



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



ARNOLD SCHWARZENEGGER  
Governor

DATE: July 1, 2008

MMCD All Plan Letter 08-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: REQUIREMENTS FOR EMPLOYEE EDUCATION  
REGARDING FALSE CLAIMS RECOVERY

On February 8, 2005, President Bush signed into law the Deficit Reduction Act (DRA), which requires certain changes in Medicaid programs. One of those changes is the requirement for employee education regarding false claims recovery. These changes went into effect January 1, 2007, as specified in the provider bulletin, "Federal Deficit Reduction Act 2005: Employee Education on False Claims Recovery" issued in December 2006.

Section 6032 of the DRA requires any entity that receives or makes annual payments under the State Plan (Medi-Cal) of at least five million dollars (\$5,000,000), as a condition of receiving such payments, to have established written policies and procedures regarding the Federal and State False Claims Act for their employees, agents, and contractors.

The Department of Health Care Services (DHCS) has determined that your entity received at least five million dollars during the 2006-2007 Federal Fiscal Year (October 1, 2006, through September 30, 2007). Therefore, you were required to be in compliance with Welfare & Institutions (W & I) Code Section 14115.75, as of January 1, 2008.

W & I Code Section 14115.75 states, in relevant part, "As a condition of payment for goods, supplies, and merchandise provided to Medi-Cal beneficiaries by a provider that receives or makes annual payments of at least five million dollars (\$5,000,000) under the Medi-Cal program, the provider shall comply with the federal False Claims Act employee training and policy requirements contained in Section 1902(a) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(68)), and with any requirements that the United States Secretary of Health and Human Services may specify... (b)... 'provider' has the same meaning as that term is defined in Section 14043.1, and also includes any Medi-Cal managed care plan...".

MMCD All-Plan Letter 08-007

Page 2 of 2


July 1, 2008

W & I Code 14043.1(o) states, "Provider' means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of any partnership, group association, corporation, institution, or entity, that provides services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary and that has been enrolled in the Medi-Cal program."

Amendment language implementing this requirement has already been completed for both the Geographic Managed Care and Two-Plan Model contracts and is included in the new boilerplate contract for the County Organized Health System plans.

If you have any questions, please contact Olmedo Correa, Chief, Medical Monitoring and Program Integrity Section at (916) 449-5139.

Sincerely,

A handwritten signature in black ink that reads "Vanessa M. Baird". The signature is written in a cursive style with a large initial "V".

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

Enclosure

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: CALIFORNIA

Page 80

Citation  
1902(a)(68) of the  
Act,  
P.L. 109-171  
(section 6032)

4.42 Employee Education About False Claims Recoveries.

- (a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by 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 health facility or school district providing school-based health services).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: CALIFORNIA

Page 81

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.

(B) An "employee" includes any officer or employee of the entity.

(C) 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 the monitoring of health care provided by the entity.

- (2) The entity must 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. The entity need not create an employee handbook if none already exists.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: CALIFORNIA

Page 82

- (3) 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.
  - (4) The requirements of this law should be incorporated into each State's provider enrollment agreements.
  - (5) The State will implement this State Plan amendment on January 1, 2008.
- (b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

Attachment 4.42A

Page 1

### METHODOLOGIES FOR COMPLIANCE OVERSIGHT

Methods for administration of the State Plan in accordance with 1902(a)(68) of the Social Security Act are:

1. The Department of Health Care Services (DHCS) will ensure entities who reach the \$5,000,000 threshold, as defined in 4.42(a)(1)(A) of the State Plan, comply with the above mentioned Act by:

- a) Making current state policy and procedures, covering 1902(a)(68), available to all entities.

A Provider Bulletin notifying all Medi-Cal providers of the new federal requirements was issued on December 4, 2006, and sent to all providers in the December 2006 Medi-Cal Update. This bulletin is posted on the Medi-Cal website.

Additionally, an "All Plan Letter" was sent to all Medi-Cal Managed Care Health Plans on March 9, 2007, and compliance language was added to managed care contracts.

- b) Providing initial written notice to each covered entity, informing them of their obligation to comply with the above mentioned Act as a condition of their continued participation in the Medi-Cal program. The initial notifications will be sent in June 2008.
- c) Requiring each entity to submit, within 90 days of receipt of the notice, a certification declaring the entity, and any contractor or agent of the entity, understands the law, is in compliance for the 2008 calendar year, and will continue to be in compliance each calendar year thereafter as long as the provisions are applicable. If an entity continuously meets the threshold, they will not be required to re-certify.

Medi-Cal Managed Care Health Plans and providers under the Selective Provider Contracting Program, including their contracted providers and entities, are subject to the false claims education requirements in their contracts, which are renewed annually. Therefore, they are not required to submit a certification.

- d) Conducting compliance reviews, as part of routine protocol, to validate that the entities are in compliance.
- e) Identifying, after the conclusion of each federal fiscal year, entities who have reached the \$5,000,000 threshold in the previous federal fiscal year, and providing them written notice of their obligation to comply with the regulations for the following calendar year and any calendar year thereafter, if the threshold is met. These notifications will be sent in December of each year and will be due within 90 days of receipt of the notice.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

Attachment 4.42A

Page 2

METHODOLOGIES FOR COMPLIANCE OVERSIGHT

2. DHCS may take administrative action for non-compliance through nonrenewal of provider enrollment or contract, or suspension or termination of provider status.

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