Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Tennessee Focused Program Integrity Review

Oversight of Medicaid Personal Care Services

July 2025

Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review of Tennessee's Medicaid Personal Care Services (PCS) program to assess the state's program integrity oversight efforts for Fiscal Years (FY) 2021 – 2023. This focused review specifically assessed the state's compliance with CMS regulatory PCS requirements within 42 CFR Parts 440 and 441. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in the delivery of these services.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS PCS review tool provided at the initiation of the review, CMS also conducted in-depth interviews with the state Medicaid agency (SMA) and evaluated program integrity activities performed by selected agencies under contract to provide PCS to Medicaid beneficiaries.

This report includes CMS' observations that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS did not identify any findings that create risk to the Tennessee Medicaid program related to PCS program integrity oversight for this review period.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid PCS program. CMS identified **two** observations related to Tennessee's PCS program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

State Oversight of Self-Directed and Agency-Based PCS

Observation #1: CMS encourages Tennessee to establish an edit in the Medicaid Management Information System (MMIS) to reject any PCS billings while an individual is institutionalized. Enabling these edits will strengthen program integrity and increase the identification and referral of potential fraud, waste, and abuse within PCS. CMS further encourages Tennessee to include Office of Program Integrity (OPI) in system edit discussions and development.

Observation #2: CMS encourages Tennessee to ensure state and contracted entities perform data mining that will allow for the identification of outliers for all claim types, including PCS. Data mining can be a useful tool in identifying patterns and evaluating claims data for high-risk provider types.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for FYs 2024-2028, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts focused program integrity reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and PCS. These reviews assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Personal Care Services

Medicaid PCS are services provided to eligible beneficiaries that help them to stay in their own homes and communities rather than live in institutional settings, such as nursing facilities. The PCS benefit is provided according to a state's approved plan, waiver, or demonstration and are optional Medicaid services, except when medically necessary for children eligible for early and periodic screening, diagnostic, and treatment (EPSDT) services. PCS are categorized as a range of assistance provided to persons with disabilities and chronic conditions to enable them to accomplish activities of daily living (ADLs) or instrumental activities of daily living (IADLs). An independent or agency-based personal care attendant (PCA) may provide ADL services, which include eating, bathing, dressing, ambulation, and transfers from one position to another, and IADL services, which include day-to-day tasks that allow an individual to live independently but are not considered necessary for fundamental daily functioning, such as meal preparation, hygiene, light housework, and shopping for food and clothing.

States administer their Medicaid programs within broad federal rules and according to requirements of the specific authority approved by CMS. Pursuant to 42 CFR Part 440, states can choose to provide PCS for eligible beneficiaries through their state plan, a waiver, or a Section 1115 demonstration. Because PCS are typically an optional benefit, they can vary greatly by state and within states, depending on the Medicaid authority used to cover the benefit. Under federal statute and regulations, PCS must be approved by a physician or through some other authority recognized by the state. Beneficiaries receiving PCS cannot be inpatients or residents of a hospital, nursing facility, intermediate care facility for the developmentally disabled, or institution for mental disease. Services can only be rendered by qualified individuals who have met certain training and enrollment requirements, as designated by each state.

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

Overview of the Tennessee Personal Care Services Program and the Focused Program Integrity Review

The Tennessee Division of TennCare (TennCare) is the division of the Tennessee Department of Finance and Administration (the single State Medicaid agency) that is responsible for the administration of the Tennessee Medicaid program, TennCare. TennCare's Office of Program Integrity (OPI) is the organizational unit tasked with oversight of program integrity-related functions, including those related to PCS. Day-to-day operations of the Section 1915(c) waivers for persons with intellectual disabilities are administered and monitored by the Department of Intellectual and Developmental Disabilities (DIDD)[2] through an interagency agreement with TennCare. The DIDD is responsible for providing services and support to Tennesseans with intellectual disabilities. In addition, during the review period Tennessee contracted with three at risk Managed Care Organizations[3] (MCOs) to administer the TennCare Section 1115 demonstration. Tennessee delivers health care services to its Medicaid enrollees entirely through managed care.

