



## P R O V I D E R   B U L L E T I N

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**To:           All Providers****Subject:   Employee Education About False Claims Recovery****Overview**

The Deficit Reduction Act of 2005 (DRA) amended the Social Security Act with important requirements related to Medicaid program integrity. Under Chapter Three of the DRA, entitled “Eliminating Fraud, Waste and Abuse,” the US Congress enacted provisions regarding the “Employee Education About False Claims Recovery” (Section 6032) and the Medicaid Integrity Program (MIP) (Section 6034). Medicaid program integrity influenced the False Claims Act (FCA) and Section 6032 of the DRA which established Section 1902(a)(68) of the Social Security Act.

In a broad sense, Medicaid program integrity works to ensure that all aspects of the Medicaid program are strong and functioning well. To this end, the new DRA requirements direct the Centers for Medicare and Medicaid Services (CMS) to improve methods to detect and prevent fraud, waste, and abuse in federal health care programs.

Under the MIP, CMS is statutorily required to develop a five-year comprehensive Medicaid integrity plan. This information is available, along with other information about combating Medicaid fraud, waste and abuse at <http://www.cms.hhs.gov/MDFraudAbuseGenInfo/>. Other recent program integrity initiatives include new tamper resistant prescription pad use requirements, and the Payment Error Rate Measurement (PERM) project. Information regarding the PERM project will be published soon.

This bulletin provides notification to affected entities about how the Indiana Family and Social Services Administration (FSSA) and the Office of Medicaid Policy and Planning (OMPP) is implementing section 6032 of the Deficit Reduction Act of 2005, section 1902(a)(68) of the Social Security Act (the Act), and the False Claims Act as they relate to “Employee Education About False Claims Recovery” and in detecting and preventing fraud, waste, and abuse in federal health care programs.

**Requirements for Health Care Entities**

“Employee Education About False Claims Recovery” establishes an entity’s requirements for compliance. Section 1902(a)(68) of the Social Security Act reads as follows:

“A State plan for medical assistance must provide that any entity that receives or makes annual payments under the [Medicaid] State plan of at least five million dollars (\$5,000,000) as a condition of receiving such payments shall --

- (A) establish written policies for all employees of the entity (including management) and of any contractor or agent of the entity, that provide detailed information about
  - a) the False Claims Act established by sections 3729 through 3733 of Title 31 of the United States Code,

- b) administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code,
  - c) any State laws pertaining to civil or criminal penalties for false claims and statements, and
  - d) whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f)).
- (B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and
- (C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

An entity is not required to create an employee handbook if one does not already exist. No template of policy language is being furnished to entities as this detail should clearly relate to the entities specific practices.”

## Requirements for States

Section 6032 further identified duties of the States to conduct reviews to assess provider compliance.

The OMPP, or its contractors, will conduct reviews annually of selected entities. The reviews will include collection and an examination of the entities' policies and procedures regarding the education it provides to employees, management, officers, and contractors or agents as set out in items (A) through (C) above. This federal legislation became effective January 1, 2007. Indiana will begin the reviews of entities during the 4<sup>th</sup> quarter of 2007.

Upon request by OMPP or its contractors, entities will provide a copy of the policies and procedures for review purposes.

Upon request by OMPP or its contractors, entities will provide a copy of the employee handbook, if one exists, for review purposes.

The State has submitted and received approval for a State Plan Amendment to meet the requirements of Section 6032. In addition, the state is promulgating rules to reflect the necessary changes in the Indiana Administrative Code (IAC).

The State has updated the provider agreement with requirement # 44, which requires that,

“For any entity that receives or makes annual payments totaling at least \$5,000,000 annually as described in 42 U.S.C. 1396a(a)(68), to establish written policies that provide detailed information about federal and state False Claims Acts, whistleblower protections, and entity policies and procedures for preventing and detecting fraud and abuse. In any inspection, review, or audit of the entity by OMPP or its contractors, the entity shall provide copies of the entity's written policies regarding fraud, waste, and abuse upon request. Entity shall submit to OMPP a corrective action plan within sixty days (60) if the entity is found not to be in compliance with any part of the requirements stated in this paragraph.”

