

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Wells</i>	DATE <i>6-27-07</i>
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DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOC NUMBER 000801	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____ <input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____ <input type="checkbox"/> FOIA DATE DUE _____ <input checked="" type="checkbox"/> Necessary Action		
2. DATE SIGNED BY DIRECTOR <i>Cc Ms. Bowling Singleton</i>			

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St, Suite 4120
Atlanta, Georgia 30303-8909



June 21, 2007

RECEIVED

JUN 27 2007

Ms. Susan B. Bowling, Acting Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Re: South Carolina Title XIX State Plan Amendment, Transmittal #07-004

Dear Ms. Bowling:

We have reviewed South Carolina's State Plan Amendment (SPA) 07-004, which was submitted to the Atlanta Regional Office on March 15, 2007. This SPA adds Section 6032 of the Deficit Reduction Act State Plan Preprint and Attachment 4.42-A to the South Carolina State Plan. The SPA provides the State's responsibility to establish policies and procedures for the education of employees covered by 1902(a)(68) of the Social Security Act (the Act) about the false claims recoveries. The SPA also sets out the monitoring assurance by the State Medicaid Agency of the providers' compliance with the requirements.

Based on the information provided, we are pleased to inform you that South Carolina SPA 07-004 was approved on June 13, 2007. The effective date is January 1, 2007. The signed CMS-179 and the approved plan pages are enclosed. If you have any questions regarding this amendment, please contact Elaine Elmore at (404) 562-7408.

Sincerely,

for *Hugh L. Webster*
Renard L. Murray, D.M.
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:
SC 07-004

2. STATE
South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE
January 1, 2007

5. TYPE OF PLAN MATERIAL (*Check One*):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:
1902(a)(68) of the Act P.L. 109-171 (section 6032).

7. FEDERAL BUDGET IMPACT:
a. FFY 2007 \$ Budget neutral
b. FFY 2008 \$ Budget neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):

ATTACHMENT 4.42-A, Pages 1 thru 3

10. SUBJECT OF AMENDMENT:

Employee Education About False Claims Recoveries

11. GOVERNOR'S REVIEW (*Check One*):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

Mr. Kerr was designated by the Governor
to review and approve all State Plans.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Robert M. Kerr

16. RETURN TO:

South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

13. TYPED NAME:
Robert M. Kerr

14. TITLE:
Director

15. DATE SUBMITTED:
March 15, 2007

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 15, 2007

18. DATE APPROVED:
June 13, 2007

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2007

20. SIGNATURE OF REGIONAL OFFICIAL:
Renard L. Murray

21. TYPED NAME:
Renard L. Murray, D.M.

22. TITLE: Associate Regional Administrator
Div of Medicaid & Children's Health Opns

23. REMARKS: Approved with the following change to Item 8 as authorized by the SA on
e-mail dated 6-20-07: Item 8 changed to read "Attachment 4.42-A, Pages 1 and 2".

Additional change authorized by the State Agency on e-mail dated 6-21-07: Item 8: Add
"pages 79y.1, 79y.1, 79y.2".

79y

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: SOUTH CAROLINA

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

79y.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: SOUTH CAROLINA

health facility or school district providing school-based health services). 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.

79y.2

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- (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, 2007.
- (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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: SOUTH CAROLINA

4.42-A Employee Education About False Claims Recoveries.

The Medicaid agency shall assure compliance with section 1902(a)(68) of the Act by the following means:

The South Carolina Department of Health and Human Services (DHHS) conducts oversight of compliance with section 6032 of the Deficit Reduction Act, regarding employee education about false claims act recoveries through a process that began with sending a bulletin to all providers on January 2, 2007, informing them of their responsibility to comply with this requirement. The department will also add a clause to all provider contracts, including those for managed care organizations (MCOs), informing them of their obligation to comply with these requirements.

SCDHHS, beginning January 15, 2006, and annually thereafter, will develop a report to identify which entities received Medicaid payments totaling more than \$5 million in Federal Fiscal Year 2006, to ensure that the State Medicaid Agency identifies aggregate payments that may have been made under more than one provider identification or tax ID number.

The State Medicaid Agency methodology to ensure that these providers comply with the requirements for employee education about False Claims recoveries will include the following components:

1. These providers, the bulk of which include hospitals, the MCOs, nursing homes, and state agencies, will be sent a letter no later than July 1, 2007, requiring them to return a certification statement to SCDHHS attesting that they have in the place the written policies and/or discussions in employee handbooks as required by section 6032 of the DRA. These providers will be required to send in their certification within 30 days upon receipt of the letter. By the end of August 2007 all entities, which meet the \$5 million threshold, will be required to certify to DHHS that they are in compliance.

2. The certifications will be confirmed by adding a compliance test to the current audit program for on-site reviews of major Medicaid providers, including MCOs. The SCDHHS Division of Audits will add a compliance test to its audit program for state agencies and MCOs on the 2007 audit schedule. The auditors will verify that these providers have established written policies for all employees, including management, and for any contractor or agent, that include detailed information about the False Claims Act; that they include in the written policies detailed information about their policies and procedures for detecting and preventing fraud, waste, and abuse; and that they 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 about the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.
3. The Division of Audits will review state agencies on a revolving schedule, and will plan to have made at least one on-site visit to each state agency and MCO, during which time compliance with section 6032 of the DRA will be verified.
4. Entities which fail to send in their certification within 30 days will be subject to an on-site review to determine why they have not responded and if they do have the policies as required.
5. Nursing homes and hospitals will be audited on a scheduled basis under audit programs which include certain agreed-upon audit procedures. A compliance test for the provisions of section 6032 of DRA will be added to these procedures. Nursing homes will be audited every three years; hospitals every three to five years. The auditors will report to SCDHHS whether these providers are in compliance with the DRA.
6. If, after reviewing the SCDHHS planned audit schedules, the State Medicaid Agency determines that a provider which meets the \$5 million test is not scheduled for an on-site audit within the next three to five years, SCDHHS will then require them to furnish the written policies and procedures and any employee handbooks as specified by the provisions of section 6032 of the DRA.
7. Each January SCDHHS will run an updated report to identify which providers received \$5 million or more in Medicaid payments during the previous federal fiscal year, and will ensure that these providers are either on a three to five year audit cycle or will require they furnish proof of compliance (by certifying and/or submitting the written policies) with the provisions for Employee Education about False Claims recoveries.