Tennessee administers Medicaid PCS to eligible beneficiaries under Section 1915(c) Home and Community-Based Services (HCBS) waiver authorities and Section 1115 demonstrations. The SMA does not administer any PCS under state plan authority. PCS falls under HCBS, which are types of person-centered care delivered in the home and community. Detailed descriptions of the Tennessee Medicaid PCS Programs and their applications can be found in Appendix C.

In FY 2023, Tennessee's total Medicaid expenditures were approximately $13.4 billion, providing coverage to approximately 1,883,303 beneficiaries. Tennessee's Medicaid expenditures for PCS totaled approximately $319.7 million, and 15,639 beneficiaries received PCS. TennCare offers both agency-based and participant-directed PCS options. Appendix C provides enrollment and expenditure data for the PCS population in Tennessee.

In September 2024, CMS conducted a focused program integrity review of Tennessee's PCS program. This focused review assessed the state's compliance with regulatory requirements at 42 CFR Parts 440, 441, 455, and 456, as well as Sections 1905(a), 1915(c), and 1915(j) of the Social Security Act (the Act). As a part of this review, CMS conducted interviews with SMA staff involved in the administration of PCS to validate the state's program integrity practices, as well as with key personnel within two PCS agencies and one MCO. CMS also evaluated the status of Tennessee's previous corrective action plan developed by the state in response to a PCS focused review conducted by CMS in 2019, the results of which can be found in Appendix A.

During this review, CMS identified a total of two observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B.

This review encompasses the three following areas:

[2] As of July 1, 2024, the DIDD merged with the Tennessee Commission on Aging and Disability to become the Department of Disability and Aging (DDA).
[3] Tennessee refers to its MCOs as Managed Care Contractors (MCCs).

A. **State Oversight of PCS Program Integrity Activities and Expenditures** – States share responsibility with CMS for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse. States must meet various statutory and regulatory requirements, such as program integrity safeguards in 42 CFR Parts 455 and 456, to maintain effective oversight of their Medicaid programs. In addition, pursuant to Section 12006(a) of the 21st Century Cures Act, all states were required to implement an Electronic Visit Verification (EVV) system for PCS by January 1, 2020. Failure to meet this requirement results in incremental Federal Medical Assistance Percentage (FMAP) reductions of up to 1 percent, unless the state has both made a "good faith effort" to comply and has encountered "unavoidable delays."

B. **Provider Enrollment and Screening –** As defined by § 440.167, PCS must be provided by an individual who is qualified to provide such services, unless defined differently by a state agency for purposes of a waiver granted under part 441, subpart G.[4] In accordance with these standards, state law often requires PCS agency staff and attendants to be subject to enhanced screening and credentialing procedures at the date of hire and annually thereafter. CMS regulations at § 455.436 require that the SMA conduct database checks to determine the exclusion status of providers, persons with an ownership or control interest, and agents and managing employees on the Department of Health and Human Services Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the System for Award Management (SAM), the Social Security Administration's Death Master File (SSA-DMF), and the National Plan and Provider Enumeration System (NPPES) upon enrollment and reenrollment, and check the LEIE and SAM no less frequently than monthly. In accordance with § 455.434, PCS agencies or attendants that enroll in Medicaid as providers are also subject to federal screening requirements found at § 455.410.