As noted in requirement number 2 of the provider agreement, all providers are required,

“To comply with all federal and state statutes and regulations pertaining to the Indiana Health Coverage Programs, as they may be amended from time to time.”

Notices of such updates to the agreement incorporate such additions. Affected contracts have been amended with the requirements of this law.

## Consequences of Noncompliance for Health Care Entities

If an entity is found not to be in compliance with any part of the requirements noted above regarding the False Claims Act and section 1902(a)(68) of the Social Security Act, entities are required to submit to OMPP a corrective action plan within 60 days.

The corrective action plan will describe the actions and methods the entity will follow to ensure that the entity comes into compliance. If an entity is required to submit a corrective action plan and does not do so within 60 days, the State may withhold payment to the entity until a corrective action plan is received. The corrective action plan will designate a contact person within the entity responsible for communicating plan implementation details with OMPP.

## Definitions

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

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

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an “entity” (such as, a state mental health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (such as, managing the claims processing system or determining beneficiary eligibility) is not for these purposes, considered to be an entity.

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

**EMPLOYEE** – An “employee” includes any officer or employee of the entity.

**CONTRACTOR or AGENT** – A “contractor” or “agent” includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

## Contact Information

Send questions about this requirement in writing directly to each managed care plan a provider is individually contracted with, or in writing to the Program Integrity Division within the OMPP in care of:

Catherine Snider  
Program Integrity Manager  
Office of Medicaid Policy and Planning  
402 West Washington Street  
Room W382  
Indianapolis, Indiana 46204-2739

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Indiana

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

4.42 Employee Education About False Claims Recoveries.

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

(1) Definitions.

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

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

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

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

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

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

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

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

**TN No. 07 - 001**

**Supersedes TN No. N/A**

**Approval Date: 6/6/2007**

**Effective Date: 1/1/2007**

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Indiana

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

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

(5) The State will implement this State Plan amendment on January 1, 2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

TN No. 07 -001

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Approval Date: 6/6/2007

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Employee Education About False Claims Recoveries

- 1a. The Indiana Office of Medicaid Policy and Planning (OMPP) or its contractors will conduct reviews annually of selected entities defined under 4.42(a)(1)(A). These reviews will include examination of the entities' policies and procedures regarding the education of employees, management, officers, contractors or agents of the entity regarding the False Claims Act, specifically on the entities' methods for detecting and preventing fraud, waste, and abuse in Federal health care programs, discussion of the laws described in the policies, whistleblower protection rights, and other provisions named in section 1902(a)(68) of the Social Security Act.
- 1b. Upon request by OMPP or its contractors, entities will provide a copy of the policies and procedures to OMPP or the OMPP contractor who conducts the review.
- 2a. During the review, the Indiana Office of Medicaid Policy and Planning (OMPP) or its contractors will further examine the entities' employee policy handbook, if one exists, for a detailed discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers, and a specific discussion of the entities' policies and procedures for detecting and preventing fraud, waste, and abuse in Federal health care programs.
- 2b. Upon request by OMPP or its contractors, entities will provide a copy of the employee handbook, if one exists, to OMPP or the OMPP contractor who conducts the review.
- 3a. Entities are required to submit to OMPP a corrective action plan within sixty days (60) if an entity is found not to be in compliance with any part of the requirements noted above regarding the False Claims Act and section 1902(a)(68) of the Social Security Act.
- 3b. The corrective action plan will describe the actions and methods the entity will follow to ensure that the entity comes into compliance. The corrective action plan will designate a contact person within the entity responsible for communicating with OMPP on implementation of the plan.
4. The State will incorporate into the provider agreement and affected contracts the requirements of this law upon approval of the State Plan amendment.
5. The State will provide information to entities through publication of material regarding the requirements to meet compliance with the False Claims Act and section 1902(a)(68).