Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Tennessee Focused Program Integrity Review

Final Report

July 2019

Table of Contents

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) is committed to performing program integrity (PI) reviews with states in order to identify risks and vulnerabilities to the Medicaid program and assist states with strengthening program integrity operations. The significance/value of performing onsite program integrity reviews include: (1) provides states with effective tools/strategies to improve program integrity operations and performance, (2) provides the opportunity for technical assistance related to program integrity trends, (3) assist CMS in determining/identifying future guidance that would be beneficial to states, and (4) assists with identifying and sharing promising practices related to program integrity.

The CMS conducted a focused review of the Tennessee Medicaid personal care services (PCS). The objective of the review was to assess the level of program integrity oversight of Medicaid PCS at the state level. A secondary objective of the review was to provide the state with useful feedback, discussions and technical assistance resources that may be used to enhance program integrity in the delivery of these services. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous program integrity review conducted in calendar year 2015.

Medicaid PCS (sometimes referred to as personal attendant or personal assistance services) includes a range of assistance services provided to beneficiaries with disabilities and chronic conditions, of all ages. Provision of these services in the beneficiary's home or community is intended to serve as an alternative to institutionalization. Assistance may either be in the form of direct provision of a task by the personal care attendant (PCA) or cuing/prompting by the PCA so that the beneficiary may perform the task. Such assistance most often involves activities of daily living (ADLs) such as eating, drinking, bathing, dressing, grooming, toileting, transferring, and mobility. Services offered under Medicaid PCS are an optional benefit, except when they are medically necessary for children who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit that provides comprehensive and preventive health care services.

Pursuant to the regulations found at 42 C.F.R. § 440.167, PCS is a Medicaid benefit furnished to eligible beneficiaries according to an approved Medicaid state plan, waiver, or section 1115 demonstration. States administer their Medicaid programs within broad federal rules and according to requirements of the specific authority approved by CMS. Services must be approved by a physician, or some other authority recognized by the state. Beneficiaries that receive 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, as designated by each state.

During the week of March 5-7, 2019 the CMS review team visited the Tennessee State Medicaid Agency (SMA) known as TennCare. They conducted interviews with numerous state staff involved in program integrity and administration of PCS to validate the state's program integrity practices with regard to PCS. The areas reviewed during this visit included the following: Overview of State's PCS, State Oversight of PCS Program Integrity Activities and Expenditures, State Oversight of Self-Directed Services, PCS Provider Enrollment, PCS Providers and Electronic Visit Verification (EVV).

Summary of Recommendations

The CMS review team identified two recommendations based upon the completed focused review modules and supporting documentation, as well as discussions and/or interviews with key stakeholders. The recommendations are detailed further in the State Oversight of Personal Care Services Program Integrity Activities and Expenditures section of the report.

Overview of TennCare's Medicaid Personal Care Services

- Tennessee's Medicaid expenditures totaled approximately $9,138,467,805 for FFY17, while the number of beneficiaries served via Medicaid totaled approximately 1,338,542.
- Tennessee's Medicaid PCS expenditures totaled approximately $268,973,691 for FFY17, while the number of beneficiaries receiving PCS totaled approximately 21,214.
- Personal or attendant care services is not a Medicaid benefit that is covered under Tennessee's Medicaid State Plan. However, Tennessee's SMA has CMS approval to provide PCS in each of three Section 1915(c) Home and Community Based Services (HCBS) Waivers: TN.0128 Statewide HCBS (or "Statewide") Waiver, TN.0357 Comprehensive Aggregate Cap HCBS (or "CAC") Waiver, and TN.0427 Tennessee Self-Determination Waiver Program.
- In addition, to HCBS waiver authority; Tennessee has been granted approval for the TennCare ll Section 1115 demonstration waiver that includes PCS in each of its Managed Long Term Support and Services programs (CHOICES and Employment and Community First (ECF) CHOICES).
- The state offers both agency-directed and consumer-directed (self-directed) PCS options through its 1115 waivers. Only the Self-Determination 1915(c) Waiver allows personal assistance to also be delivered through self-direction, using the services of the State's contracted fiscal agent.

