Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Tennessee Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Tennessee Medicaid Program. The MIG conducted the onsite portion of the review at the Bureau of TennCare (TennCare) offices. The MIG review team also visited the office of the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI-MFCU).

This review focused on the activities of the Office of HealthCare Informatics (HCI) which is primarily responsible for Medicaid program integrity. This report describes five effective practices, four regulatory compliance issues, and two vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Tennessee improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Tennessee's Medicaid Program

TennCare administers the Medicaid program. As of June 30, 2008, the program served 1,274,000 recipients, approximately 95 percent of whom were enrolled with a managed care plan. The State had 31,115 participating managed care providers as of June 30, 2008, and had 5,571 providers participating in the fee-for-service (FFS) program. Tennessee's pharmacy providers are reimbursed under the State's FFS program. Tennessee uses a Pharmacy Benefits Manager (PBM) to provide services such as provider enrollment and prepayment review for pharmacy providers. Medicaid expenditures in Tennessee for the State fiscal year (SFY) ending June 30, 2008 totaled $7,330,791,200. During SFY 2008, the Federal medical assistance percentage varied from 63.65 to 63.71 percent.

Program Integrity Section

The HCI is the organizational component dedicated to the prevention and detection of provider fraud and abuse. The HCI is a component of TennCare's Fiscal Department. At the time of the review, HCI had approximately 15 full-time equivalent staff and 1 supervisor reporting to the TennCare Chief Financial Officer. The table below presents the total number of investigations, sanctions, identified overpayments, and amounts recouped in the past three SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary & Full Investigations**	Number of State Administrative Actions or Sanctions (Approximation)	Amount of Overpayments Identified	Amount of Overpayments Collected
2006	449	10	$22,882,575	$14,926,569
2007	378	12	$14,254,076	$11,673,220
2008*	186	32	$11,220,691	$9,754,587

*Incomplete data - includes first three quarters only.
**Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.

Methodology of the Review

In advance of the onsite visit, the review team requested that Tennessee complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as provider enrollment, claims payment and post payment review, managed care, surveillance and utilization review subsystem, and the MFCU. A four-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of September 22, 2008, the MIG review team visited the TennCare and TBI-MFCU offices. The team conducted interviews with numerous State, contractor, and TBI-MFCU officials. Finally, to determine whether the managed care organizations (MCOs) were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed managed care contract provisions and gathered information through interviews with representatives of four MCOs.

Scope and Limitations of the Review

This review focused on the activities of the HCI, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, contract management, and provider training. Tennessee's Children's Health Insurance Program operates as a stand alone program under Title XXI of the Social Security Act and was, therefore, excluded from this review.

This review focused on the activities of TennCare as they relate to program integrity. Unless otherwise noted, TennCare provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that TennCare provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These practices include organizational measures to improve communication across agencies responsible for Medicaid program integrity and oversight, and enhancements to State program integrity legislation that facilitate efforts to combat provider fraud.

Creation of a Provider Fraud Task Force

The State of Tennessee established a Provider Fraud Task Force (PFTF) in 2007. It includes representatives from the Office of the Attorney General, the TBI-MFCU, and the State agency. The PFTF functions as a governing body which oversees matters related to provider fraud control. It has greatly enhanced communication between agencies that support Medicaid program integrity and provide oversight. Both TennCare and TBI-MFCU officials, for example, credited the PFTF with laying the foundation for greatly improved collaboration between these two essential program integrity components. Per the TBI-MFCU, the number of referrals to the MFCU rose almost 23 percent as a direct result of the PFTF, and the quality of the referrals has also dramatically increased.

The PFTF uses an intranet-based case tracking system. Referrals are entered into the PFTF Case Tracking database. To date, the cases entered are all State-originated, but the PFTF has discussed adding MCO cases in the future. The database is accessible to all participants in the PFTF and allows each case to be tracked from start to finish. It also allows for the auditing of cases and supports a statistical reporting function. In addition, the database includes procedures for case documentation, case closure and case referral to outside agencies. With PFTF approval, for example, the system generates the referral of provider fraud cases to the TBI-MFCU, while recipient fraud cases go to another law enforcement agency.

