Compliance

And

Attestation

Documents

Attestation of Compliance with Section 6032

of the Federal Deficit Reduction Act

Provider/Subcontractor: All Tennessee Care Givers

Address: 5705 Stage Road #162, Bartlett, TN 38104

FEIN: ___________________________________

I hereby attest that, as a condition for the above-identified Provider/Subcontractor to receive payments under the Tennessee Medicaid Program, I have read Section 6032 of the Deficit Reduction Act of 2005 (the Act) and confirm that:

- The Provider/Subcontractor's written policies and procedures contain detailed information about the Federal laws identified in Section 6032(A) and about Tennessee laws imposing civil or criminal penalties for false claims and statements, and about whistleblower protections under such laws, including the Tennessee Medicaid False Claims Act and Tennessee Whistleblower Protection (§§ 71-5-181 through -183); and
- The Provider/Subcontractor's written policies and procedures also contain detailed information regarding its own policies and procedures to detect and prevent fraud, waste and abuse in Federal health care programs; and
- The Provider/Subcontractor's written policies and procedures are included in any employee handbook maintained by the Provider/Subcontractor; and
- The Provider/Subcontractor provides copies of these written policies to its employees (including management); or
- In the alternative, Provider/Subcontractor may distribute to its employees and abide by the UnitedHealth Group Integrity of Claims, Reports and Representations to Government Entities in lieu of its own policies and procedures.

The Provider/Subcontractor confirms that the Provider/Subcontractor includes those identified in Attachment A (if attached).

I possess all necessary powers and authority to execute and make the representations contained in the Attestation of Compliance on behalf of the Organization and any Entity/provider identified on Attachment A. By affixing my signature hereto, I am confirming that the statements made in this attestation are true and accurate to the best of my knowledge and belief.

Signature:____

Print or Typed Name: Todd Bagatelas Date:__________________

Return to the address below – attention: UnitedHealthcare Community Plan Compliance Officer or fax to (866) 950-5161

COMPLIANCE REMINDERS

Deficit Reduction Act of 2005 (DRA) & Federal and State False

Claims Acts

The Deficit Reduction Act of 2005 contains many provisions reforming Medicare and Medicaid which are aimed at reducing Medicaid fraud. Under Section 6032 of the DRA, every entity that receives at least five million dollars in Medicaid payments annually must establish written policies for all employees of the entity, and for all employees of any contractor or agent of the entity, providing detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a contracted provider with UHCCP, you and your staff are subject to these provisions. The UnitedHealth Group/United Healthcare Community Plan (UHCCP) policy, titled "Integrity of Claims, Reports and Representations to Government Entities" can be found on the provider website. This policy details the company's commitment to compliance with federal and state false claims acts, provides a detailed description of these acts and of the mechanisms in place within our organization to detect and prevent fraud, waste and abuse, as well as the rights of employees under the Federal False Claims Act to be protected as whistleblowers.

A The policy, as well as the State and Federal False Claims Act are available at:
https://www.uhcrivervalley.com/10provider/01americhoice/integrityofclaims.asp.

State Medicaid Letter – Medicaid Providers to Screen for Exclusions

In the January 16, 2009, State Medicaid Directors letter, states are to advise providers of their obligation to screen all of their employees and contractors to determine whether any employee or contactor has been excluded from participation in the Medicaid program. Providers are required to search the HHSOIG website monthly to capture exclusions and reinstatements that have occurred since the last search. Providers are to immediately notify their Provider Relationship Manager regarding any exclusion information that is discovered.

A The State Medicaid Directors letter is available at:
http://www.cms.hhs.gov/SMDL/downloads/SMD011609.pdf.

A The HHS-OIG Exclusions Database is available at: http://exclusions.oig.hhs.gov.

