Employee Education Requirement Regarding False Claims Recoveries

The Deficit Reduction Act of 2005 instituted a requirement for health care entities which receive or make **$5.0 million or more in Medicaid payments during a federal fiscal year** to establish written policies and procedures informing and educating their employees, contractors and agents about federal and state false claim acts and whistleblower protections.

If an entity furnishes items or services at more than a single location, under more than one contractual or other payment arrangement, or uses more than one provider or tax identification number, it is the aggregate of all payments to that entity that are used to determine if the entity reached the $5.0 million annual threshold.

These requirements are separate from, but related to, the mandatory provider compliance programs under New York Social Services Law § 363-d.

Health Care Entity

- A governmental or component agency providing Medicaid health care items or services for which Medicaid payments are made, or
- An 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 Medicaid.

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Section 1: Employee Education Requirement

A covered health care entity must establish and disseminate detailed written policies regarding:

- the federal False Claims Act;
- the New York State False Claims Act;
- the specific statutory and regulatory provisions named in section 1902(a)(68)(A) of the Social Security Act;
- any other applicable state civil or criminal laws and state and federal whistleblower protections; and
- information regarding the health care entity's policies and procedures for detecting and preventing waste, fraud and abuse

"Contractor" or "Agent"

- 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.

to all employees (including management), contractors or agents of the health care entity. For a summary of the relevant State and federal laws, please go to:

http://www.omig.ny.gov/images/stories/relevant_fca_statutes_122209.pdf

Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents of the health care entity.

It is the responsibility of each health care entity to establish and disseminate written policies for compliance by its contractors or agents.

Employee Handbook

If the health care entity **has** an employee handbook, then the handbook must include therein:

- 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 health care entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

There is no requirement that a health care entity create an employee handbook if none already exists.

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Section 2: Health Care Entity Certification Requirements

Oversight of this new requirement for affected New York enrolled Medicaid providers will primarily be the responsibility of the Office of the Medicaid Inspector General (OMIG) which will incorporate criteria to address these mandates into its periodic audits and investigations.

*Each applicable health care entity is required to submit to OMIG **on or before October 1, 2007** and on or before January 1, every year thereafter a certification:*

- *that it maintains the written policies, and*
- *that any employee handbook includes materials,*

required under the above mandates and that they have been properly adopted and published by the health care entity, and disseminated among employees, contractors and agents.

The written policies and any employee handbook shall be retained for a period of six years from the latter of the due date or the actual date of submission of the certification.

During audits, OMIG will review the certifications of the health care entity, the written policies and any employee handbook maintained by the health care entity, for compliance with the Social Security Act and any additional requirements of which health care entities are notified.

The Centers for Medicare and Medicaid Services may, at its discretion, independently determine health care entity compliance with this regulation.

Certification Form

The certification form is available online at:

https://www.omig.ny.gov/index.php?option=com_content&view=article&id=639

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Sanctions and Penalties

Failure to timely submit the required certifications, or to bring the written policies and any employee handbook into compliance may be considered an unacceptable practice and subject the health care entity to sanctions and/or penalties.

Additional Information

For more details on this requirement, please go to:

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

For a list of frequently asked questions, go to:

http://www.cms.hhs.gov/smdl/downloads/SMD032207Att1.pdf.

Questions? Please call the Office of the Medicaid Inspector General's Bureau of Compliance at: (518) 408-0401 or email at compliance@omig.ny.gov.

Fraud impacts all taxpayers.

Do you suspect that an enrollee or a provider has engaged in fraudulent activities?

Please call:

1-877-87FRAUD

Your call will remain confidential.

or complete an online Complaint Form at:
www.omig.ny.gov