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VHCA
Richmond District Meeting
Guidelines for Educating
Employees and Contractors
on the New False Claims Act

Presented by Peter M. Mellette,
President, Mellette PC
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What is the False Claims Act?

- A federal law passed to address Civil War abuses by contractors (31 USC 3729).
- Applied over the last 2 decades to health care claims.
 - Includes claim filing, related statements, conspiracy, false possession of government property and false records
 - Includes each item or service billed
 - \$5,500 - \$11,000 penalty applies to each item billed plus up to 3 times the cost of the fraudulent item
- State law includes similar provisions (Va. Code 8.01-216).
- See Handout 1 for comparison of federal and state law.

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What has happened so far...

- Section 6032 of the Deficit Reduction Act of 2005 (“DEFRA”) went into effect January 1, 2007.
- DEFRA requires any **“entity”** that receives more than **\$5 million** in Medicaid payments to establish **written policies** providing information about the False Claims Act, Program Fraud Civil Remedies Act and **applicable state laws** to its employees and certain **contractors**.
- CMS released a guidance document on December 13, 2006 which clarifies DEFRA’s applicability. (See Handout 2)
- DMAS issued a Medicaid memo dated December 22, 2006 reminding DMAS providers of DEFRA. (See Handout 3)

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What has happened so far...

- On January 11, 2007, CMS held a national teleconference in question and answer format to address provider concerns with DEFRA compliance.
- Only 43 callers out of over 800 present were able to ask questions and CMS indicated that further questions should be directed to:
medicaid_integrity_program@cms.hhs.gov
- On March 22, 2007, CMS issued a set of Frequently Asked Questions to supplement the Dec. 13, 2006 guidance document. CMS also advised States that this “final” guidance document was effective immediately.

What constitutes an “entity”?

- The entity must receive \$5 million or more in Medicaid payments, based on:
 - Each state’s determination of whether to calculate the \$5 million based on date of service or date of payment
 - The federal fiscal year (October 1 to September 30)
 - The amount actually received (not charged) and not including copays
 - \$5 million or more in a single state



What does a provider need to do to comply with the new laws?

- Establish written policies and procedures for all employees (including management, contractors and agents) giving detailed information about the False Claims Act and other such laws and giving detailed information about the providers own policies and procedures for detecting, investigating and resolving issues of fraud, waste and abuse
- Communicate these written policies to all employees and to some contractors and agents
- The written policies can be in paper or electronic form.
- These policies and procedures must be included in the employee handbook if one exists.
- All agreements with certain contractors should incorporate the requirements of the law.



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What should a policy include?

- Statement of policies and procedures
- Explanation of federal and state law claims (including an explanation of whistleblower protection)
- Examples of a false claim
- Steps an employee should take when s/he detects a false claim (including different avenues for reporting, i.e. reporting to supervisor, compliance hotline, etc.)
- See AHCA Model Policy (Handout 4)

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Model Provider DRA Policy and/or Employee Handbook Insert

PURPOSE

[THE PROVIDER] is committed to its role in preventing health care fraud and abuse and complying with applicable state and federal law related to health care fraud and abuse. The Deficit Reduction Act of 2005 requires information about both the federal False Claims Act and other laws, including state laws, dealing with fraud, waste, and abuse and whistleblower protections for reporting those issues. To ensure compliance with such laws, [THE PROVIDER] has policies and procedures in place to detect and prevent fraud, waste, and abuse, and also supports the efforts of federal and state authorities in identifying incidents of fraud and abuse. INSERT ONE OF TWO SENTENCES HERE:

[IF THE PROVIDER HAS EXISTING POLICIES]

This policy sets forth information concerning the [PROVIDER'S] existing policies and procedures, including avenues for reporting concerns internally, and an overview of the Federal Civil False Claims and Program Fraud Civil Remedies Acts and applicable state laws.

[IF THE PROVIDER DOES NOT HAVE EXISTING POLICIES]

This policy sets forth [THE PROVIDER'S] policies and procedures for detecting and preventing fraud, waste, and abuse and an overview of the Federal Civil False Claims and Program Fraud Civil Remedies Acts and applicable state laws.

POLICIES AND PROCEDURES

[A PROVIDER THAT ALREADY HAS IN PLACE POLICIES AND PROCEDURES OR A CORPORATE COMPLIANCE PLAN CONCERNING THE DETECTING AND PREVENTING OF FRAUD, WASTE, AND ABUSE MAY CHOOSE TO SUMMARIZE OR REFER TO EXISTING POLICIES AND PROCEDURES HERE. A PROVIDER THAT DOES NOT HAVE SUCH POLICIES IN PLACE WILL WANT TO CREATE POLICIES THAT REFLECT ITS ONGOING EFFORTS TO DETECT AND PREVENT FRAUD, WASTE, AND ABUSE. The PROVIDER will want to include language that states that its policies and procedures are intended to detect and prevent fraud, waste, and abuse in its hospital or system, including fraud, waste, and abuse in the Federal and State health care programs.]

