

Medicaid Providers Become Obligated to Educate Employees About Fraud and Abuse and Whistleblower Protections

By Robert R. Stauffer, Edward F. Malone and Sandi J. Toll

On January 1, 2007, a little known deadline in Section 6032 of the 2005 Deficit Reduction Act took effect that will have a significant impact on health care providers that receive at least \$5 million in annual Medicaid business. This section, entitled "Employee Education About False Claims Recovery," established Section 1902(a)(68) of the Social Security Act (the "SSA") (42 U.S.C. 1396a(a)(68)), and now requires health care providers to establish written policies that provide detailed information about federal and state laws relating to fraud, waste, and abuse and whistleblower protections as well as the entity's own policies and procedures for detecting and preventing such behavior. The penalties for non-compliance may eventually cost covered entities millions of dollars in Medicaid payments.

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Under Section 6032 of the Deficit Reduction Act, the SSA was amended to require any entity that receives or makes annual payments of at least \$5,000,000 in Medicaid payments to implement the following procedures as of January 1, 2007 as a condition for receiving payment. Specifically, Section 1902(a)(68) of the SSA states that these entities must:

- "(A) [E]stablish 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 [federal] False Claims Act..., [federal] administrative remedies for false claims and statements..., any State laws pertaining to civil or criminal penalties for false claims and statements, and 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."
- "(B) [I]nclude as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse."
- "(C) [I]nclude in any employee handbook for the entity, a specific discussion of the [aforementioned federal and state] laws..., the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse."

On December 13, 2006, the Centers for Medicare and Medicaid Services ("CMS") issued guidance in the form of a letter to State Medicaid agencies regarding how to implement Section 1902(a)(68)'s requirements into their state plans and provider enrollment agreements. Although CMS provided some general guidance regarding which entities are subject to Section 1902(a)(68)'s requirements and the type of information that must be contained in their written policies and procedures, CMS expressly stated that it is "not providing model language" for entities to use. However, CMS noted that states "may elect" to provide model language if they chose to do so.

Who Is Covered?

Under the CMS guidance, an entity is subject to Section 1902(a)(68)'s requirements if it is "a government 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.” A “covered entity” will have met the \$5,000,000 amount as of January 1, 2007 if it received or made payments in that amount in federal fiscal year 2006.

What Must A Covered Entity Do?

CMS stated that each covered entity must “establish and disseminate written policies which must also be adopted by its contractors or agents.” A “contractor” or “agent” is defined to include “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 entity.” Notably, CMS did not indicate how a covered entity is supposed to ensure that its contractors and agents adopt and comply with such written policies and procedures.

Although covered entities can disseminate their policies in written or electronic form, they “must be readily available to all employees, contractors or agents.” However, CMS provided covered entities with a major exception: if an entity does not already have an employee handbook, it does not need to create one in order to comply with Section 6032.

What Should The Policies Contain?

As previously noted, CMS expressly chose not to provide covered entities with model language for their written policies and employee handbooks. Instead, CMS only reiterated the language

contained in Section 1902(a)(68) and stated that a covered entity’s policies must contain “detailed information” about the (i) federal False Claims Act; (ii) federal administrative remedies for false claims and statements; (iii) any state laws pertaining to civil or criminal penalties for false claims and statements; and (iv) any whistleblower protections available under such federal and state laws. The policies must also include “detailed information” about the entity’s policies and procedures for detecting and preventing waste, fraud and abuse.

If the covered entity has an employee handbook, CMS again only reiterated what is already included in Section 1902(a)(68) – that the employee handbook must now include a “specific discussion” of the federal and state laws identified in the covered entity’s written policies as well as the covered entity’s procedures relating to fraud, waste, and abuse detection and prevention. The employee handbook must also contain “the rights of employees to be protected as whistleblowers” when they report potential fraud and abuse to the appropriate governmental authorities.

What Are The Responsibilities Of State Medicaid Agencies?

CMS noted that State Medicaid agencies must incorporate Section 1902(a)(68)’s requirements into their provider enrollment agreements and decide which information will be included in its State Plans. While each state is also required to determine how it will ensure an

entity’s compliance, oversight and enforcement of Section 1902(a)(68) is not limited to the states as CMS can also “review a State’s procedures through its routine oversight of States.”

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Given that CMS expressly decided not to provide model language in its guidance letter, there remains a great deal of uncertainty surrounding the implementation of Section 1902(a)(68) requirements, particularly with respect to the nature of the policies and procedures that covered entities should adopt. Some guidance may be gleaned, however, from CMS requirements for compliance policies that Medicare Part D providers must adopt (the subject of a recent OIG audit assessing the extent to which providers have adopted programs that satisfy CMS requirements) and from OIG guidances on compliance programs for various sectors of the health care industry.

Jenner & Block LLP provides information on recent developments and general topics of interest in the field of health care law. The information presented here is not intended to be legal advice. Please address any questions or comments to:

Robert R. Stauffer
330 N. Wabash Avenue
Chicago, IL 60611-7603
Tel: 312 923-2905
E-mail: rstauffer@jenner.com