# Department of Health and Human Services

# Centers for Medicare & Medicaid Services

# Center for Program Integrity

# Tennessee Focused Program Integrity Review

# Final Report

# December 2015

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## Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review to determine the extent of program integrity oversight of the managed care program at the state level and assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the State Medicaid agency.

TennCare is the state of Tennessee's Medicaid program that provides health care for approximately 1.3 million Tennesseans and operates with an annual budget of approximately $10 billion. TennCare members are primarily low-income pregnant women, children, and individuals who are elderly or have a disability. TennCare covers approximately 20 percent of the state's population, 50 percent of the state's births, and 50 percent of the state's children. The review focused on the activities of the Division of Audit and Program Integrity within TennCare, which is responsible for Medicaid program integrity activities. The review also included a follow up on the state's progress in implementing its corrective actions related to CMS's last program integrity review in 2011. This report describes effective practices, one noteworthy practice, and a vulnerability in the state's managed care program integrity operations. An assessment of the Medicaid agency's corrective action plan (CAP) is included as an addendum to this report.

## Background: State Medicaid Program Overview

TennCare is administered by the Bureau of TennCare, which is a division of the Tennessee Department of Finances and Administration. TennCare is the only program in the nation to enroll the entire state's Medicaid population in managed care. The TennCare program operates under a Section 1115 waiver from CMS. Unlike traditional fee-for-service Medicaid, TennCare is an integrated, full-risk, managed care program, covering medical, behavioral, long-term services and supports, prescription drugs, and dental services to children under the age of twenty one.

## Methodology of the Review

In advance of the onsite visit, CMS requested that Tennessee complete a managed care review guide that provided the review team detailed insight to the operational activities of the areas that were subject to the focused review. A five-person team reviewed the responses and materials that the state provided in advance of the onsite visit.

During the week of June 1-5, 2015, the CMS review team visited TennCare and other agencies, as well as the program integrity staff of five MCOs to discuss their program integrity activities at length. At the time of this review, the MCOs operating in Tennessee consisted of Magellan Medicaid Administration, Inc.; UnitedHealthcare Plan of the River Valley d/b/a UnitedHealthcare Community Plan; Volunteer State Health Plan, Inc. d/b/a BlueCare; Amerigroup Tennessee, Inc.; and DentaQuest USA Insurance Co., Inc. In addition, the team also conducted sampling of Medicaid provider investigations and other primary data to substantiate TennCare's implementation of their managed care program integrity policies and procedures.

## Results of the Review

The review team identified two areas of concern with the state's managed care program integrity activities and managed care oversight, thereby creating risk to the Medicaid program. These issues and CMS's recommendations for improvement are described in detail in this report. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible.

### Section 1: Managed Care Identified Risks

| **42 CFR 455.436: Federal database checks** |
|---|
| The 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 and Entities (LEIE), the Excluded Parties List System (EPLS) on the System for Award Management (SAM), the Social Security Administration's Death Master File (DMF), the National Plan and the Provider Enumeration System upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly. |
| The state is at risk of being non-compliant with this regulation. |
| TennCare relies on the MCOs to perform all of the required federal database checks for managed care providers who are initially enrolling, re-enrolling, reactivating, or revalidating, or when there is a requested change of ownership. Only Amerigroup reported checking providers against the DMF upon enrollment and reenrollment. All other database checks were conducted upon enrollment and reenrollment and the MCOs were checking the DMF, LEIE, and EPLS on a monthly basis thereafter. This is an identified risk to the Medicaid managed care program, since the state does not ensure that MCOs check the DMF at the time of initial enrollment and reenrollment. |
| **Recommendation:** The state should monitor MCOs' compliance with contractual requirements for checking the Social Security Administration's DMF when credentialing and re-credentialing providers. |
| |
| **42 CFR 455.23: Suspension of payments in cases of fraud.** |
| The Federal regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the State Medicaid agency must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payment only in part. Under 42 CFR 455.23(d) the State Medicaid agency must make a fraud referral to either a Medicaid fraud control unit (MFCU) or to an appropriate law enforcement agency in States with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary. |
| The state is in partial compliance with this regulation, but lacks a complete written policy or procedure that covers the complete regulatory citation. |