The MIG recently published a document titled, "Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units," which provides guidance for interactions between State Program Integrity Units and MFCUs. The positive collaboration exhibited between Tennessee and its MFCU reflects the goals of that document. The exceptional State Program Integrity Unit-MFCU relationship was forged as a result of the formation of the PFTF.

Enhancements to State program integrity legislation

On May 28, 2008, the State of Tennessee passed legislation regarding the investigation of fraud in the TennCare and Medicaid programs. The new law makes it a felony to lie or willfully withhold evidence in connection with an investigation of TennCare fraud. While the intent to defraud can be difficult to prove in court, the new law makes it easier for the State to obtain criminal convictions and subsequent exclusions of problem providers because there is a lower threshold of evidence needed to prove that a provider

lied or withheld information during the course of an investigation. Tennessee indicated to the review team that further statutory enhancements were pending in the legislature.

Additionally, the MIG review team identified three practices that are particularly noteworthy. The MIG recognizes TennCare's efforts in obtaining high quality managed care encounter data, in utilizing other State databases to enhance program integrity efforts, and in developing a centralized enrollment process for all MCO providers.

Verification and validation of managed care encounter data
Tennessee uses a three step process to verify and validate encounter data. Encounters are processed through a software program which assesses data quality and accuracy prior to adjudication. The software selectively rejects "bad" data based on a standard set of edits and audits and sends the "bad" data back to the MCOs for cleaning and resubmission. Encounters are then processed through the FFS claims engine using the same edits and audits as applied to FFS claims. Lastly, TennCare uses a contractual withhold every month that requires a certain percentage of clean claims. As a result, there is currently less than a 1 percent error rate for encounter data in the Medicaid Management Information System.

Utilization of State databases outside the Medicaid agency to enhance program integrity efforts
The HCI has developed algorithms which allow the review of data from other State agency databases including the Department of Labor State Wage File and the Department of Health State Death File. For example, the State Wage File is run against the List of Excluded Individuals/Entities (LEIE) database to determine if excluded persons are working for a health care-related employer. The State then checks persons and employers to determine if they are accepting TennCare payments. Similarly, TennCare staff runs the State Death File against claims data to determine if claims were incorrectly paid for both deceased beneficiaries receiving services and for deceased physicians who are on the claims as either a rendering or ordering physician.

Required enrollment in Medicaid prior to enrollment in an MCO provider network
All MCO providers must first obtain a Tennessee Medicaid provider identification number by enrolling through the State, a process which includes completing a Disclosure of Ownership and Control Interest Statement form. The State functions as the single repository for all disclosure information collected on enrolled providers. This information can be used to determine if applicants are included on any exclusions list and helps prevent excluded providers from gaining access to Medicaid MCO networks.

Regulatory Compliance Issues
The State is not in compliance with Federal regulations related to required disclosure and notification activities.

The State's pharmacy provider application does not require disclosure of ownership, control, or relationship information. The State did not collect disclosure information prior to contracting with the PBM.

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

Tennessee's pharmacy provider application does not require the disclosure of any ownership, control, or relationship information. Also, Tennessee did not require that its PBM disclose ownership, control and relationship information prior to contracting.

Recommendations: Modify the pharmacy provider application to capture the full range of required ownership, control, and relationship information. Require the PBM to disclose ownership, control, and relationship information as a condition of contracting.

Tennessee's provider agreements do not require disclosure of business transactions upon request. The State did not require the PBM to provide such information, upon request, prior to contracting.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or the U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors. While TennCare's Ownership and Control Interest Statement requires the disclosure of business transaction information at the time of execution of the provider agreement, the individual provider agreement does not require providers to agree to provide the business transaction information at a later date upon request. In addition, the provider agreements used by the State's PBM do not require disclosure of the business transaction information specified in the regulation. Moreover, Tennessee did not require its PBM to disclose business transaction information upon request as a condition of contracting.