Disclosure of Criminal Conviction, Ownership & Control Interest

In accordance with 42 CFR, Part 455, Subpart B and as required by CMS, individual physicians and other healthcare professionals must disclose criminal convictions, while facilities and businesses must additionally disclose ownership and control interest, prior to payment for any services rendered to Medicare or Medicaid enrollees. It is your responsibility as a contracted provider to immediately notify us of any changes to the information previously provided. Report changes to UHCCP at (800) 690-1606.

Limited English Proficiency (LEP) and Interpretation Services

As a contracted provider, you are responsible for offering interpretation services, without charge, to members. This is a requirement under Title VI and applies to any provider that accepts Federal funds. Several agencies provide interpretation and translation services statewide. One agency is Health Assist Tennessee. Health Assist Tennessee has medically trained interpreters as well as an American Sign Language interpreter for deaf or hard of hearing members. Using a trained medical interpreter leads to a better experience for the provider and patient. For additional information:

A Health Assist Tennessee http://www.healthassisttn.org or (615) 313-9841 ext. 280.
A Language Line www.languageline.com or (800) 752-6096 ext. 4.
A Hearing Bridges http://hearingbridges.org/interpreting_and_transcribing/ or (615) 248-8828.

Non-discrimination

All providers that participate in Federal and State programs must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Title II of the Americans with Disabilities Act of 1990, and all other laws that apply to organizations that receive Federal funding. You and your staff must treat members fairly. This means members have the right to equal access to appointment times, are not subjected to extended wait times, are given assistance with interpretation or translation services as

necessary, and are provided proper accommodations for any disabilities. If a member feels they have been discriminated against, they have the right to file a complaint by calling the customer service phone number on the back of their ID card. TennCare members may also complete the Unfair Treatment Complaint Form in the TennCare Member Handbook. SNP members may file a Grievance form.

A TennCare Member Handbook: www.uhcrivervalley.com/TennCare.
A SNP Grievance form:
https://www.uhcrivervalley.com/downloads/secureplusscomplete/MEDICAREGRIEVANCEFORM_Americhoice.pdf

Grier Posters

All providers who see TennCare members are required to have *Grier* posters in their office - visible to members - in English and Spanish. If you need additional posters, please contact Customer Service at 1-800-690-1606 or e-mail provider relations at AmeriChoice_TN_Outreach@uhc.com.

Advance Directives

There are many types of Advance Directives such as a Durable Power of Attorney for Health Care, an Appointment of Health Care Agent, a Living Will, an Advance Care Plan or a Declaration for Mental Health Treatment. The Patient Self-Determination Act (PSDA) requires Medicare and Medicaid providers to give adult individuals information about their rights under state laws governing advance directives, including: (1) the right to participate in and direct their own health care decisions; (2) the right to accept or refuse medical or surgical treatment; (3) the right to prepare an advance directive; and (4) information on the provider's policies that govern the utilization of these rights. If the patient has made an advance directive, a copy of the form should be filed in the patient's chart.

A Additional information on advance directives is available at: http://health.state.tn.us/AdvanceDirectives/index.htm.
A A provider guide on Declarations of Mental Health Treatment is available at:
http://state.tn.us/mental/t33/MHTDecProviderGuide.pdf.

Cultural Competency

In order to assist you and your staff in promoting high quality healthcare to increasingly diverse patients, the U.S. Department of Health & Human Services, Office of Minority Health, offers free online accredited courses for continuing education credit.

A Office of Minority Health is available at: http://www.omhrc.gov.
A Additional course information is available at: https://www.thinkculturalhealth.com.

Program Integrity, Fraud & Abuse

Healthcare fraud and abuse is a serious offense. The Department of Health & Human Services, Office of Inspector General website offers a wealth of information regarding fraud and abuse prevention, detection and reporting. As an UHCCP provider, you are required to report all suspected fraud and abuse activities.

