Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Tennessee Comprehensive Program Integrity Review

Final Report

March 2012

Reviewers:
Bonnie Harris, Review Team Leader
Tonya Fullen
Mark Rogers
Eddie Sottong
Joel Truman, Review Manager

Table of Contents

Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Tennessee Medicaid Program (TennCare). The MIG review team conducted the onsite portion of the review at the Bureau of TennCare, a division of the Tennessee Department of Finances and Administration. The review team also visited the office of the Tennessee Bureau of Investigation, which houses the State Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Division of Audit and Program Integrity (DAPI) within TennCare, which is responsible for Medicaid program integrity activities. This report describes four effective practices, one noteworthy practice, six regulatory compliance issues, and one vulnerability 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 January 1, 2011, the program served 1,207,762 beneficiaries. All Medicaid beneficiaries in Tennessee are enrolled in managed care entities (MCEs). At the time of the review, there were three Medicaid managed care contractors in the State. TennCare also uses a dental benefits manager (DBM) and a pharmacy benefits manager (PBM). These function in most respects like fiscal agents for the State, processing and paying dental and pharmacy claims, respectively. The fee-for-service (FFS) Medicaid program is extremely limited in Tennessee. The FFS billings occur for services provided in pre-managed care enrollment periods, certain waiver services, and carve-outs, such as pharmacy and dental. At the time of the review, TennCare had 61,209 participating managed care providers. Nearly 19,000 of this total were pharmacy providers registered with the Medicaid program. Medicaid expenditures in Tennessee for the State fiscal year (SFY) ending June 30, 2011 totaled $9,030,228,085.

Medicaid Program Integrity Division

The DAPI within TennCare is the organizational component dedicated to fraud and abuse activities. At the time of the review, DAPI had 26 full-time equivalent positions allocated to Medicaid program integrity functions with 5 vacant positions. The table below presents the total number of preliminary and full investigations and overpayment amounts identified and

collected in the last four SFYs as a result of program integrity activities by TennCare and its MCE contractors.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected
2008	98	76	$33,884,148	$24,028,014
2009	68	66	$46,833,173	$29,344,081
2010	109	95	$40,672,861	$22,388,912
2011***	102	67	$32,638,879	$11,056,807

*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. Prior to April 2011, the MCEs sent referrals directly to the MFCU
*** Partial year figures for SFY 2011. The amount of overpayments identified for SFY 2011 does not include one MCO; and the amount of overpayments collected is down considerably more than in previous years for two MCOs.

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 program integrity, provider enrollment/disclosures, and managed care. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of August 8, 2011, the MIG review team visited the TennCare and MFCU offices. The team conducted interviews with numerous TennCare officials as well as with staff from the MFCU. To determine whether the contracted Medicaid MCEs, DBM, and PBM were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed State staff responsible for program integrity and provider enrollment oversight. The team reviewed contract provisions for each entity. The team also conducted sampling of provider enrollment applications, case files, selected claims, and other primary data to validate TennCare's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of TennCare, 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.

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 provided.

Results of the Review

Noteworthy Practices

As part of its comprehensive review process, the CMS review team identified one practice that merits consideration as a noteworthy or "best" practice. The CMS recommends that other States consider emulating this activity.

Comprehensive program integrity operations manual

Tennessee's DAPI has developed a written comprehensive program integrity manual to serve as a resource for TennCare and contractors so they can see how all the moving parts of managed care program integrity fit together. The manual is designed to promote coordination and synchronization within the TennCare program to ensure program accountability and wise use of resources. Contractors are given a copy of the operations manual as part of their operating procedures within the TennCare program.

Effective Practices

As part of the comprehensive review process, the CMS invites each State to self-report practices that it believes are effective and demonstrate a commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Tennessee reported registering MCE network providers in the Medicaid Management Information System (MMIS), utilizing a number of State databases to enhance program integrity efforts, the use of a common disclosure form across MCEs, and use of a multi-component committee in making program integrity decisions about providers.

