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.