C. **State Oversight of Self-Directed and Agency-Based PCS –** States may elect to offer self-directed PCS through several pathways, including the state plan, Section 1915(c) waivers, and specific provisions under Sections 1915(j) and 1915(k). These options allow participants, or their authorized representatives, to exercise choice and control over the planning, budgeting, and purchase of self-directed PCS. CMS regulations at 42 CFR 441 Subpart J govern the use of self-direction under these options, outlining the requirements for oversight and support of participants' control in managing their care. Self-directed PCS under the state plan and section 1915(c) waivers enable beneficiaries to tailor their care according to their specific needs and preferences while maintaining autonomy. Alternatively, beneficiaries may receive agency-based PCS, where a personal care agency provides oversight, management, and supervision of their services. Agency based PCS are available through either state plan or waiver authority. In accordance with §§ 441.302 and 441.570, the SMA must ensure that adequate safeguards are in place to protect the health and welfare of individuals receiving PCS through any of these options maintain

[4] The conditions of participation for home health aides participating in PCS programs are further detailed at § 484.80.

financial accountability for all funds expended on PCS provided through waiver or state plan authority to uphold program integrity and compliance with federal standards.

III. Results of the Review

A. State Oversight of PCS Program Integrity Activities and Expenditures

States share responsibility with CMS for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse. States must meet various statutory and regulatory requirements, such as program integrity safeguards in 42 CFR Parts 455 and 456, to maintain effective oversight of their Medicaid programs.

As required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and beneficiaries. In addition, Section 1902(a)(30) of the Act and federal regulations at 42 CFR Part 456 require the state plan to provide for the establishment and implementation of a statewide surveillance and utilization control program that provides methods and procedures to safeguard against unnecessary or inappropriate utilization of care, services, and excess payments. States often meet these requirements through implementation of a surveillance and utilization review subsystem (SURS) within the Medicaid Management Information System (MMIS) and/or discrete SURS Units that are a part of larger program integrity efforts.

In Tennessee, the TennCare OPI is primarily responsible for Medicaid program integrity activities. The OPI identifies fraud and abuse within the Medicaid program through reviewing paid claims and conducting field reviews and investigations, to determine provider abuse, deliberate misuse, and suspicion of fraud. Audits are conducted of provider records, financial information, and statistical data to determine reasonableness and allowance of costs reimbursable under the TennCare program. Audits may be prospective or retrospective in nature.

TennCare has established PCS program participation and reporting requirements through state rules/policy. TennCare OPI is comprised of two units, investigations and compliance. The investigations unit collaborates with the MCOs and law enforcement agencies to investigate, refer, and prosecute suspected fraud and abuse committed by TennCare providers. The compliance unit oversees MCO program integrity activities, including documentation, reporting and compliance with contractual and regulatory requirements, along with the requirements outlined in the Managed Care Program Integrity Manual. TennCare OPI is also responsible for the Provider Review Committee (PRC), which is comprised of representatives from OPI, Office of Provider Services, Office of Managed Care Operations, and the TennCare Office of General Counsel. The PRC reviews cases of suspected provider fraud and abuse to determine if the degree of fault supports a credible allegation of fraud. An investigation of fraud and/or abuse may be referred to TennCare OPI, the Medicaid Fraud Control Division (MFCD), Tennessee Office of Attorney General Medicaid Fraud and Integrity Division, and/or Tennessee Office of Inspector General by an MCO's special investigations unit.

An allegation of fraud is evaluated by the OPI using information from many sources, including fraud hotline complaints, claims data mining, and/or patterns identified through provider audits, civil false claims cases, and law enforcement investigations. The Case Tracking System (CTS) is

used to electronically manage cases, document key actions through the lifecycle of a case, and as a document repository and records management system for case files and records. A referral must include documentation submitted to OPI and the MFCD demonstrating suspected fraud and/or abuse by a provider in the MCO's network. A referral contains a variety of information, including post-payment review of the provider's claims and associated overpayment amounts, previous education received by the provider for improper claims activity, provider status and history with the MCO, and the MCO policies and guidelines relevant to the allegations of suspected fraud or abuse. The MCOs provide targeted education to providers that address specific deficiencies identified in an audit or by other means.