Registration of managed care network providers in the MMIS

All MCE providers are registered and assigned a provider identification number in the Tennessee MMIS. The State functions as the single repository for all registered providers. The registration process makes use of enrollment information collected on MCE-specific forms and on a Disclosure of Ownership and Control Interest form mandated for use by TennCare.

The presence of a single repository of registered providers gives the State the capacity to perform comprehensive monthly exclusion and debarment checks on MCE personnel and network providers to keep disqualified individuals out of the TennCare system. However, the review team found certain gaps in the exclusion and debarment searches which the State undertook in practice. These issues are discussed in the Regulatory Compliance section below.

Utilization of outside State databases to enhance program integrity efforts

The DAPI has developed algorithms, which allow the review of data from other State agency databases, including the Department of Labor's State Labor Work Force File and the Department of Health's State Death File. The Work Force File, for example, is run against the Medicare Exclusion Database (MED) file to determine if excluded

persons are working for a health care-related employer. The State then checks whether the persons and employers in question are accepting TennCare payments. During SFY 2011, these routine screenings identified approximately 70 excluded individuals who either directly or indirectly received Medicaid payments since their exclusions. The State indicated that it was currently in the process of recovering the unallowable funds received by the excluded individuals. Tennessee also runs claims being processed for payment against an automatic feed from the State Death file. This increases the likelihood that payments for services to deceased beneficiaries will be caught at the front end and helps to reduce the need for time-consuming and expensive pay-and-chase activities.

Use of a common disclosure form for all MCE providers

TennCare has established a policy whereby all MCE, dental, and pharmacy providers are required to be enrolled and credentialed by each plan using a common Disclosure of Ownership and Control Interest form mandated by TennCare. The disclosure forms are collected by MCEs, which check the names listed against a variety of Federal databases at the time of initial enrollment. Owners and managing employees are stored in a separate database for monthly Federal database checks. The information collected is used during initial and subsequent registration by MCEs to determine if providers or other names disclosed have been excluded from Federal health programs or debarred from Federal contracting. This policy allows the State to monitor and verify the effectiveness of MCE processes for enrolling network providers and helps ensure that excluded or debarred individuals and entities do not gain access to the Medicaid program.

Notwithstanding the conceptual value of using a common disclosure form across managed care plans, the review team found certain deficiencies in the form itself. In addition, not all MCEs were using it in practice at the time of the review. These issues are discussed in the Regulatory Compliance section below.

Creation of a Provider Review Committee

The TennCare program has established a Provider Review Committee (PRC) that reviews provider matters related to program integrity. The PRC consists of the Director of Provider Services, the Division Chief of Managed Care Network, and the Chief of the Division of Audit and Program Integrity. Taking into account the advice of the State agency's general counsel, the PRC's key function is to review and render decisions on provider-related program integrity issues. When there is a program integrity concern about the provider that may rise to the level of limiting the provider's ability to participate in the Medicaid program, the impact of such a limitation is reviewed by the PRC. This helps to identify and prevent potentially negative impacts on the State's service delivery networks, maintain continuity of care for beneficiaries, and ensure consistency in the way provider notifications, appeals, and terminations are carried out at both the State and MCE level.

Regulatory Compliance Issues

The State does not comply with Federal regulations regarding the referral of suspected fraud

cases to the MFCU and the content of its payment suspension letter. It also failed to meet certain requirements concerning mandatory disclosures, database searches, reporting of adverse actions, and notifications about excluded providers.

The State does not refer all cases of suspected provider fraud to the MFCU.
Under the Federal regulation at 42 CFR § 455.21, State Medicaid agencies must refer all cases of suspected provider fraud to the MFCU; promptly comply with requests for access to records or information, including computerized data, from the agency or its contractors, and from providers; and initiate administrative or judicial actions to recover improper payments from providers.

