

State of California—Health and Human Services Agency
Department of Health Services



California
Department of
Health Services

SANDRA SHEWRY
Director



ARNOLD SCHWARZENEGGER
Governor

DATE: MAR 09 2007

MMCD All Plan Letter 07007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: FEDERAL DEFICIT REDUCTION ACT OF 2005
(EMPLOYEE EDUCATION ABOUT FALSE CLAIMS)

This All Plan Letter (APL) discusses Section 6032 of the federal Deficit Reduction Act of 2005 (DRA). Additional APLs concerning the DRA will be forthcoming, as more information and guidance is provided by the Centers for Medicare and Medicaid Services (CMS).

DRA Section 6032 created a new Section 1902(a)(68) of the Social Security Act. Generally speaking, Section 6032, as interpreted by CMS, requires any entity, including any Medicaid managed care organization, that receives or makes annual payments of at least \$5,000,000 under the State Plan or under any waiver of such plan to establish written policies for its employees (including management), subcontractors and agents that give detailed information about federal and state false claims laws and whistleblower protections. The written policies must also include detailed information about the entity's policies and procedures for detecting and preventing fraud, waste and abuse. If the entity has an employee handbook, the handbook must include specific discussion of the state and federal laws dealing with false claims, the rights of employees to be protected as whistleblowers, and the policies and procedures for detecting and preventing fraud, waste and abuse. The entity's written policies must be adopted by its subcontractors and agents and any other person who, on behalf of the entity, furnishes or authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity. DRA Section 6032 took effect on January 1, 2007.

On December 13, 2006, CMS issued State Medicaid Director Letter (SMDL) #06-025 discussing DRA Section 6032. A copy of SMDL #06-025 is attached hereto for your convenience. SMDL #06-025 requires the State to implement oversight measures to monitor compliance with Section 6032. As Section 6032 makes clear, an entity must be in compliance with the statute as a condition of receiving payment from Medi-Cal. Accordingly, all Medi-Cal managed care health plans should submit their Section 6032

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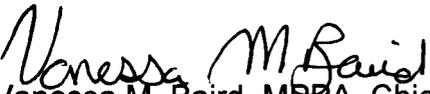
MAR 09 2007

policies and procedures, plus any relevant employee handbook excerpts, to the California Department of Health Services for review and approval within 30 calendar days from the date of this letter.

If you have not already received it, specific contract amendment language requiring compliance with Section 6032 will be forwarded to you in the near future.

If you have questions about the DRA implementation process or the information in this letter, please contact your Contract Manager. Thank you for your continued cooperation.

Sincerely,


Vanessa M. Baird, MPPA, Chief
Medi-Cal Managed Care Division

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

DEC 13 2005

SMDL #06-025

Dear State Medicaid Director:

We are writing to offer guidance to State Medicaid agencies on the implementation of section 6032 of the Deficit Reduction Act of 2005. This provision establishes section 1902(a)(68) of the Social Security Act (the Act), and relates to "Employee Education About False Claims Recovery."

The following definitions are included in the accompanying State Plan Preprint, although additional guidance in this letter further clarifies the Preprint:

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 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.

An "employee" includes any officer or employee of the entity.

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 monitoring of health care provided by the entity.

It is the responsibility of each entity to 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. Although section 1902(a)(68)(C) refers to “any employee handbook,” there is no requirement that an entity create an employee handbook if none already exists.

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. The Centers for Medicare & Medicaid Services (CMS) is not providing model language, though States may elect to do so.

The provisions of section 1902(a)(68) of the Act must be implemented no later than January 1, 2007, except as provided in the section 6034(e) delayed effective date of the Deficit Reduction Act of 2005. To the extent a State determines that it requires legislation to implement this section and wishes to avail itself of the section 6034(e) delayed effective date, it must request through CMS that the Secretary concur with the determination that legislation is required.

The requirements of this law should be incorporated into each State’s provider enrollment agreements. Each State must also determine the manner by which it will ensure an entity’s compliance with section 1902(a)(68), which information each State must include in its State Plan along with a description of the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis. Each State shall so amend its State Plan not later than March 31, 2007, or by the end of the quarter in which the effective date of delayed implementation occurs, as described in section 6034(e). CMS may, at its discretion, independently determine compliance through audits of entities or other means. CMS may also review a State’s procedures through its routine oversight of States.

If you have any questions on this guidance, please direct them in writing to: Mr. Robb Miller, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Medicaid Integrity Group, 7500 Security Boulevard, Mailstop B2-15-24, Baltimore, MD 21244 or Ms. Claudia Simonson, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Medicaid Integrity Group, Division of Field Operations, 233 North Michigan Avenue, Suite 600, Chicago, IL 60601 or robb.miller@cms.hhs.gov or claudia.simonson@cms.hhs.gov.

Sincerely,



Dennis G. Smith
Director

Enclosure

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cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Carden
Director of Policy and Programs
Association of State and Territorial Health Officials

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Lynne Flynn
Director for Health Policy
Council of State Governments