A The Office of Inspector General website is at: www.oig.hhs.gov.
A Report SNP fraud & abuse to: 1-800-HHS-TIPS (800) 447-8477 or HHSTips@oig.hhs.gov.
A Report TennCare fraud & abuse to the Office of Inspector General at
http://www.tn.gov/tnoig/ReportTennCareFraud.html or (800) 433-3982.
A Report fraud and abuse to UHCCP (800) 690-1606.

Claims Integrity

UnitedHealth Group's Integrity of Claims, Reports and Representations to Government Entities Policy

UnitedHealth Group requires compliance with the requirements of federal and state laws that prohibit the submission of false claims in connection with federal health care programs, including Medicare and Medicaid. Every UnitedHealth Group employee, and in particular, every employee of each UnitedHealth Group business organization that receives or makes payments of $5 million or more under a state Medicaid contract, as well as employees of UnitedHealth Group's contractors, must receive the information set forth in this policy.

Guidelines

Federal and state governments have adopted a number of statutes to deter and punish misrepresentations with regard to health care programs. Failure to comply with these laws could result in civil and criminal sanctions imposed on individuals and UnitedHealth Group's subsidiaries by government entities. In addition to sanctions imposed by the government, employees' noncompliance with this policy (and any state or federal law designed to detect and prevent fraud, waste and abuse) may result in discipline up to and including termination of employment.

- ***Federal False Claims Act*:** The federal False Claims Act prohibits knowingly submitting (or causing to be submitted) to the federal government a false or fraudulent claim for payment or approval. It also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by a state Medicaid program, the federal government or its agents, such as a carrier or other claims processor.

Civil penalties can be imposed on any person or entity that violates the federal False Claims Act, including monetary penalties of $5,500 to $11,000 as well as damages of up to three times the federal government's damages <u>for each false claim</u>.

- ***Federal Fraud Civil Remedies*:** The Program Fraud Civil Remedies Act of 1986 also allows the government to impose civil penalties against any person who makes, submits or presents false, fictitious or fraudulent claims or written statements to designated federal agencies, including the U.S. Department of Health and Human Services, which is the federal agency that oversees the Medicare and Medicaid Programs.

- ***State False Claims Acts:*** Several states also have enacted broad false claims laws modeled after the federal False Claims Act or have legislation pending that is similar to the federal False Claims Act. Other states have enacted false claims laws that have provisions limited to health care fraud.

- ***Whistleblower and Whistleblower Protections:*** The federal False Claims Act and some state false claims acts permit private citizens with knowledge of fraud against the U.S. Government or state government to file suit on behalf of the government against the person or business that committed the fraud.

Individuals who file such suits are known as a "qui tam" plaintiff or "whistleblower." The federal False Claims Act and some state false claims acts also prohibit retaliation against an employee for investigating, filing or participating in a whistleblower action.

Managers Responsibilities. Managers must inform their employees that the UnitedHealth Group does not tolerate or condone activities that result in or contribute to the submission of false claims to any federal health care programs, including Medicare and Medicaid, and a manager must take appropriate action if he or she learns about possible fraudulent or abusive activities.

Business Organization Responsibilities. UnitedHealth Group's policy on Detecting Fraud and Abuse requires each Business Organization to establish procedures to detect, investigate eliminate and report fraud and abuse. **UnitedHealth Group's Responsibilities.** UnitedHealth Group's Ethics and Integrity policy on Detecting Fraud and Abuse and Business Organizations' policies on Detecting Fraud and Abuse provide details regarding internal policies, procedures and individuals' responsibilities to prevent and detect fraud, waste and abuse. Additionally, UnitedHealth Group's Ethics and Integrity Program provides for rigorous internal investigations and prompt resolution of alleged violations. Depending on the nature of the violation, investigations of integrity or compliance issues may be performed by the Compliance Officer,

Legal Services, Corporate Security, Human Capital and/or other appropriate staff or consultants.
UnitedHealth Group provides this same information to Contractors so their employees also are educated on applicable federal and state laws designed to prevent and detect fraud, waste and abuse.