The DAPI was created in July 2010 to provide a central focus for program integrity within the TennCare program. During the first quarter of calendar year 2011, the division became operational and for the first time since the creation of TennCare in 1994 has provided the State agency with the ability to conduct preliminary analysis of provider referrals received from the MCEs as well as referrals developed internally through data mining. Previously, all MCE referrals were forwarded directly to the MFCU. Because of the new capacities of DAPI, this practice has stopped. TennCare told the review team that since April 2011, the PRC makes final determinations on the disposition of referrals. In practice, it sends only criminal referrals to the MFCU, while routing suspected fraud cases that it believes should be handled through civil proceedings directly to the Office of Attorney General.

The current Memorandum of Understanding (MOU) between TennCare and the MFCU has been in effect since 2007. It does not adequately reflect existing procedures for case referrals. The MOU gives responsibility for preliminary investigations of suspected provider fraud and abuse to the Office of Inspector General (OIG). The OIG may also perform a full investigation and refer the matter to the appropriate authorities for criminal, civil, or administrative proceedings. This violates the regulation at 42 CFR § 455.21(a)(1) by allowing potential fraud cases to be diverted away from the MFCU. During interviews, the TennCare program integrity director indicated that a new MOU will address this problem and require all fraud cases, civil and criminal, to be forwarded to the MFCU. However, it is still being negotiated was not in effect at the time of the review.

While the DAPI referral procedures are new and may take time to refine, the review team was concerned that the process of referring cases to the MFCU has seemingly come to a halt in Tennessee. Under the previous direct referral procedures, the MCEs sent approximately 30 referrals to the MFCU in SFY 2011. In comparison, DAPI made only two referrals to the MFCU from April 2011 through the week of the onsite the review.

Recommendations: Develop and implement policies and procedures that provide for all suspected provider fraud cases to be directly referred to the MFCU in accordance with the requirements of 42 CFR § 455.21(a)(1). When updating the existing MOU with the MFCU include methods for ensuring that it is consistent with the regulation.

The State does not provide appropriate notice of withholding to providers.
Under the Federal regulation at 42 CFR § 455.23(b)(1), the State Medicaid agency must

send providers notice of suspension of program payments within five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold such notice; or within thirty days if requested by law enforcement in writing to delay sending such notice. The request for delayed notification may be renewed in writing up to twice and in no event may exceed 90 days. Subsection (b)(2) specifies that the notice include or address all of the following: (i) state that payments are being suspended in accordance with this provision; (ii) set forth the general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation; (iii) state that the suspension is for a temporary period, as stated in paragraph (c) of this section, and cite the circumstances under which the suspension will be terminated; (iv) specify, when applicable, to which type or types of Medicaid claims or business units of a provider suspension is effective; (v) inform the provider of the right to submit written evidence for consideration by the State Medicaid Agency; and (vi) set forth the applicable State administrative appeals process and corresponding citations to State law.

TennCare's notice of payment withholding letter is not compliant with the regulation at 42 CFR § 455.23. This applies to both the revised version of the regulation that took effect on March 25, 2011 and the previous version of the regulation. The withholding letter did not state that provider payments were being withheld in accordance with the Federal regulation. Additionally, the State's notice failed to convey that the provider could submit written evidence for consideration by the agency in response to the withholding action. During interviews, TennCare officials said that they believed it was duplicative to afford providers an opportunity to furnish additional supporting documents because such documents would be submitted if the provider requested an appeal. However, the language of the regulation explicitly requires such an opportunity to be communicated when the notice of payment withholding is sent.

Recommendation: Modify the notice of suspension letter by adding the required language in accordance with the requirement of CFR § 455.23(b)(1).

