reliable and acceptable method for determining such overpayments.
14. I agree to comply with the privacy and confidentiality provisions of any applicable laws governing the use and disclosure of protected health information, including the privacy regulations adopted by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Public Acts 104-191 (45 CFR Parts 160 and 164, Subparts A and E). I also agree to comply with the HIPAA security regulations, as applicable, for electronic protected health information (45 CFR Parts 160 and 164, Subparts A and C). I will abide

by the Trading Partner section of this Agreement, and the HIPAA regulations regarding electronic transactions and code sets, as applicable. (45 CFR Parts 160 and 162).

15. This Agreement shall be governed by the laws of the State of Michigan and applicable federal law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
16. The provisions of this Agreement are severable. If any provision is held or declared to be illegal, invalid or unenforceable, the remainder of the Agreement will continue in full force and effect as though the illegal, invalid or unenforceable provision had not been contained in this Agreement.
17. Failure or delay on the part of either party to exercise any right, power, privilege, or remedy in this Agreement will not constitute a waiver. No provision of this Agreement may be waived by either party except in writing, signed by an authorized representative of the party making the waiver.

Pharmacy Provider – Employer/Employee Conditions

18. The **applicant** is employed by the business listed, now referred to as the "**employer**", to provide Medical Assistance Program services to eligible beneficiaries at the service address listed.
19. The **employer** shall use the **applicant's** Pharmacy provider identification number assigned at the service location when billing for pharmacy services provided by the applicant to eligible beneficiaries.
20. The **applicant**, as a condition of employment, agrees that the employer shall directly receive the payments made in his/her name by the MDCH for services billed and paid for eligible beneficiaries.
21. The **employer** and the **applicant** shall advise MDCH within thirty (30) days after any changes in the employment relationship.
22. The **employer** and the **applicant** agree to be jointly and severally liable for any overpayments billed and paid under Act No. 280 of the Public Acts of 1939, as amended, for services provided by the applicant to eligible beneficiaries.

Trading Partner Provisions

The MDCH/FHSC and its Trading Partner desire to facilitate the exchange of pharmacy transactions ("Transactions") by electronically transmitting and receiving data in agreed formats in substitution for conventional paper-based documents.

1. **Companion Documents; Standards; Other Documentation.**
   MDCH makes available certain inbound and outbound Electronic Data Interchange (EDI) transaction sets/formats and associated versions. From time to time during the term of this Agreement, FHSC may modify supported transaction sets/formats. In submitting Transactions to FHSC, Trading Partner agrees to conform to FHSC-issued provider publications and FHSC Payer Specifications as amended from time to time. The FHSC Payer Specifications for Michigan Medicaid, incorporated by reference herein, contain specific instructions for conducting each Transaction and as such supplement Implementation Guides issued under the Standards for Electronic Transactions mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended. The FHSC Payer Specifications for Michigan Medicaid are not intended to be complete billing instructions and do not alter or replace applicable pharmacy guides or other pharmacy provider billing publications issued by MDCH or by other third party payers. The Trading Partner agrees to comply with the requirements set forth in the applicable FHSC Payer Specifications for Michigan Medicaid. The Trading Partner, or its vendor or other authorized technical representative responsible for EDI software, will document Trading Partner information, data formats and related versions, trading partner identifiers, and other information MDCH requires to receive and transmit specific Transactions supported by FHSC.
2. **Support.**
   As to software, equipment, and services associated with each party's performance under this Agreement, the parties agree to provide support services sufficient for Transactions to be exchanged. Each party will assist the other in establishing and/or maintaining support procedures, and will complete appropriate problem determination procedures prior to contacting the other with a support related matter. The parties agree to use all commercially reasonable efforts to avoid and resolve performance and unavailability issues. Each party will perform remedial action as requested by the other to assist in problem resolution. Each party, at its own expense, shall provide and maintain the equipment, software, services, and testing necessary to effectively and reliably transmit and receive transactions.
3. **Data Retention.**
   FHSC will log all Transactions for the purposes of problem investigation, resolution, and servicing. The Trading Partner is responsible for maintaining and retaining its own records of data submitted to FHSC on behalf of MDCH. Trading Partners who are pharmacy providers will ensure that electronic pharmacy claims submitted to FHSC can be readily associated and identified with the correct patient pharmacy records, and that these records are maintained in a manner that permits review and for the time period as may be required by MDCH or other third party payer responsible for claim payment.