Overview of TennCare's Administration of Personal Care Services

- The SMA does not administer any PCS waiver services. The three HCBS 1915(c) waivers are administered by a delegated Sister State Agency - the Department of Intellectual and Developmental Disabilities (DIDD) through an interagency agreement with the SMA.
- Under the TennCare ll section 1115 demonstration waiver personal care visits and attendant care services are provided in the CHOICES program, while supportive home care and personal assistance services are provided in the ECF CHOICES program. PCS are delivery through managed care organizations (MCOs).
- TennCare contracts with three MCOs to administer its section 1115 demonstration waiver; Blue Cross Blue Shield of Tennessee, aka BlueCare; Amerigroup, a wholly owned subsidiary of Anthem; and United HealthCare Community Plan.

Summary of Personal Care Services in Tennessee

The Division of TennCare administers Medicaid PCS to eligible beneficiaries under 1915(c) HCBS waiver authority and Section 1115 demonstration waiver authority. The provision of PCS in the beneficiaries' homes or community settings is intended to serve as an alternative for individuals who would otherwise require institutional care. The Table 1 below provides details of the programs.

Table1.

Program Name /Federal Authority	Administered By	Description of the Program
Section 1915 (c) HCBS Waiver: TN.0128 Statewide Waiver	The Department of Intellectual and Development Disabilities (DIDD) serves as the Operational Administrative Agency for this waiver, which is administered under the oversight of the Division of TennCare.	• Program was implemented in 1986. • Serves adults with intellectual disabilities and children under age six with intellectual disabilities and children under age six with developmental delay who qualify for and absent the provision of services provided under the Statewide Waiver, would require placement in a private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). • Reimbursement method: Fee for service • Self-direction: No
Section 1915 (c) HCBS Waiver: TN.0357 CAC Waiver	Department of Intellectual and Development Disabilities (DIDD)	• Program was implemented in 1992. • Serves individuals who have been institutionalized in a public institution, are 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 ICF/IID. • Reimbursement method: Fee for service • Self-direction: No

Program Name /Federal Authority	Administered By	Description of the Program
Section 1915 (c) HCBS Waiver: TN.0427 Tennessee Self-Determination Waiver	Department of Intellectual and Development Disabilities (DIDD)	• Program was implemented in 2005 • 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. • Reimbursement method: Fee for service • Self-direction: Yes permitted with contracted fiscal agent.
TennCare ll Section 1115 Demonstration Waiver: CHOICES	Contracted Managed Care Organizations (MCOs).	• Program was 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). This program includes two PCS services: Personal Care visits and Attendant Care. • Reimbursement method: managed care capitation • Self-direction: Yes permitted with contracted fiscal agent.
TennCare ll Section 1115 Demonstration Waiver: Employment and Community First (ECF)CHOICES	Contracted Managed Care Organizations (MCOs).	• Program was implemented in 2016. • Serves people of all ages who have an intellectual or developmental disability (I/DD) and includes two PCS services: Supportive Home Care for

Program Name /Federal Authority	Administered By	Description of the Program
		individuals (primarily children under age 21) living at home with their families and Personal Assistance. • Reimbursement method: Partial managed care capitation or risk payments[1] • Self-direction: Yes permitted with contracted fiscal agent.
		• Self-direction: Yes permitted with contracted fiscal agent.

Summary of Personal Care Services Expenditures and Beneficiary Data

Table 2.

Program Name /Federal Authority	FFY 2016	FFY 2017	FFY 2018
TN.0128 Statewide Waiver/1915 (c)	$27,089,388	$26,617,338	$26,688,275
TN.0357 CAC Waiver/1915 (c)	$2,903,622	$2,784,478	$2,679,851
TN.0427 Tennessee Self-Determination Waiver/1915 (c)	$15,882,781	$16,807,535	$17,007,945
CHOICES Program/1115 Demo Waiver	$209,221,832	$220,734,781	$226,141,391
ECF CHOICES/1115 Demo Waiver	N/A	$2,029,559	$7,963,754
Total Expenditures	**$255,097,623**	**$268,973,691**	**$280,481,216**