Recommendations: Modify the standard provider agreement and pharmacy provider agreement to require the disclosure of information identified in 42 CFR § 455.105(b) at any time upon

request. Require the PBM to disclose business transaction information, upon request, as a condition of contracting.

Tennessee's PBM does not collect all required health care-related criminal conviction disclosures during the pharmacy provider application process.

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the HHS Office of Inspector General (HHS-OIG) whenever such disclosures are made.

The pharmacy provider application used by the Tennessee PBM does not ask for the disclosure of health care-related criminal convictions. As a result, in circumstances where a pharmacy had an applicable conviction to report, the State would not be in a position to send the disclosure to HHS-OIG as required by the regulation.

Recommendations: Modify the pharmacy provider application to collect the disclosure of health care-related criminal conviction information as required by 42 CFR § 455.106. Develop and implement policies and procedures to ensure that applicable criminal convictions are reported to the State.

The State does not report to HHS-OIG adverse actions taken by MCOs during provider credentialing.

The regulation at 42 CFR §1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. A review of the MCO contracts and interviews with individuals representing the contracted MCOs demonstrated that Tennessee does not require MCOs to report adverse action taken on credentialing applications. Without being notified of adverse actions in MCO credentialing, the State cannot report appropriate adverse actions to HHS-OIG.

Recommendations: Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on provider participation in the program. Require MCOs to notify the State when the MCO denies provider credentialing for program integrity-related reasons or otherwise limits the ability of providers to participate in the program.

Vulnerabilities

The review team identified two areas of vulnerability relating to the general oversight of MCO program integrity efforts and failure to check certain individuals for exclusions.

Lack of consistency in reporting and tracking managed care program integrity activities.
In some respects, TennCare could improve its oversight of the program integrity work of its contracted MCOs. For example, the State does not maintain a central repository of program integrity targets. The State's failure to centrally track providers who are under investigation leads to a potential duplication of effort. There is no way of knowing if the same providers are under review by HCI, the various MCOs, and the TBI-MFCU. Additionally, while MCOs report cases of suspected fraud and abuse directly to the TBI-MFCU, they do not consistently report them to TennCare and are not contractually required to do so. Similarly, while all MCOs file an annual report to TennCare that includes referral information, this may not be frequent enough for the State to maintain effective oversight.

Recommendations: Amend the MCO contracts to increase the frequency of reporting of fraud and abuse activities. Require MCOs to report all suspected fraud and abuse to TennCare as well as to the TBI-MFCU. Track targeted cases centrally to ensure that fraudulent providers are identified across managed care networks.

Not checking for exclusions on owners, agents and managing employees.
TennCare requires disclosure of information about persons with ownership or control interests, agents, and managing employees on its provider applications. However, the review team found that HCI, two of four MCO contractors and the State agencies that oversee Tennessee's home and community based waiver programs do not verify whether such persons are excluded from Federal health programs by HHS-OIG.

Recommendation: Develop and implement policies and procedures for State oversight agencies and MCOs to check the LEIE to verify that non-providers listed on the State disclosure form are not excluded from participation in the Medicaid program.

CONCLUSION

The State of Tennessee applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- creation of a Provider Fraud Task Force,
- enhancements to State health care fraud legislation,
- effective verification and validation of managed care encounter data,
- utilization of outside State databases to enhance PI efforts, and
- enrollment of every provider through Tennessee Medicaid prior to enrollment in an MCO provider network

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of four areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, two areas of vulnerability were identified. The CMS encourages TennCare to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require TennCare to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report. The corrective action plan should address how the State of Tennessee will ensure that the deficiencies will not recur. It should include the time frames for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Tennessee has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Tennessee on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.