

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID AND MEDICAL ASSISTANCE
Statutory Authority: 31 **Delaware Code**, Section 512 (31 **Del.C.** §512)

PROPOSED

PUBLIC NOTICE

Employee Education About False Claims Act

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**), pursuant to 42 CFR §447.205, and under the authority of Title 31 of the **Delaware Code**, Chapter 5, Section 512, the proposed provides notice to the public that the Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) has filed a Title XIX Medicaid State Plan Amendment (SPA) with the Centers for Medicare and Medicaid Services (CMS) to comply with the mandated provisions of the Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) pertaining to Employee Education About False Claims Recovery.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Policy and Program Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 (new fax number) by May 31, 2007.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSED AMENDMENT

Statutory Authority

Deficit Reduction Act of 2005 (Public Law 109-171), enacted on February 8, 2006, Section 6032, *Employee Education About False Claims Recovery*

Background

The federal Deficit Reduction Act of 2005 (DRA) calls for active enforcement of Medicaid fraud and abuse as part of a "Medicaid Integrity Program" (MIP). In particular, effective January 1, 2007, Section 6032 of the DRA requires any entities that receive or make annual payments under the Title XIX Medicaid State Plan of at least \$5 million dollars, as a condition of receiving such payments, to have established written policies and procedures about the Federal and State False Claims Act for their employees, agents and contractors.

Specifically, Section 6032 amends the Social Security Act, Title 42, United States Code, Section 1396a(a), by inserting an additional relevant paragraph. To summarize, this new paragraph mandates that any entity that receives or makes annual payments under the State Plan of at least \$5 million dollars annually, as a condition of receiving such payments, must comply with the following requirements:

- 1) Establish written policies for all employees of the entity, including management and any contractor(s) or agent(s) of the entity. These written policies shall provide detailed information about the following:
 - Federal False Claims Act, including administrative remedies for false claims and statements established under Title 31, USC, Chapter 38.
 - State laws pertaining to civil or criminal penalties for false claims and statements; whistleblower protections under such laws; and the role of these laws in preventing and detecting fraud, waste and abuse in Federal health care programs.
- 2) The written policies must include details about the entity's policies and procedures for detecting and preventing fraud, waste and abuse.
- 3) Any employee handbook for the entity must include specific discussion of the laws about false claims and statements, the rights of employees to be protected as whistleblowers, and the entity's policies and

procedures for detecting and preventing fraud, waste and abuse.

Based on guidance in the form of State Medicaid Director Letter (SMDL) #06-024, dated December 13, 2006,

CMS has interpreted the word "entity" to include:

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.

CMS has clarified that payments to the entity are to be aggregated for purposes of the annual threshold:

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 6032] 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.

CMS has clarified that the annual threshold is based on the Federal fiscal year:

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 6032] 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.

These changes are effective January 1, 2007.

Summary of Proposals

The state plan amendment will establish DHSS's oversight of policies and procedures to implement the education of employees regarding the false claims act.

Pursuant to this plan amendment, the Department will provide oversight and monitoring of entities that receives or makes Title XIX Medicaid payments of at least \$5,000,000 annually based on payments received or made in Federal fiscal year 2006.

The provisions of this amendment are subject to approval by the Centers for Medicare and Medicaid Services (CMS).

DMMA PROPOSED REGULATION #07-20

NEW:

79 x 1

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

4.42 Employee Education About False Claims Recoveries.

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

- (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 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 January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

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

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

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

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(3) An entity shall establish written policies for all employees (including management, and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1920(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 of **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.

ATTACHMENT 4.42-A

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FALSE CLAIMS ACT ATTACHMENT

1. The Delaware Health and Social Services (DHSS), the single state agency, will send a letter to any entity that receives annual payments of at least \$5 million during the October 1, 2005 to September 31, 2006 period regarding the requirements of Section 6032 of the Deficit Reduction Act of 2005, the "Employee Education About False Claims Recovery," These letters will be sent by March 30, 2007.
2. DHSS will request copies of an affected provider's written policies, and the plan to disseminate those policies to staff, within three (3) months of State Plan approval.
3. Affected providers written policies and procedures will be reviewed for compliance with the Act. Said policies and procedures will include an explanation of the false claims act; the providers' policies and procedures for detecting and preventing waste, fraud and abuse; the rights of the employee to be protected as whistle blowers; and, the telephone numbers and/or addresses for reporting fraud and abuse.
4. Thereafter, DHSS will contact affected providers on a yearly basis for any update or change to its written policies. DHSS will accomplish this verification by provider survey.
5. New affected providers identified each year will be required to submit their polices and dissemination plan and will be handled per #2, 3, 4.
6. DHSS has a range of sanctions contained in its administrative regulation for non-compliance with Medicaid policies. These sanctions range from requiring a plan of correction to termination from the Medicaid program. These sanctions will be applied to non-compliance with the "Employee Education About False Claims Recovery."

10 DE Reg. 1660 (05/01/07) (Prop.)