The PCS expenditures overall remained consistent with some gradual increase demonstrated during the three FFYs reviewed. However, the CHOICES Program / 1115 demonstration waiver experienced an almost 12 percent increase in expenditures from FFY 2016 to FFY 2018. This expenditure increase may have been attributed to the greater level of care required for the

1TennCare is currently capitating only the physical and behavioral health payments for the ECF CHOICES population until there is sufficient experience for an actuarially sound rate for ECF CHOICES services. Administrative services or actual reimbursement payments are presently occurring for the ECF CHOICES services portion of the monthly capitation payment to the MCOs.

population served in the CHOICES Program/ 1115 demonstration waiver. The ECF CHOICES/1115 Demonstration waiver was not implemented until July 2016.

Table 3.

	FFY 2016	**FFY 2017**	**FFY 2018**
Total PCS Expenditures	$255,097,623	$268,973,691	$280,481,216
% Agency-Directed PCS Expenditures	83.5%	80%	78%
% Self-Directed PCS Expenditures	16.5%	20%	22%

A larger portion of PCS expenditures were allocated to agency-directed services in Tennessee during the three FFYs reviewed. Overall, the percentage of expenditures attributed to each of the PCS delivery models slightly increased in self-directed PCS. The state utilized incentive payments to MCOs in order to encourage participation in self-directed services. This trend may likely continue since beneficiaries are afforded the decision-making authority to recruit, hire, train, and supervise the individuals who furnish their services under self-directed care models.

Table 4-A.

Program Name /Authority	**FFY 2016**	**FFY 2017**	**FFY 2018**
TN.0128 Statewide Waiver/1915 (c)	1101	1034	990
TN.0357 CAC Waiver/1915 (c)	80	81	75
Self-Determination Waiver/1915 (c)	306	275	252
CHOICES Program/1115 Demo	17,015	16,048	15,486
ECF CHOICES/1115 Demo	N/A	203	341
Total Agency-directed Unduplicated Beneficiaries	18502	17641	17144

*Unduplicated beneficiary count is the number of individuals receiving services, not units of service. The trend for participating beneficiaries in the agency-directed PCS programs has been decreasing over the review period.

Table 4-B.

Program Name /Authority	**FFY 2016**	**FFY 2017**	**FFY 2018**
TN.0427 Tennessee Self-Determination Waiver/1915 (c)**	561	579	588
CHOICES Program/1115 Demo	2,663	3,032	3,290
ECF CHOICES/1115 Demo	0	237	454
Total Self-directed Unduplicated Beneficiaries	3,224	3,848	4,332

*Unduplicated beneficiary count is the number of individuals receiving services, not units of service. Growth within the waivers occurred as more beneficiaries moved into self-directed PCS.

Overall, PCS expenditures and the number of unduplicated beneficiaries receiving PCS remained constant with some gradual changes during the three FFYs reviewed. The CMS review team noted that the CHOICES Program/1115 demonstration waiver had the largest number of

unduplicated beneficiaries receiving PCS and the highest overall expenditures. The ECF CHOICES Waiver only had two FFYs of data depicted, since it was not implemented until 2016.

Results of the Review

The CMS team identified one area of concern with TennCare's PCS program integrity oversight, thereby creating a potential risk to the Medicaid program. The CMS will work closely with the state to ensure that the identified issue is satisfactorily resolved as soon as possible. This issue and CMS' recommendations for improvement is described in detail in this report. In addition, CMS has included technical assistance resources for the state to consider utilizing in its provision of PCS.

State Oversight of Personal Care Services Program Integrity Activities and Expenditures

TennCare's PCS oversight activities are described comprehensively in the managed care contract language. TennCare's standard MCO contract captures all of the elements of a solid PI program with the exception of the concern identified by this report. TennCare demonstrates a commitment to meeting and/or exceeding the federal program integrity regulatory standards. For example, the managed care contract has specific language that addresses the contractor's requirements for having adequate staffing and resources to perform all required program integrity activities along with monetary damages for failing to perform specific responsibilities or requirements as stipulated within the contract.