DEPARTMENT OF HEALTH & HUMAN SERVICES ATTESTATION LETTER

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL #09-001

January 16, 2009

Dear State Medicaid Director:

The Center for Medicaid and State Operations (CMSO) is issuing this State Medicaid Director Letter to strengthen the integrity of the Medicaid program and help States reduce improper payments to providers. This letter advises States of their obligation to direct providers to screen their own employees and contractors for excluded persons. This letter specifically:

(1) Clarifies Federal statutory and regulatory prohibitions regarding Medicaid payments for any items or services furnished or ordered by individuals or entities that have been excluded from participation in Federal health care programs;

(2) Reminds States of the consequences for failure to prevent payments for items or services furnished or ordered by excluded individuals and entities;

(3) Sets forth the Centers for Medicare & Medicaid Services' (CMS) policy with respect to States' responsibility to communicate to providers their obligation to screen employees and contractors for excluded individuals and entities both prior to hiring or contracting and on a periodic basis, and the manner in which overpayment calculations should be made; and

(4) Identifies the List of Excluded Individuals/Entities (LEIE) as a resource providers may utilize to determine whether any of their employees and contractors has been excluded.

Background

The HHS Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156.

When the HHS-OIG has excluded a provider, Federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. (Section 1903(i)(2) of the Act; and 42 CFR section 1001.1901(b)) This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;

payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and

payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded. (42 CFR section 1001.1901(b))

The listing below sets forth some examples of types of items or services that are reimbursed by Medicaid which, when provided by excluded parties, are not reimbursable*:

Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or indirectly (such

as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients;

Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by a Medicaid program;

Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation reimbursed by a Medicaid program, to hospital patients or nursing home residents;

Services performed for program recipients by excluded individuals who sell, deliver or refill orders for medical devices or equipment being reimbursed by a Medicaid program;

Services performed by excluded social workers who are employed by health care entities to provide services to Medicaid recipients, and whose services are reimbursed, directly or indirectly, by a Medicaid program;

Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Medicaid program;

* This list is drawn from the 1999 HHS-OIG Special Advisory Bulletin: The Effect of Exclusion From Participation in Federal Health Care Programs.

Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and

Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and reimbursed, directly or indirectly, by a Medicaid program.

Consequences to States of Paying Excluded Providers

Because it is prohibited by Federal law from doing so, CMS shall make no payments to States for any amount expended for items or services (other than an emergency item or service not provided in a hospital emergency room) furnished under the plan by an individual or entity while being excluded from participation (unless the claim for payment meets an exception listed in 42 CFR section 1001.1901(c)). Any such payments actually claimed for Federal financial participation constitute an overpayment under sections 1903(d)(2)(A) and 1903(i)(2) of the Act, and are therefore subject to recoupment. It is thus incumbent on States to take all reasonable steps to prevent making payments that must ultimately be refunded to CMS.

Previous Guidance Regarding Preventing Payments For Goods and Services Furnished by Excluded Individuals and Entities

In a State Medicaid Director Letter issued on June 12, 2008, CMS notified States of their own obligation to attempt to determine whether an excluded individual has an ownership or control interest in an entity that is a Medicaid provider, and of States' obligation to report information regarding such excluded individuals to the HHS-OIG. In a State Medicaid Director Letter issued on March 17, 1999, and in a follow-up State Medicaid Director Letter issued on May 16, 2000 ("Medicare/Medicaid Sanction Reinstatement Report"), CMS described the HHS-OIG's authority to exclude persons based on actions taken by State Medicaid Agencies.

In the State Medicaid Director Letter dated May 16, 2000, CMS reminded States that the Medicare/Medicaid Sanction-Reinstatement Report, formerly known as HCFA Publication 69 and now replaced by the Medicare Exclusion Database (the MED) is a vital resource available to States for ascertaining and verifying whether an individual or entity is excluded and should not be receiving payments. The guidance also stated that the payment prohibition applies to any managed care organization contracting with an excluded party.