The OPI conducts robust programmatic audits to ensure compliance with established program guidelines. Pre-payment audits/reviews are conducted on providers who have demonstrated patterns of billing errors and require the provider to submit medical records to the MCOs prior to claims adjudication. Post-payment audits/reviews are conducted to identify incorrectly paid claims, identify problematic policies and procedures, and to confirm potential or suspected fraud or abuse. Detailed information on post-payment actions taken as a result of PCS provider audits can be found in Appendix C.

In Tennessee, these oversight and monitoring requirements are met. TennCare has an interagency agreement with DIDD to organize delivery of long-term services and supports to beneficiaries receiving benefits and to provide oversight and monitoring for the state's 1915(c) waiver programs, and the MCOs provide oversight and monitoring for all other PCS providers.

States are also required to implement an EVV system to help oversee PCS providers. EVV is used to verify that PCS visits occurred and can be performed through a number of methods, including telephonic or GPS-enabled mobile applications. Pursuant to Section 12006(a) of the 21st Century Cures Act, all states were required to implement an EVV system for PCS by January 1, 2020. Failure to meet this requirement results in incremental FMAP reductions of up to one percent, unless the state has both made a "good faith effort" to comply and has encountered "unavoidable delays."

Currently, Tennessee does utilize an EVV system for in-home scheduling, tracking and billing for PCS providers. MCOs have the ability through a Contractor Risk Agreement to choose their own EVV vendor, provided the system meets minimum functionality requirements specified by TennCare. In addition, the agreement specifies how MCOs use and oversee the EVV system to achieve its intended purposes. Both PCS agencies and the MCO interviewed reported use of EVV. Tennessee implemented their current EVV in 2010 and is in compliance with Section 12006(a) of the 21st Century Cures Act.

CMS did not identify any findings or observations related to these requirements.

B. Provider Enrollment and Screening

CMS regulations at § 455.436 require that the SMA conduct database checks to verify the exclusion status of the provider, persons with an ownership or control interest, and agents and managing employees on the HHS-OIG's LEIE, SAM, SSA-DMF, and NPPES upon enrollment

and reenrollment, and check the LEIE and SAM no less frequently than monthly.

For agency directed services available under the state plan and Section 1915(c) waiver authorities, responsibility for compliance with § 455.436 is delegated to the agency. CMS confirmed that TennCare has a state policy in place addressing this requirement. For PCAs not enrolled with the state, federal database checks (e.g., LEIE or SAM) are not required under federal law for either traditional or managed care Medicaid, though states may impose their own requirements. For self-directed services, DIDD's case managers perform the provider screenings and provide fiscal intermediary and other support services to beneficiaries who choose to self-direct their service. TennCare relies on the MCOs to perform required database checks for managed care PCS providers who are enrolling, re-enrolling, reactivating, revalidating, or when there is a requested change of ownership. TennCare also contracts with a Fiscal Employer Agent (FEA) to screen potential PCS providers for its self-directed beneficiaries.

In accordance with § 455.410, PCS agencies or attendants that enroll in Medicaid as providers are subject to federal screening requirements found at § 455.450. SMAs must require providers, as a condition of enrollment in Medicaid, to consent to Fingerprint-based Criminal Background Checks (FCBCs) when required to do so under state law, or by the level of screening based on fraud, waste, and abuse risk as determined for that category of provider, in accordance with § 455.434. High risk and moderate risk providers are subject to enhanced screening. In accordance with the TennCare Policy Manual, PRO-16-001, Tennessee has assigned HCBS providers to a limited risk category which requires verification that the provider meets applicable federal regulations or state requirements for the provider type prior to enrolling, verification that the provider meets applicable licensing requirements, and database checks must be conducted on an ongoing basis to ensure the provider continues to meet the applicable criteria for the provider type. Providers must be registered with TennCare in order to receive payment for services. Providers must also contract with one or more of the contracted MCOs to become a part of their provider network.

As part of this review, CMS interviewed several PCS agencies to determine if they are exercising appropriate oversight of the quality and integrity of services provided to beneficiaries under the care of their agency, in accordance with state standards. Two PCS agencies—Buffalo River Services and Senior Solutions Home Care and one MCO—BlueCare were selected for interviews. Each organization reported compliance with these requirements.