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|---|
| The TennCare managed care contract does not contain the complete regulatory language specified at 42 CFR 455.23. Although there is a TennCare policy that addresses "Credible Allegation of Fraud," it does not fully address all sections within the regulation. The lack of a policy that covers the entire regulation leaves the state at risk of not fully addressing all sections of the regulation in the event there is a change in staff. |
| **Recommendations:** The state should ensure the TennCare managed care contract fully addresses the complete regulatory requirements specified at 42 CFR 455.23. |

## Section 2: Managed Care Program Integrity

### Overview of the State's Managed Care Program

The TennCare Managed Care Operations Division, within the Bureau of TennCare, is principally responsible for providing oversight of the managed care program and is where the TennCare Program Integrity Unit (PIU) is housed. The PIU oversees the program integrity operations within the managed care program. The TennCare Managed Care Operations Division performs annual MCO compliance reviews and ensures the satisfactory MCO submissions of approximately 241 contract deliverables generally on a weekly, monthly, quarterly, bi-annual, or annual basis.
The PIU is heavily involved in the managed care contracting process resulting in TennCare having a robust managed care contract with all of the essential program integrity elements necessary to have a strong Medicaid program integrity managed care program. TennCare has worked to achieve a flexible contracting process that allows it to maintain the ability to amend the contract on a semi-annual basis.

### Summary Information on the Plans Reviewed

During the week of the onsite review, the CMS review team met with the program integrity staff of five MCOs to discuss their program integrity activities at length.

**Table 1. Summary data for TennCare MCOs.**

| MCO | Medicaid Enrollees* | Medicaid Contracted Providers* | Size and Composition of SIU | Average Annual Medicaid Expenditures (SFY**12-14) |
|---|---|---|---|---|
| Magellan | 1,300,000 | 32,766 | 1.75 FTEs (investigator and manager) and 12 other part time staff (1 investigators, 5 analysts, 2 reporting / data-mining specialist and 4 managers) | $817 Million |

* Figures based on data reported by the plans as of June 2015.
**State Fiscal Year (SFY)
*** This figure includes expenditures for the previous Dental MCO in 2012 and 2013. Expenditures dropped to $144 million in 2014.

| MCO | Medicaid Enrollees* | Medicaid Contracted Providers* | Size and Composition of SIU | Average Annual Medicaid Expenditures (SFY**12-14) |
|---|---|---|---|---|
| United | 450,000 | 20,138 | 9 FTEs (1 SIU manager, 4 health care investigators, 3 clinical reviewers and 1 claims analyst) | $2.6 Billion |
| BlueCare | 600,000 | 26,630 | 5 FTEs (1 SIU manager, 4 full-time investigators) | $1.7 Billion |
| Amerigroup | 385,411 | 14,564 | 3 FTEs (3 investigators) and several part-time positions assist as needed. | $879 Million |
| Dentaquest | 230,000 | 865 | 3 FTEs (1 compliance Manager, 2 Auditors) and 2 part-time staff assist as needed. Other part-time staff also available. | $160 Million*** |