[The Provider] takes health care fraud and abuse very seriously. It is our policy to provide information to all employees, contractors and agents about the federal and state false claims acts, remedies available under these provisions and how employees and others can use them, and about whistleblower protections available to anyone who claims a violation of the federal or state false claims acts. We also advise our employees, contractors and agents of the steps [the Provider] has in place to detect health care fraud and abuse.

FEDERAL AND STATE FALSE CLAIMS LAWS

What about employee training and education?



- CMS recently confirmed that providers are not required to hold training on false claims for employees, contractors or agents.
- It is, however, imperative that the written policies and procedures are communicated and made available to all employees, contractors or agents.
- If the written policies and procedures are included in the employee handbook, the nursing facility must disseminate them to contractors and agents.

Who qualifies as a contractor?

- CMS has listed the following positions as being a “contractor” under DEFRA:
 - Anyone who “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.”
- Managed care organizations and their component parts have to comply as well.



Which contractors furnish Medicaid health care items or services?

- Under the CMS's Frequently Asked Questions, contractors who furnish Medicaid health care items or services include, but are not limited to:
 - Contract therapists
 - Physicians (including house staff, hospitalists and independent contractors), and
 - Pharmacies

Is an attending physician at a nursing facility considered a “contractor” or “employee”?



- According to CMS, an attending physician at a nursing facility would be a patient’s agent and would not be required to agree to the facility policy.
- But a medical director or nurse practitioner employed by a nursing facility would be required to agree to the policy

Should a contractor be required to adopt the provider's policies?

Re: Deficit Reduction Act of 2005 ("DRA") Education Requirements for Contractors and Agents

Dear _____:

The DRA requires providers such as ours to provide information to all its contractors and agents regarding the Federal False Claims Act ("FCA"), administrative remedies for false claims and statements, applicable state false claims provisions and whistleblower protections under these laws.

Enclosed you will find a copy of our policy which addresses our role in preventing healthcare fraud, waste and abuse. Please provide this information to all employees who have contact with our nursing facility related to delivery of Medicaid healthcare items or services, billing or coding functions, or who are involved in the monitoring of healthcare provided by the nursing facility.

Please sign in the space provided below acknowledging your receipt of this information and your agreement to provide this information to your employees. Return a copy of your executed letter to the following: _____.

You should also be aware that in the event our contract with you is renewed or extended, we will require an amendment to the contract that confirms your agreement to inform (educate) your employees as contemplate by the DRA regarding the applicable federal and state false claims acts.

Thank you very much for your time.

Sincerely,

ACKNOWLEDGED AND AGREED this ____ day of _____, 2007:

By: _____
Its: _____

- CMS has not been entirely clear on whether a contractor must “adopt” a provider’s policies.
- The best approach is to require a contractor to acknowledge in writing the provider’s policies.
- See Handout 5.

Do a provider and contractor need to amend their agreement?

- CMS has stated that a provider must determine if it needs to amend its agreement with a contractor, but that its policies must be incorporated into its relationship with the contractor.
- The best approach is to require a contractor to acknowledge the provider's policies, but also include an amendment requiring a contractor to educate its employees in any extension or renewal of the current agreement.

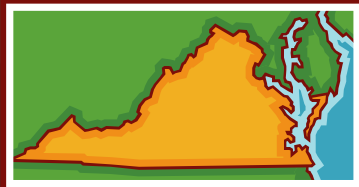


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What if there is no amended state plan?

- Providers are expected to comply with the new law regardless of whether a state has adopted a state plan amendment complying with DEFRA.
 - To date only four states have adopted such amended state plans: West Virginia, Kentucky, Idaho and Kansas.
- A provider should be prepared to revise its policies and procedures once the Virginia state plan amendment goes into effect.



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Section 6032 State Plan Preprint
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

Citation 4.42 Employee Education About False Claims Recoveries
1902(a)(68) of (a) The Medicaid agency meets the requirements
the Act, regarding establishment of policies and procedures for
P.L. 109-171 the education of employees of entities covered by
(section 6032) 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

TN No. _____ Approval Date: _____ Effective Date: _____
Supersedes _____
TN No. _____

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What is the next step?

- A provider has several options for ensuring that it complies with DEFRA requirements:
 - Adopt and distribute policies and new employee handbook incorporating the requirements of DEFRA
 - Implement an interim policy until the state plan amendment is issued
 - Create required policies with a retroactive effective date
 - Establish a list of state false claim laws. (See Handout 1)



Who should a provider consult with questions?

- Providers should submit additional questions to CMS via the e-mail address mentioned at the beginning of the program.
- Providers should also communicate with State Medicaid Agencies
- Finally, providers should consult with legal counsel



Questions?



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