4. **Proper Receipt and Verification for Transactions.**
Upon proper receipt of NCPDP Standard Transactions, the receiving party shall promptly and properly transmit a functional acknowledgement in return, unless otherwise specified. The functional and interchange acknowledgements must be accepted and reviewed, when applicable, to confirm the receipt of a Transaction. The ability to send or receive functional acknowledgements is applicable only to NCPDP Standard Transactions. Additionally, FHSC originated outbound Transactions must be accepted and reviewed, when appropriate, to obtain FHSC's response to specific inbound Transactions. The acknowledging party does not attest to the accuracy of the data contained in the transmission; rather, it only confirms receipt of the transmission.

5. **Liability.**
FHSC shall not be responsible to the Trading Partner nor anyone else for any damages caused by loss, delay, rejection, or any misadventure affecting such electronic information. In addition, FHSC shall be excused from performing any EDI service or function, in whole or in part, as a result of an act of God, war, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control, including shortages or fluctuations in electrical power, heat, light, or air conditioning. FHSC's sole liability to the Trading Partner, or to any other person or entity in connection with FHSC's responsibilities under this Agreement, shall be to reprocess information supplied by the Trading Partner or duplicate information from a backup supplied by the Trading Partner upon FHSC's request, which shall be the sole remedy against FHSC for claimed damage or injury of any nature. FHSC shall not be liable for any indirect, special, or consequential damages arising out of any access, use, or any reliance upon, the EDI services MDCH/FHSC provides to the Trading Partner. FHSC assumes no responsibility for claims preparation, review, information accuracy, pricing, adjudication, payment, adjustment, accounting, reconciliation or any other matter related to the claims transmitted for delivery to other third party payers. The Trading Partner agrees to defend, indemnify, and hold harmless FHSC, its Trading Partners, officers, agents, employees, assigns and successors from and against any and all claims, losses, and actions, including all costs and reasonable attorney fees arising out of electronic Transactions the Trading Partner submits to FHSC on behalf of MDCH.

6. **Standard Transactions.**
All Standard Transactions, as defined by HIPAA, will be conducted by the parties using only code sets, data elements, and formats specified by the Transaction rules and instructions in the FHSC Payer Specifications for Michigan Medicaid. The parties agree that when conducting Standard Transactions, they will not change the definition, data condition, or use of a data element or segment in a standard, add data elements or segments to the maximum defined data set, use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s), or change the meaning or intent of the HIPAA standards implementation specifications.

7. **Testing.**
All new Trading Partners will cooperate with FHSC upon request in testing processes prior to submission of production data. Existing Trading Partners will cooperate with FHSC upon request in testing processes for any changes in submission format prior to submission of production files. FHSC will notify the Trading Partner of the effective date for production data after successful testing.

8. **Data and Network Security.**
The parties agree to use reasonable security measures to protect the integrity of data transmitted under this Agreement and to protect this data from unauthorized access. The Trading Partner shall comply with FHSC data and network security requirements which may change from time to time, and as may be required by the HIPAA security regulations.

9. **Automatic Amendment for Regulatory Compliance.**
This Agreement will automatically be amended to comply with any final regulation or amendment to a final regulation adopted by the U.S. Department of Health and Human Services concerning the subject matter of this Agreement upon the effective date of the final regulation or amendment.

10. **Miscellaneous.**
Provisions 3 and 8 shall survive termination of this Agreement.

The Trading Partner will notify FHSC of any changes in Trading Partner information supplied including, but not limited to, the name of the service bureau, billing service, recipient of remittance file, or provider code at least 30 calendar days prior to the effective date of such change.