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

Under 42 CFR § 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or managed care entity, must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity 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. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under § 455.104(b)(2), a disclosing entity, fiscal agent, or managed care entity must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or managed care entity as spouse, parent, child, or sibling. Moreover, under § 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or managed care entity in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or managed care entity has an ownership or controlling interest. In addition, under § 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing

entity, fiscal agent, or managed care entity. As set forth under § 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and managed care entities prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or managed care entity.

Tennessee uses a common Disclosure of Ownership and Control Interest form, to collect § 455.104-related disclosures from all MCEs, dental, and pharmacy contractors, and their network providers. However, mandatory use of this form is not in the contract of one MCE and in the State's DBM and PBM contracts. These entities have not yet made use of the updated form. The MIG's 2008 review identified the problem with pharmacy contracts and agreements and this remains uncorrected.

The review team found that the revised Disclosure of Ownership and Control Interest form solicits most of the additional information required under the revised § 455.104 regulation, although revised information from one of the MCEs and both the DBM and PBM will only be available when their contracts are renewed during SFY 2012. However, the disclosure form does not ask about family relationships between persons with ownership and control interests in the disclosing entity and subcontracts, as required in section § 455.104(b)(2).

Recommendations: Develop policies and procedures for the appropriate collection of disclosures from disclosing entities, fiscal agents, or MCEs regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities, fiscal agents, or MCEs. Modify disclosure forms as necessary to capture all disclosures required under the regulation at 42 CFR § 455.104. The MIG's 2008 recommendation was similar in regards to pharmacy.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

The Federal regulation at 42 CFR § 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS) no less frequently than monthly.

Prior to implementation of this new regulation, CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties.

The State agency is not searching the EPLS as required by 42 CFR § 455.436 (c)(2) at the time of registration, or subsequently on a monthly basis, for debarred providers. Although

MCE contractors reported checking Federal databases for exclusions and debarments at the time of initial credentialing and re-credentialing they are not checking on a monthly basis. TennCare representatives indicated that they perform a manual EPLS check on a sample of providers twice a year. The reason for the limited search is that they have not been able to configure a downloadable process that would allow automatic checks against their provider files. During interviews, it was also noted that TennCare has begun to store managing employee information in a database that is not searchable at this time. The State told the team it expected the database to be fully functioning in the near future.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider as required under the regulation at 42 CFR § 455.436. Search the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

The State does not report all adverse actions taken on provider participation to the HHS-OIG (Uncorrected Partial Repeat Finding)

The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The State Medicaid agency does require its MCEs to inform the State when the MCEs have denied enrollment or credentialing to a provider for program integrity reasons. This issue was corrected after the 2008 MIG review. However, during an interview, the State Medicaid agency provided a letter to the review team as an example of a provider denied at credentialing in March 2011. When the team raised questions about this case, DAPI indicated that it had not yet conducted an investigation to determine if the case should be reported to the HHS-OIG. Per the regulation, the State must report all providers to HHS-OIG whose applications are denied for cause within 20 working days.

Recommendation: Develop and implement procedures for reporting to HHS-OIG program integrity-related adverse actions on a provider's participation in the Medicaid program as required by 42 CFR § 1002.3(b)(3). The MIG made the same recommendation regarding reporting to HHS-OIG in the 2008 review report.

The State does not provide notice of exclusion consistent with the regulation.

Under the regulation at 42 CFR § 1002.212, if a State agency initiates exclusion pursuant to the regulation at 42 CFR § 1002.210, it must provide notice to the individual or entity subject to the exclusion, as well as other State agencies; the State medical licensing board, as applicable; the public; beneficiaries; and others as provided in §§ 1001.2005 and 1001.2006.

The State agency has a policy on permissive exclusions, but the policy does not provide the full range of required notifications when the State terminates providers. Interviews with DAPI management and a review of the Program Integrity Operations manual showed that the public is not notified when a provider is terminated.

Recommendation: Develop and implement policies and procedures to ensure that all parties identified by the regulation at 42 CFR § 1002.212 are notified of a State-initiated exclusion.