TennCare's managed care contracts are amended twice a year, and are effective January 1 and July 1 of each year. This requires TennCare executive staff to review the contract for their respective business areas. TennCare adopted this schedule to ensure managed care contracts are reviewed and updated timely for program changes that occur. Other benefits include, but are not limited to: Making routine developments such as extending the term; updating capitation rates based on the calibration of risk adjustment factors; adding reports to enhance oversight; and assuring continued compliance with program initiatives (i.e., payment reform, Opioid epidemic strategies, best practices, state and federal policies, rules, regulations and legislation).

Tennessee implemented its MMIS in 2004 to support the administration of the state's Medicaid managed care program. According to the program administrator, the MMIS provider subsystem, claims processing subsystem, and SURS are used to collect and process all the data created by the state's managed care organizations, including provider enrollment and claims data for individual providers. Program integrity staff rely on the claims processing subsystem as they review all providers' claims data submitted by the managed care organizations, and the subsystem incorporates algorithms and national correct coding initiative prepayment edits to identify potential payment of improper claims filed by providers with managed care organizations. By requiring managed care organizations to report detailed claims data, Tennessee administrators are able to use their systems to support program integrity activities as if the state was operating a fee-for-service model, unlike other managed care plans that only collect encounter data.

The oversight of program integrity in the delivery of PCS is a primary responsibility of the Office of Program Integrity. The Office of Program Integrity accomplishes this responsibility by

collaborating between various internal divisions within TennCare, along with DIDD, as well as other external contracted entities. The Office of Program Integrity partners with their internal data experts that utilize proactive data analysis in order to generate leads for new cases. In addition to data analysis; the receipt of tips and referrals from the MCOs provides effective methods for responding proactively in detecting fraud, waste, and abuse of the TennCare program.

The Office of Program Integrity utilizes a centralized case management system called "T-Prime" in order to manage all of its provider investigations, including PCS. The T-Prime system provides the Office of Program Integrity with the ability to share resources and information between various divisions of State government.

The state asserts the benefits derived from utilizing T-Prime in relation to PCS oversight are (1) the ability to search current or archived PCS investigations, and analyze and filter through all fields, including the meta-data; (2) supporting documentation for specific PCS investigations is permanently stored here and is accessible by the Medicaid Fraud Control Unit (MFCU) or the Attorney General (AG) once they accept a referral from TennCare; (3) the secure transfer of large quantities of PCS data; (4) the sharing of documents between the MFCU, the AG, and TennCare or TennCare's contracted entities; and (5) the searching of keywords within the database to find links between PCS investigations.

Notwithstanding the benefits of the managed care contract language, the review team identified a concern with TennCare having all of the adequate written PCS program integrity policies and procedures at all organizational levels. Although DIDD currently reviews all policies of providers, including program integrity policies and procedures, during annual provider quality assurance surveys for the 1915(c) population, the CMS review team expressed concerns with program integrity policies and procedures at all PCS levels throughout the entirety of the Medicaid program. Some of the interviewed agencies lacked the necessary policies and procedures in the event of key staff turnover. TennCare mentioned being in the process of analyzing all of its policies and procedures and felt the CMS recommendation was timely and in line with current efforts to review all program integrity policies and procedures with their contracted entities.

Recommendation #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.

Recommendation #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 of Corrective Action Plan from 2015 Program Integrity Review

Tennessee's last CMS program integrity review was in June, 2015 and the report for that review was issued in December, 2015. The report contained two recommendations related to conducting federal database checks and payment suspensions. Prior to the onsite review in March 2019, the CMS review team conducted a thorough desk review of the corrective actions taken by Tennessee. It was determined that the findings of the 2015 review were found to be compliant. The corrective actions were considered compliant and the issues closed.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Tennessee to consider utilizing:

- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute, which can help, address the risk areas identified in this report. Courses that may be helpful to Tennessee are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Review the document titled "Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services". This document can be accessed at the following link https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Visit and utilize the information found on the CMS' Medicaid Program Integrity Education site. More information can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html.
- Consult with other states that have PCS programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of staff in program integrity.

Conclusion

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that these areas will be improved. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

The CMS looks forward to working with Tennessee to further strengthen its program integrity function.