MDCH / FHSC

PHARMACY PROVIDER ENROLLMENT & TRADING PARTNER AGREEMENT

To be completed by FHSC Staff only		
Provider ID Number	Provider Type	Eligibility Begin Date / /
Group ID Number	Location Code	Eligibility End Date / /

NOTE: Review "Instructions" (page 8) for detailed information of this Agreement.

PROVIDER / APPLICANT INFORMATION

1. Business Name of Pharmacy (Parent Company)		2. Doing Business As	
3. Applicant Name and Title		4. Phone Number ( ) -	5. Fax Number ( ) -

Note: All identification numbers require a photocopy of documentation.

6. State License Number	7. Tax ID Number/EIN Number	8. State Tax ID Number	9. N.P.I. Number Applicant/Store
10. NCPDP Number	11. DEA Number	12. Medicare Number	

13.A Classification of Pharmacy (Check one that applies.)

☐ Chain (5 or more stores) ☐ Independent (1 to 4 stores)

13.B Pharmacy Business Type (Check all that apply.)

☐ Community/Retail	☐ Mail Order	☐ Long Term Care	☐ Veterans Health Administration
☐ Home Infusion	☐ Institutional Pharmacy	☐ Managed Care Pharmacy	☐ Clinic Pharmacy
☐ Specialty Pharmacy	☐ Military Pharmacy	☐ Compounding Pharmacy	☐ Indian Tribal/Urban Indian Health Services
☐ Franchise	☐ Government	☐ Other (explain) -	

14. Business Type (Check all that apply.)

☐ Sole Proprietor ☐ Non-profit ☐ Partnership ☐ Corporation ☐ 340B ☐ Government

SERVICE ADDRESS			BILLING ADDRESS		
15. Street Address (include suite number)			21. PO Box or Street Address (include suite number)		
16. City	17. State	18. Zip Code	22. City	23. State	24. Zip Code
19. Phone Number ( ) - ext.	20. County		25. Phone Number ( ) - ext.		

26. CORRESPONDENCE INFORMATION

Contact Person Name	E-mail Address	Phone Number ( ) - ext.	
PO Box or Street Address (include suite number)	City	State	Zip Code
If Trading Partner is a Provider who elects to receive an 835, and Trading Partner uses multiple submitters, Trading Partner must designate one recipient for all 835 electronic remittance advices.	Unique Receiver ID or Name		

27. AUDIT CORRESPONDENCE INFORMATION

Audit Contact Name:	PO Box or Street Address (include suite number)		
Phone Number ( ) - ext.	City	State	Zip Code

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

NOTE: Include a photocopy of ownership and control interest documents as required by 42 CFR 455.104.

28. Ownership Information. **THIS IS REQUIRED.** (List the individual owners. The owner's signature acknowledges agreement with the conditions and provisions of the "Pharmacy Provider Enrollment & Trading Partner Agreement". Use page 7 for additional ownership information.)

Owner's Name	Date of Ownership	Percent Owned	Owner's Social Security Number
Print Name and Title	/ /	%	- -
Signature	Relationship to any owners (See instructions.)		Date Signed
Print Name and Title	/ /	%	- -
Signature	Relationship to any owners (See instructions.)		Date Signed

29. Ownership Interest Information. List ownership interest in other entities reimbursable by Medicaid and/or Medicare. (List the individual owners. Use page 7 for additional ownership information.)

Owner's Name			Owner's Name		
Entity Name			Entity Name		
Entity Mailing Address (PO Box **or** Street, including suite number)			Entity Mailing Address (PO Box **or** Street, including suite number)		
City	State	Zip Code	City	State	Zip Code
Entity Federal Tax Identification Number	Phone Number ( ) -		Entity Federal Tax Identification Number	Phone Number ( ) -	

30. MANAGING EMPLOYEE [as defined by 42 CFR 455.101 (c)]

Print Name and Title	Managing Employee's Social Security Number - -	Date Signed / /
Signature		

BY SIGNING THIS AGREEMENT, I ASSERT THAT I HAVE READ AND AGREE TO THE PHARMACY PROVIDER ENROLLMENT & TRADING PARTNER AGREEMENT – CONDITIONS AND PROVISIONS.