PCS providers must be licensed by DIDD or the Department of Mental Health and Substance Abuse Services as a personal assistance service agency or by the Department of Health as a home care organization. Also, proof of liability insurance is required along with background checks as part of the TennCare registration process and the DIDD/MCO credentialing and recredentialing process. The MCOs contract with PCS provider agencies that are responsible for hiring and training their PCS staff. The PCS provider agencies are responsible for ensuring criminal background checks and registry checks are completed on any employee or volunteer who has direct care with a beneficiary.

For the 1915(c) HCBS waivers, providers are required to be licensed while providing services for the PCS program. Providers are required to show current licensure during annual Quality

Assurance surveys.

Within self-directed PCS, beneficiaries or their representatives hire and manage direct service workers. The FEA is responsible for conducting background checks in accordance with state law and TennCare policy and ensuring that all employees, agents, subcontractors, providers, or anyone acting on behalf of the contractor conducts criminal background checks and registry checks in accordance with state and federal laws and TennCare policy.

TennCare requires that individual workers that provide hands-on care through the self-directed program obtain and maintain a Medicaid identification number. TennCare's FEA ensures that workers meet all TennCare requirements prior to providing self-directed services, including, completing a background check, signing an abbreviated Medicaid agreement, obtaining a Medicaid provider ID number, and signing a service agreement.

CMS determined that TennCare has met federal screening requirements.

CMS did not identify any findings or observations related to these requirements.

C. State Oversight of Self-Directed and Agency-Based PCS

A self-directed PCS state option allows beneficiaries or their representatives, if applicable, to exercise decision-making authority in identifying, accessing, managing, and purchasing their PCS. A state offering a self-directed option must assure that certain necessary safeguards have been taken to protect the health and welfare of individuals furnishing services under the program and assure the financial accountability for funds expended for self-directed services in accordance with § 441.464. These safeguards must include prevention against the premature depletion of the beneficiary directed budget, as well as identification of potential service delivery problems that might be associated with budget underutilization.

TennCare ensures these requirements are met through the FEA, which provides each beneficiary receiving self-directed PCS with a case manager to monitor the participant's expenditures. This case manager is tasked with advising the beneficiary on care choices and reporting significant budget variances that may indicate potential fraud or abuse to TennCare OPI. Additionally, TennCare OPI conducts audits of self-directed beneficiary records to identify any potential outliers.

The self-directed program allows the beneficiary to directly manage selected services, including recruitment and management of service providers. During the majority of the review period, the FEA, Public Partnerships Limited, provided financial management support for TennCare self-directed beneficiaries. Effective July 1, 2023, TennCare contracted with Consumer Direct Care Network Tennessee to provide these services.

Under the 1915(c) waivers, the DIDD conducts audits of the individuals receiving self-directed waiver services to check for compliance with waiver assurances related to the service plan, health, and level of care to identify any potential outliers. Case managers that are employed by the DIDD are responsible for ongoing monitoring of services provided in the self-directed

waivers through telephone contacts and face-to-face monitoring visits. Under the 1115 demonstration, the MCOs Care/Support Coordinators are responsible for ongoing monitoring of services provided, including self-directed PCS.

For self-directed PCS, the employer of record (EOR) (e.g., the beneficiary, a representative designed by the beneficiary, legal guardian) is responsible for monitoring the provision of services by the PCA they employ. Once care has been provided, the PCA will submit time for payment, either electronically or via paper. The EOR will review the time submitted, validate the care was provided consistent with the program rules and for the dates and times shown. Once the EOR has completed the review, the time is approved for payment. The time is also run through the FEA's payroll system to validate against the program requirements such as active authorization, and up to date certifications for the worker. Once validations are completed, the services are submitted for payment.