Vulnerabilities

The review team identified one area of vulnerability in the State's practices related to the tracking of program integrity cases.

Ineffective tracking of MFCU referrals and preliminary investigations.

Since the last program integrity review in 2008, and with the creation of DAPI, TennCare has acquired a new complement of dedicated staff who work on program integrity issues full-time. The new configuration has facilitated timely and effective data mining and improved TennCare's capacity to investigate suspected fraud cases. It has also enhanced DAPI's ability to develop cases for referral to the MFCU and to support other law enforcement agencies. In April 2011, a new MCE contract provision went into effect requiring the plans to refer all cases of suspected provider fraud and abuse directly to TennCare, instead of sending them directly to the MFCU. In the same month, TennCare met with the MFCU and the Office of Attorney General to review all historical MFCU referrals made by the MCEs. The MFCU returned 66 pending referrals to TennCare for internal review and preliminary investigation.

The DAPI utilizes a referral-tracking database to capture a status update every 90 days on cases referred to the MFCU. The DAPI also has a database for tracking investigations. However, as presented to the review team, the two systems are still in an early stage of development. In sample run-throughs of each system, the team observed that the two databases do not always furnish complete information on a case and do not link with each other at any point. For example, the status of two recent referrals to the MFCU could not be determined in the referral-tracking database, but in the investigations database it was unclear why the preliminary investigation warranted the referral. The review team was able to ascertain from the MFCU that one case was hand-delivered at a meeting and the second one was sent by email. There was no indication of the status of these cases in either tracking system.

The TennCare Provider Fraud Task Force (PFTF) was established in 2007 to manage suspected cases of provider fraud and abuse. It includes members from program integrity staff, the MFCU, and other essential members and still holds monthly meetings. However, the status of cases discussed at the PFTF meetings is not reflected in the DAPI tracking systems, and per the program integrity director, the MFCU is reluctant to provide information on the status of cases in writing. At the time of the review, the State agency hoped to insert an agreement to report the progress of cases in writing as part of the updated MOU it was attempting to negotiate with the MFCU.

Recommendation: Develop a strategic plan to address the high-level synchronization of the two tracking systems, since they are currently designed as stand-alone databases. Amend the State-MFCU MOU to include a clear process for reporting on

the status of cases. Refer to the *Best Practices For Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units* document issued in September 2008 as guidance for interaction between the State program integrity unit and the MFCU for developing methods for tracking referrals and their status.

Conclusion

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

- use of a comprehensive program integrity operations manual,
- utilization of outside State databases to enhance program integrity efforts,
- use of a common disclosure form for all MCE providers,
- creation of a Provider Review Committee, and
- use of a common disclosure form across MCEs.

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

However, the identification of six areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, one area of vulnerability was identified. The CMS encourages the State to closely examine the vulnerability that was 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 timeframes 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.

Official Response from Tennessee
May 2012

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
Bureau of TennCare
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

May 1, 2012

Angela Brice-Smith
Director
Medicaid Integrity Group
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Brice-Smith:

Please find attached to this letter the Bureau of TennCare's response to the audit done by the Medicaid Integrity Group during the week of August 8, 2011. I would like to take a minute and let you know that the team that came to audit the Bureau was courteous and professional while working in our facility. They were helpful in articulating the various scenarios where the Bureau could improve on its policy and procedures to comply with Federal regulations.

In this response we have addressed the six issues and vulnerability noted in the audit. The response contains a synopsis of the action that the Bureau has taken to address the issues and vulnerability. The attachments show how the Bureau's policy or procedures have been changed to eliminate the concerns expressed in the audit. This improvement process has also resulted in an updated Memorandum of Understanding with the Tennessee MFCU and other stakeholders in detecting or prosecuting healthcare fraud. The new MOU is attached to the response as attachment one.

If we can answer any questions concerning our response please let us know.

Sincerely,

Darin J. Gordon
Deputy Commissioner