In a second State Medicaid Director Letter dated May 16, 2000 ("State's Obligation to notify the Department of Health and Human Services Office of Inspector General"), CMS reminded States of their responsibility to promptly notify the HHS-OIG of any action taken by a State to limit the ability of an individual or entity to participate in its program. *See* 42 CFR section 1002.3(b)(3).

† This State Medicaid Director Letter uses the term "managed care entity" to refer briefly to managed care organizations (MCOs), prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case management (PCCM). States should not confuse this abbreviation with the statutory definition of managed care entity which only refers to MCOs and PCCMs. *See* section 1932(a)(1)(B) of the Act.

Policy Clarification: States Should Advise Medicaid Providers to Screen for Exclusions

To further protect against payments for items and services furnished or ordered by excluded parties, States should advise all current providers and providers applying to participate in the Medicaid program to take the following steps to determine whether their employees and contractors are excluded individuals or entities:

States should advise providers of their obligation to screen all employees and contractors to determine whether any of them have been excluded. States should communicate this obligation to providers upon enrollment and reenrollment.

States should explicitly require providers to agree to comply with this obligation as a condition of enrollment.

States should inform providers that they can search the HHS-OIG website by the names of any individual or entity.

States should require providers to search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search.

States should require that providers immediately report to them any exclusion information discovered.

This line of defense in combating fraud and abuse must be conducted accurately, thoroughly, and routinely. States must notify the HHS-OIG promptly of any administrative action the State takes against a provider for failure to comply with these screening and reporting obligations. *See* 42 CFR section 1002.3(b)(3). States can satisfy this obligation by communicating the relevant information to the appropriate Regional Office of the OIG Office of Investigations.

States also should inform providers that civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs)† who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients. (Section 1128A(a)(6) of the Act; and 42 CFR section 1003.102(a)(2))

Policy Clarification: Calculation of Overpayments to Excluded Individuals or Entities

As stated above, Federal health care programs, including Medicaid, are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. The amount of the Medicaid overpayment for such items or services is the actual amount of Medicaid dollars that were expended for those items or services. When Medicaid funds have been expended to pay an excluded individual's salary, expenses, or fringe benefits, the amount of the overpayment is the amount of those expended Medicaid funds. We recognize that there may be instances when the connection between expended Medicaid funds and the

items or services furnished by the excluded individual or entity are too attenuated to trace. When such circumstances arise, the overpayment is no more than the amount which the State is certain was paid with Medicaid dollars.

Where Providers Can Look for Excluded Parties

While the MED is not readily available to providers, the HHS-OIG maintains the LEIE, a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. The LEIE website is located at http://www.oig.hhs.gov/fraud/exclusions.asp and is available in two formats. The on-line search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security Number (SSN) or Employer Identification Number (EIN). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the on-line format, the downloadable database does not contain SSNs or EINs.

Additionally, some States maintain their own exclusion lists, pursuant to 42 CFR section 1002.210 or State authority, which include individuals and entities whom the State has barred from participating in State government programs. States with such lists should remind providers that they are obligated to search their State list routinely whenever they search the LEIE.

Conclusion

We know you share our commitment to combating fraud and abuse. We all understand that provider enrollment is the first line of defense in this endeavor. If we strengthen our efforts to identify excluded parties, the integrity and quality of the Medicaid program will be improved, benefiting Medicaid recipients and taxpayers across the country.

If you have any questions or would like any additional information on this guidance, please direct your inquiries to Ms. Claudia Simonson, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Medicaid Integrity Group, 233 North Michigan Avenue, Suite 600, Chicago, Illinois 60601 or claudia.simonson@cms.hhs.gov. Thank you for your assistance in this important endeavor.

Sincerely,

Herb B. Kuhn

Deputy Administrator , Acting Director, Center for Medicaid and State Operations