Beneficiaries can also elect to have their care overseen, managed, and supervised by a personal care agency. Agency-based PCS in Tennessee is available under waiver authority. In accordance with §§ 441.302 and 441.570, the SMA must assure that certain safeguards have been taken to protect the health and welfare of individuals furnishing services under the program and to assure the financial accountability for funds expended for agency-based PCS. Tennessee ensures that these requirements are met through the use of an annual audit of each PCS agency that includes, but is not limited to reviews of personnel files, client records, and service billing records. The PCS agencies are subject to recoupments and corrective actions plans if programmatic deficiencies are discovered during the audit.

CMS noted the SMA does not have PCS prepay edits in place within the MMIS and relies on the MCOs to perform this function. During the interview with BlueCare, it was noted that the MCO does not have prepay edits in place to prevent overlap of PCS with institutional care. BlueCare does have widespread data mining efforts in place to identify outliers; however, those efforts are not targeted to PCS and BlueCare does have a post-payment audit process in place to identify these claims retroactively. Lastly, CMS noted that TennCare does not include OPI in discussions regarding the development of system edits.

Observation #1: CMS encourages Tennessee to establish an edit in the MMIS to reject any PCS billings while an individual is institutionalized. Enabling these edits will strengthen program integrity and increase the identification and referral of potential fraud, waste, and abuse within PCS. CMS further encourages Tennessee to include OPI in system edit discussions and development.

Observation #2: CMS encourages Tennessee to ensure state and contracted entities perform data mining that will allow for the identification of outliers for all claim types, including PCS. Data mining can be a useful tool in identifying patterns and evaluating claims data for high-risk provider types.

IV. Conclusion

CMS supports Tennessee's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified two observations that require the state's attention.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

CMS looks forward to working with Tennessee to build an effective and strengthened program integrity function.

V. Appendices

Appendix A: Results of the Prior Review

Tennessee's last CMS program integrity review was in March 2019, and the report for that review was issued in July 2019. The report contained two recommendations. During the virtual review in September 2024, CMS conducted a thorough review of the corrective actions taken by Tennessee to address all recommendations reported in calendar year 2019. The findings from the 2019 Tennessee focused PI review report have all been satisfied by the state.

Findings

1. ***The state should conduct a comprehensive assessment of its organizational PCS program integrity policies and procedures in order to determine if they are accurate. TennCare should review a sample of its provider policies and procedures from top down or issue additional guidance to providers regarding these policies and procedures in order to ensure that oversight roles and responsibilities are clearly outlined at every organizational level. Upon the completion of the review, the state should compile, develop, implement and/or update as necessary all PCS program integrity policies and procedures at every appropriate organizational level (DIDD, MCO, PCS agency) to ensure that all oversight roles and responsibilities are clearly outlined.***
   Status at time of the review: Corrected

2. ***The state may consider incorporating the evaluation of written program integrity policies and procedures as a checklist requirement during the state's annual quality monitoring process.***
   Status at time of the review: Corrected

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the CMS frequently asked questions document, Allowability of Using National Provider Identifiers (NPIs) for Medicaid Personal Care Attendants (PCAs), at https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/faqs-using-npis-for-medicaid-pcas.pdf
- Access Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services at https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/vulnerabilities-mitigation-strategies.pdf
- Access the Preventing Medicaid Improper Payments for Personal Care Services fact sheet and booklet at https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/pcs-prevent-improperpayment-factsheet.pdf and https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/pcs-prevent-improperpayment-booklet.pdf
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. https://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.

Appendix C: Program Information

Table C-1 provides detailed information on the PCS programs available in Tennessee.

