State of Tennessee
Department of Finance and Administration
Bureau of TennCare
Division of Long Term Care
310 Great Circle Road
Nashville, TN 37243

Date: June 23, 2011

To: Administrators, Intermediate and Skilled Nursing Facilities

From: Patti Killingsworth, Assistant Commissioner
Chief of Long Term Care

IMPORTANT INFORMATION RE: Violations of the Medicaid False Claims Act

As you know, the federal as well as Tennessee False Claims Acts (Tennessee Code Annotated 71-5-181 -- 71-5-185) specify that a person or entity who presents ***or causes to be presented*** a claim for payment under the Medicaid program knowing such claim is false or fraudulent, or who makes, uses, or causes to be made or used, a record or statement to get a false or fraudulent claim under the Medicaid program paid for or approved by the state knowing such record or statement is false is in violation of the Tennessee as well as Federal False Claims Acts and is subject to federal and state civil penalties. The state civil penalty is not less than five thousand dollars ($5,000) and not more than twenty-five thousand dollars ($25,000), plus three (3) times the amount of damages which the state sustains because of the act of that person or entity.

PAEs (Pre Admission Evaluation forms) are submitted to TennCare for purposes of establishing eligibility for NF services. When approved, a PAE may also result in approval of Medicaid institutional eligibility and in a capitation payment to the Managed Care Organization (MCO) as well as payment of claims for physical and behavioral health, pharmacy and LTC services. It is therefore critical that the information submitted on a PAE is complete and accurate, and does not result in payments being inappropriately authorized to an MCO or to the NF or other health care providers.

It has come to our attention that there are two (2) situations in which NFs may be submitting information to TennCare which violates the False Claims Acts.

The first is **submission of a NF PAE when a person has elected to receive hospice services in the NF.** Hospice services are not LTC services. When a person has elected to receive hospice services in a NF, the NF is providing hospice room and board and not NF services. However, if a PAE is submitted for NF services with a Medicaid Only Payer Date (MOPD) that Medicaid-reimbursed NF services will begin and the person meets NF level of care, a CHOICES capitation payment will be generated in error to the MCO, resulting in an overpayment and a violation of the False Claims Act. Further, the physician who certified the PAE may also be in violation of the False Claims Act, because he has certified medical necessity for NF services (which is required for approval of the PAE), when in fact, hospice services are being received.

NFs are therefore advised to:

1) **Immediately cease submission of a PAE when a person has elected to receive hospice in the NF; and**

2) **Withdraw from TPAES any NF PAE submitted on behalf of a person receiving hospice (and not NF) services at the time the PAE was submitted.** To withdraw, locate the PAE in TPAES, Click the "Edit Enrollment" button and delete the date from the "Medicaid Only Payer Date" field. Please note that you cannot withdraw in TPAES a PAE that has already been approved by the Bureau. This action can be remedied *only* by deleting the MOPD.

The second situation pertains specifically to the Medicaid Only Payer Date (MOPD) in TPAES. This is the date that the facility certifies that Medicaid reimbursement for NF services will begin because the person has in fact been admitted to the facility and all other sources of reimbursement (including Medicare and private pay) have been exhausted. This date must be ***known*** (and not estimated) because it too may result in establishment of eligibility for LTC services and in many cases, eligibility for Medicaid, and in payment of a capitation payment as well as payments for Medicaid (including but not limited to LTC) services received. To the extent that a facility submits a MOPD that is incorrect, overpayments may be made to the MCO as a result of the NFs actions, resulting in a violation of the False Claims Act.

NFs are therefore advised to:

1) **Ensure that staff submitting PAEs on behalf of the facility enter a MOPD *only* when such date is known and confirmed.**

Further, if facility staff have submitted a MOPD when such date was NOT known and confirmed at the time of submission:

2) **Withdraw from TPAES any NF PAE submitted with a MOPD when Medicaid reimbursement for NF services is not being sought.** To withdraw, locate the PAE in TPAES, Click the "Edit Enrollment" button and remove the date from the "Medicaid Only Payer Date" field. Please note that you cannot withdraw in TPAES a PAE that has already been approved by the Bureau. This action can be remedied *only* by deleting the MOPD.

3) **Modify the MOPD if any PAE has been submitted with an incorrect MOPD to accurately reflect the date on which Medicaid reimbursement for NF services actually began.** To correct, locate the PAE in TPAES, Click the "Edit Enrollment" button and remove the date from the "Medicaid Only Payer Date" field and replace with the correct date.

If anyone acting on behalf of your facility has submitted any of these types of information that has resulted in an overpayment being paid—to you or to an MCO or other health care provider, **you have 60 days to return any overpayments you have received and complete these notifications so that appropriate adjustments can be made and potential violations can be avoided**. (See §6402 of the Affordable Care Act, effective March 2010.)

In addition, the Bureau has identified situations in which a NF's failure to provide proper notification of a change in a resident's status may result in violations of these Acts. These are situations in which a resident discharges from the facility or remains in the facility but elects to receive hospice benefits. In these cases, if the NF does not timely notify the MCO, using the form and process established by TennCare (see memo and form distributed on 9/13/10), the Bureau will continue to pay a capitation payment to the MCO for LTC services when the person is no longer receiving such services, resulting in an overpayment. As with the previous examples, in many cases, this also results in the person's eligibility in the Institutional category being extended in error, and in payments for physical and behavioral health, and pharmacy services for which the person no longer qualifies.

NFs are therefore advised to:

Submit to the MCO *immediately* a CHOICES Discharge/Transfer/Hospice Form *anytime* a TennCare CHOICES member is discharged from your facility or is no longer receiving NF services (including when a member elects to receive hospice). This includes:

- Transfers to another nursing facility
- Discharges to the hospital (even when return to the facility is expected)
- Discharges home, with or without HCBS
- Election of hospice services
- Upon a resident's death

The **Discharge/Transfer/Hospice Form** is to be **completed by the discharging facility and sent to the member's MCO.**

Please note that while a facility is contractually obligated to submit the form for transfers to another facility and such notification is very important in terms of coordinating care for the resident, failure to notify the MCO of a transfer would not result in a potential violation of the False Claims Acts. However, failure to submit the form for discharges and hospice elections will.

The Bureau is in process of identifying instances in which any of the actions discussed in this memo may have occurred in order to initiate recovery of any overpayments. It is therefore imperative that you take appropriate actions *immediately* in order to correct these overpayments and avoid violations that will otherwise be identified.

If you have any questions regarding this memo, please contact Pat Santel, Deputy of Long Term Care Operations at (615)507-6777 or Tony Mathews, Assistant Deputy of Long Term Care Operations at (615)507-6027.