(Important: Facsimile signatures will not be accepted.)

31. Does any employee have Criminal Convictions relating to Title V, Title XVIII, Title XIX, Title XX or Title XXI?

☐ NO ☐ YES *

* See "Instructions" for further details.

32. Signature of Applicant	33. Date Signed

Mail completed Agreement **and** required documentation to:

First Health Services Corporation
Michigan Medicaid - Provider Enrollment Department
4300 Cox Rd.
Glen Allen, VA 23060

USE THIS SHEET FOR ADDITIONAL OWNERSHIP INFORMATION. (MAKE PHOTOCOPIES AS NEEDED.)

28. (continued) Ownership Information. THIS IS REQUIRED. (List the individual owners. The owner's signature acknowledges agreement with the conditions and provisions of the "Pharmacy Provider Enrollment & Trading Partner Agreement".)

Owner's Name	Date of Ownership	Percent Owned	Owner's Social Security Number
Print Name and Title	/ /	%	- -
Signature	Relationship to any owners (See instructions.)		Date Signed
Print Name and Title	/ /	%	- -
Signature	Relationship to any owners (See instructions.)		Date Signed
Print Name and Title	/ /	%	- -
Signature	Relationship to any owners (See instructions.)		Date Signed
Print Name and Title	/ /	%	- -
Signature	Relationship to any owners (See instructions.)		Date Signed

29. (continued) Ownership Interest Information. List ownership interest in other entities reimbursable by Medicaid and/or Medicare. (List the individual owners.)

Owner's Name			Owner's Name		
Entity Name			Entity Name		
Entity Mailing Address (PO Box **or** Street, including suite number)			Entity Mailing Address (PO Box **or** Street, including suite number)		
City	State	Zip Code	City	State	Zip Code
Entity Federal Tax Identification Number	Phone Number ( ) -		Entity Federal Tax Identification Number	Phone Number ( ) -	
Owner's Name			Owner's Name		
Entity Name			Entity Name		
Entity Mailing Address (PO Box **or** Street, including suite number)			Entity Mailing Address (PO Box **or** Street, including suite number)		
City	State	Zip Code	City	State	Zip Code
Entity Federal Tax Identification Number	Phone Number ( ) -		Entity Federal Tax Identification Number	Phone Number ( ) -	

INSTRUCTIONS FOR THE PHARMACY PROVIDER ENROLLMENT & TRADING PARTNER AGREEMENT

PHOTOCOPIES OF THIS AGREEMENT MUST NOT BE USED TO REQUEST ENROLLMENT.

This Agreement is to be completed by all eligible providers who wish to receive payment for services provided under the programs for which the Michigan Department of Community Health serves as the fiscal intermediary.

An ***original*** Agreement must be submitted for ***each*** pharmacy provider rendering services. ***NOTE: Photocopies of this Agreement (except page 7) will not be accepted.***

TYPE or PRINT in BLACK INK.

Item 1: Print the business name of the pharmacy (or the parent company name) that is licensed in Michigan.

Item 2: Print the name under which the pharmacy does business as.

Item 3: Print the name of the individual and the individual's title who is completing this Agreement.

Item 4: Print the phone number of the business listed in Item 2.

Item 5: Print the fax number of the business listed in Item 2.

Item 6: Print the state license number of the business listed in Item 2. A photocopy of the current state license ***must*** be submitted with this Agreement for in-state, out-of-state, newly licensed, and limited/temporary licensed pharmacies.

Item 7: Print the tax ID number/employer ID number (EIN) for the business listed in Item 2. A photocopy of the tax ID number/EIN number ***must*** be submitted with this Agreement.

Item 8: Print the state tax ID number. A photocopy of the pharmacy state tax ID number ***must*** be submitted with this Agreement.

Item 9: Print the NPI of the business listed in Item 2. A photocopy of the NPI ***must*** be submitted with this Agreement.

Item 10: Print the NCPDP number of the business listed in Item 2. Each pharmacy practice location must have its own unique NCPDP number. A photocopy of the NCPDP number ***must*** be submitted with this Agreement.

