



MEDICAL ASSISTANCE BULLETIN

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF PUBLIC WELFARE

ISSUE DATE January 2, 2007	EFFECTIVE DATE January 1, 2007	NUMBER 99-07-01
-------------------------------	-----------------------------------	--------------------

SUBJECT
False Act Claims Provisions of Deficit Reduction Act of 2005
Employee Education About False Claims Recovery

BY

James L. Hardy, Deputy Secretary
Office of Medical Assistance Programs

PURPOSE:

The purpose of this bulletin is to notify participating Medical Assistance (MA) providers, including MA Managed Care Organizations (MCOs) of the requirements of Section 6032 of the Federal Deficit Reduction Act (DRA) of 2005, P.L. 109-171 (S 1932) (Feb. 8, 2006), which pertains to employee education about false claims recovery.

SCOPE:

This bulletin applies to MA providers, including MA MCOs, who annually receive or make payment of at least \$5 million from the MA Program.

BACKGROUND/DISCUSSION:

On February 8, 2006, the DRA of 2005 was signed into law. Among the several provisions which impact the Commonwealth's MA Program is Section 6032 which imposes new requirements on any entity that receives or makes at least \$5 million in annual MA payments.

Specifically, Section 6032 requires that, as a condition of payment, each such entity 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 the False Claims Act established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under Chapter 38 of Title 31, for false claims and statements established under Chapter 38 of Title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll free number for your provider type.

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap

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.”

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 SMDL #06-024, (Dec. 13, 2006).

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 SMDL #06-024, (Dec. 13, 2006).

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. CMS SMDL #06-024, (Dec. 13, 2006).

Additional information provided by CMS may be accessed at:

<http://www.cms.hhs.gov/smdl/downloads/SMD121306.pdf>

PROCEDURE:

Any MA provider, including any MA MCO that receives or makes \$5 million in annual MA payments, must comply with Section 6032 as a condition of receiving payment under the MA Program. To comply with Section 6032, the provider must ensure that no later than January 1, 2007, it has implemented 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 Pennsylvania laws imposing civil or criminal penalties for false claims and statements, or providing whistleblower protections under such laws, including 62 P.S. §§ 1407 (relating to provider prohibited acts, criminal penalties and civil remedies) and 1408 (relating to other prohibited acts, criminal penalties and civil remedies), the Pennsylvania Whistleblower Law, 43 P.S. §§ 1421-1428;
- 2) In addition to the 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 MA Programs.
- 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 MA Programs, to the provider or to the appropriate authorities.

Any MA provider that receives or makes annual payments of \$5 million or more under the MA Program must certify that it complies with Section 6032 of the DRA. Specifically, each year, providers must complete and submit the attached form attesting compliance with Section 6032 of the DRA to the Bureau of Program Integrity. Providers must submit their initial annual attestation form no later than December 31, 2007.

The Office of Medical Assistance Programs, through the BPI, has the responsibility to ensure compliance with the requirements. If there are any questions, please do not hesitate to contact the BPI at (717) 705-6872.