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Corporate Compliance Plans – CMS Attempts to Clarify False Claims Policy Requirements

On January 11, 2007, the Centers for Medicare and Medicaid Services ("CMS") conducted a conference call in an attempt to answer questions from health care providers and health plans that sought guidance on the requirements of section 6032 of the Deficit Reduction Act of 2005 (the "DRA"), which requires certain health care providers and health plans to establish written fraud and abuse/whistleblower informational policies for all employees, contractors and agents as of January 1, 2007. Although some of the questions were answered, Robb Miller, CMS' Program Integrity Group Acting Director, acknowledged that CMS would need to "drill down" on several questions that remain unanswered.

As described in our *November 27, 2006 Reinhart E-Newsletter*, providers and health plans that make or receive $5 million or more in Medicaid reimbursement must establish written policies and procedures for all employees, contractors and agents that provide detailed information about certain fraud and abuse laws and whistleblower protection laws. Specifically, the policies must include detailed information about state and federal false claims laws, detailed provisions about the entity's relevant policies and procedures for detecting and preventing fraud, abuse and waste, and details about whistleblower protections that must be outlined in an employee handbook.

On December 13, 2006, CMS issued Federal Policy Guidance to State Medicaid Directors that provided some clarification to the section 6032 policy requirements. First, the guidance established that, when an entity furnishes items or services at multiple locations or under multiple contractual or other payment arrangements, section 6032 policy requirements apply if the aggregate Medicaid payments to that entity meet the $5 million annual threshold, regardless of whether one or more provider identification or tax identification number is used to submit claims. Second, the December 13th guidance explained that 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. The requirements would not apply to other contractors or agents (*e.g.*, contractors that provide janitorial services, office supplies, etc.). Finally, the December 13th guidance indicated that there is no requirement for an entity to

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create an employee handbook if none already exists.

As evidenced by the more than 800 callers that participated in the January 11th conference call, providers and health plans were still confused and had questions even after the December 13th guidance was released. Some of these questions were answered while others remain open issues.

Among the questions answered included how the $5 million dollar threshold would be calculated. Robb Miller explained that the threshold amount would be calculated based on the total dollar amount actually paid out by the Medicaid program (*i.e.*, not the claimed amount). However, the states will be able to decide whether the date of service or the date of payment will be used for purposes of calculating the sum of all payments made annually (*i.e.*, between October 1st and September 30th). In addition, Robb Miller explained that, in a multi-entity health system, section 6032 policy requirements will apply to each entity in the system if the aggregate Medicaid collections for all of the system's entities total $5 million or more. However, multi-state entities/systems do not need to aggregate payments received in separate states. Finally, with respect to calculating the threshold amount, any "patient paid amount" is not included.

In addition to clarifying the threshold dollar amount calculation, Robb Miller stated that there is no training requirement mandated by section 6032. Thus, although entities must establish and distribute the section 6032 policies, they do not need to conduct training sessions in order to educate employees, contractors and agents about such policies.

The primary question that was not definitively answered by CMS was whether an entity must require its contractors and agents to adopt, or comply with, its section 6032 policy or whether the entity is simply required to document that it sent a copy of the policy to each agent and contractor. Robb Miller indicated that CMS would "follow up" on that question. That said, from a risk standpoint, it is probably a good idea for an entity to require its contractors and agents to comply with the section 6032 policy. Depending on the provisions contained in the current agreements between an entity and its contractors/agents, this could potentially be accomplished by simply providing notice of the policy (along with a copy of the policy) to the agent/contractor. An entity may also have the ability to unilaterally amend some agreements to require compliance with its section 6032 policy. However, the terms of some contractor/agent agreements may require a mutually agreed-upon amendment which could give rise to a renegotiation.