Table C-1. Tennessee Medicaid PCS Programs

Program Name/Federal Authority	Administered By	Description of the Program
1115 Demonstration		
TennCare	The three MCOs selected by the SMA to deliver services	Under the TennCare demonstration, Tennessee's CHOICES program, approved in 2009 and implemented in 2010, includes nursing facility services and HCBS for adults 21 years of age and older with a physical disability and seniors (age 65 and older).
Section 1915(c) HCBS Waiver Authorities		
Comprehensive Aggregate Cap (CAC) HCBS Waiver	DIDD	The waiver serves individuals who have been institutionalized in a public institution, were part of a certified class because they were determined to be at risk of placement in a public institution, or have significant services/support needs consistent with that of the population served in a public Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and who qualify for and, absent the provision of services provided under the CAC waiver, would require placement in an ICF/IID. The waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver participants Individual Service Plan (ISP), based on the waiver participant's individually identified goals and need for specific services to advance toward, achieve, or sustain those goals.
Self-Determination Waiver	DIDD	The waiver serves children and adults with intellectual disabilities and children under age six with developmental delay who qualify for and, absent the provision of services provided under the Self-Determination Waiver, would require placement in a private ICF/IID. The waiver affords beneficiaries the opportunity to directly manage selected services, including the recruitment and management of service providers. Participants electing self-direction are empowered and have the responsibility for managing, in accordance with waiver service definitions and limitations, a self-determination budget affording flexibility in service design and delivery. Serves persons who have an established non-institutional

Program Name/Federal Authority	Administered By	Description of the Program
		place of residence where they live with their family, a non-related caregiver, or in their own home and whose needs can be met effectively by the combination of waiver services through this program and natural and other supports available to them. The Self-Determination Waiver does not include residential services such as supported living. The Self-Determination Waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment in competitive integrated settings, and to engage in community life. A person-centered planning process is used to identify services to be included in each waiver participants ISP, based on the waiver participant's individually identified goals and need for specific services to advance toward, achieve, or sustain those goals.
Statewide HCBS Waiver	DIDD	The waiver serves children and adults with intellectual disabilities and children under age six with a developmental disability who qualify for and, absent the provision of services provided under the Statewide HCBS Waiver, would require placement in an ICF/IID. The waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment in competitive integrated settings, and to engage in community life. A person-centered planning process is used to identify services to be included in each waiver participants ISP, based on the waiver participant's individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

Table C-2. Tennessee PCS Enrollment by Authority

	FY 2021	FY 2022	FY 2023
1115 Demonstration - TennCare	14,060	13,736	14,153
1915(c) HCBS Waiver Authority	1,638	1,559	1,486

Table C-3. Summary of Tennessee PCS Expenditures by Authority

	FY 2021	FY 2022	FY 2023
1115 Demonstration - TennCare	$226,150,284	$229,054,338	$265,060,230
1915(c) HCBS Waiver Authority	$45,356,655	$52,317,935	$54,672,150

Table C-4. Waiver Authority Expenditures by Type

1915(c) HCBS Waiver Authority	FY 2021	FY 2022	FY 2023
CAC HCBS Waiver	$2,998,687	$3,575,784	$3,542,943
Self-Determination Waiver	$18,340,784	$21,188,086	$22,278,055
Statewide HCBS Waiver	$24,017,184	$27,554,065	$28,851,152

Table C-5. Program Integrity Post Payment Actions Taken – PCS Providers

Agency-Directed and Self-Directed Combined	FY 2021	FY 2022	FY 2023
Identified Overpayments	$0*	$0*	$0*
Recovered Overpayments	$0*	$0*	$0*
Terminated Providers	1	1	0
Suspected Fraud Referrals	14	13	25
Number of Fraud Referrals Made to MFCD	13	11	22

*Program Integrity related overpayments are typically part of a fraud referral and recovered as part of a settlement with the MFCD and/or Office of Attorney General; otherwise, it's pursued administratively by the MCO or FEA. The OPI did not pursue any program integrity related overpayments for PCS during the review period.

Appendix D: State Program Integrity Review Response

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
N/A	N/A	N/A	N/A

Acknowledged by:

/s/Floyd N. Price
Floyd N. Price
Director, Office of Program Integrity

August 8, 2025