Item 11: Print the DEA number of the business listed in Item 2. A photocopy of the DEA number ***must*** be submitted with this Agreement.

Item 12: Print the Medicare number for the business listed in Item 2. A photocopy of the Medicare number ***must*** be submitted with this Agreement.

Item 13A: Check the appropriate box for the classification of pharmacy that best describes your primary business.

Item 13B: Check the appropriate box(es) for the classification of pharmacy that best describes your pharmacy business type.

Item 14: Check the appropriate box(es) for the business type. A list of 340B drugs and changes **must** be provided for exclusion from the rebate process. (Nonprofit organizations do not complete Items 28-29.)

Items 15-20: Print the street address (include suite number if applicable), city, state, zip code, phone number & extension, and county as the physical location of the business listed in Item 2.

Items 21-25: Complete these Items if you want checks, remittance advices, and IRS 1099 forms sent to an address other than the service address. Print the street address or P.O. Box address, city, state, zip code, and phone number.

Item 26: Complete this section if you want letters, bulletins, etc. from Michigan Department of Community Health (MDCH) sent to an address other than the service address. Print the contact person's name, e-mail address, phone number, street address or P.O. Box, city, state, and zip code. Print the Unique Receiver ID or Name that is assigned to the business identified in Item 7. ***All providers*** under that corporate Tax Identification Number (TIN)/EIN must indicate the same Unique Receiver ID or Name. ***This Unique Receiver ID or Name will be the entity that receives the 835 Health Care Payment/Advice Transactions for providers under the same TIN/EIN.***

Item 27: Complete these Items if a Corporate Entity wants to receive notification on MDCH Audit Findings and Gross Adjustments for individual pharmacies.

INSTRUCTIONS FOR THE PHARMACY PROVIDER ENROLLMENT & TRADING PARTNER AGREEMENT

Item 28: **Must be completed:**

a. Complete this Item for each individual having 5% or more ownership in the business identified in Item 2. Each individual owner must print his/her name and title, date of ownership, percentage owned, and social security number. A signature and date signed for each individual owner is also required. List the relationship to any person related to the owner or individual with a 5% or more controlling interest (i.e., spouse, parent, child, siblings, etc.). If additional space is needed, use Page 7. (Page 7 may be photocopied as needed to obtain the information and signature for each individual owner.) ***Facsimile signatures will not be accepted.***

b. Complete this item if not applicable by printing **"No Individual and/or entity meets this requirement"** in the *Print Name and Title* field. A confirmation signature and date from authorized individual listed in item 32.

Item 29: **Must be completed:**

a. Complete this Item for each individual listed in Item 28 who also has ownership interest in other entities reimbursable by Medicaid and/or Medicare. If additional space is needed, use Page 7. (Page 7 may be photocopied as needed to obtain the information for each individual owner.)

b. Complete this item if not applicable by printing **"No Individual and/or entity meets this requirement"** in the *Owner's Name* field. A confirmation signature and date from authorized individual listed in item 32.

Item 30: The Managing Employee as defined in 42 CFR 455.101 (c), of the business listed in Item 2 **must complete this Item.** Print name, title, social security number, date signed and signature.

Item 31: Check the appropriate box if you have criminal conviction and sanctions relating to Title V, Title XVIII, Title XIX, Title XX, or Title XXI. Federal laws 42 CFR 455.106 and 42 U.S.C. § 1320a-7 require the State to collect criminal convictions information related to Medicare (Title XVIII), Medicaid (Title XIX), or other State Health Care Programs (Title V, Title XX or Title XXI) for any person who has ownership or control interest, or is a managing employee of the provider. If this applies, provide information and/or documentation on a separate page.

Items 32-33: The applicant (identified in Item 3) who can be held responsible for the business listed in Item 2 **must** sign and date this Agreement.

Retain a photocopy of the completed Pharmacy Provider Enrollment and Trading Partner Agreement for your records.

Mail the completed Agreement <u>and</u> required documentation to:

First Health Services Corporation
Michigan Medicaid - Provider Enrollment Department
4300 Cox Rd.
Glen Allen, VA 23060