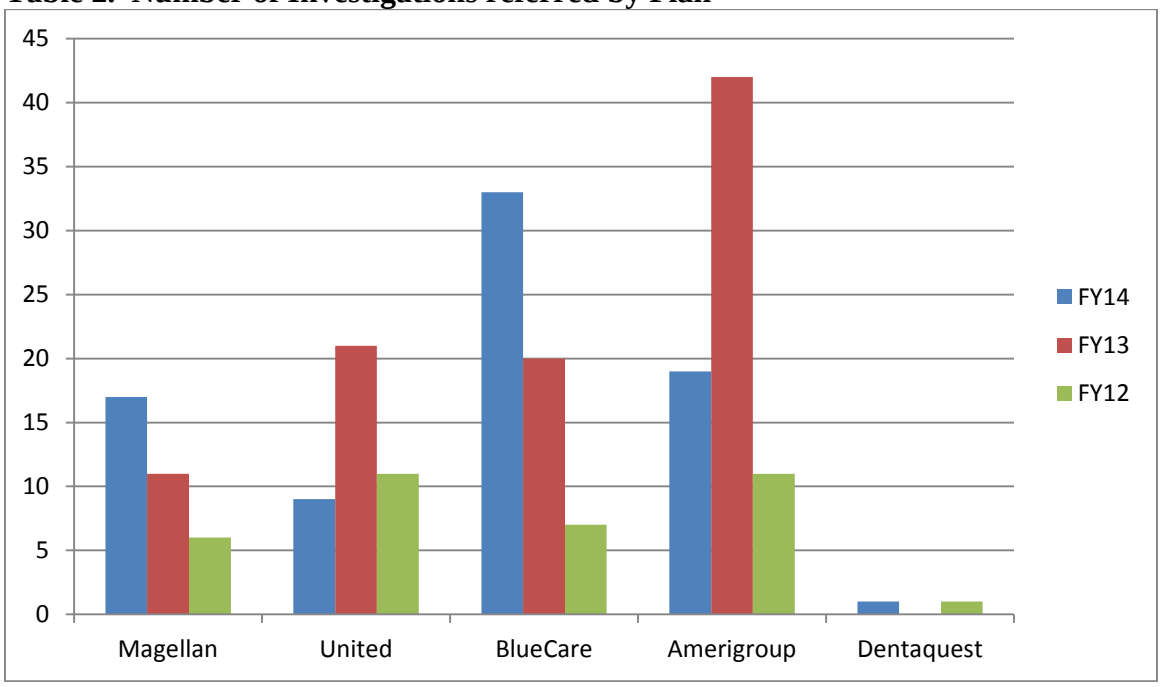
## MCO Program Integrity Activities

Investigations of Fraud, Waste, and Abuse

The TennCare managed care contract has an extensive fraud and abuse section. Four of the five MCOs interviewed had a compliance program with an in-house Special Investigation Unit (SIU) that oversaw the TennCare line of business, while the dental contractor has a Utilization Review Department that functions as an SIU. The contract specifically states the required staffing levels and positions that the MCO must maintain. The TennCare PIU and Managed Care Operations regularly monitors the MCO program integrity activities through routine weekly or monthly updates, or the use of quarterly reports. This process allows the PIU to track the managed care program integrity activities and provides them with the opportunity to determine whether or not the same provider is under investigation by the state or another MCO. Furthermore, it allows the state to manage the MCOs activities relative to cases involving suspected fraud. The MCO contract requires that all TennCare MCOs report all program integrity cases opened within the previous two weeks (referred to as"Tips") regardless of whether fraud, waste, or abuse is suspected. When suspicious activity is detected, the MCO submits a case referral to the state and MFCU simultaneously. The state then conducts its own preliminary investigation and makes a determination as to whether a credible allegation of fraud exists. In the event the state determines that a credible allegation of fraud does exist, the state will then request the MCO to suspend payments to the provider, unless the state has a good cause exception not to suspend. All MCO referrals are written in accordance with CMS referral performance standards as per the MCO managed care contract.

The chart below shows the number of investigations referred by each plan to TennCare in the past three fiscal years.

**Table 2. Number of Investigations referred by Plan**




## Meetings and Training

TennCare's PIU and state managed care staff meets regularly on issues related to program integrity. TennCare routinely performs training for the MCOs on an ongoing basis throughout the year. Training is offered to SIU personnel and usually incorporated during the quarterly fraud and abuse meetings and the semi-annual fraud and abuse roundtable. The most recent training provided by the TennCare PIU to MCOs was the semi-annual fraud and abuse roundtable on March 4, 2015.

## Encounter Data

TennCare does receive encounter data from the MCOs and reported that it does receive all the certified data the state requires to do data mining. The state also receives Tips which is all activity that an MCO has with a provider and all the data that is associated with the activity. This results in the full data disclosure between the MCOs and the state.
In addition, TennCare may assess liquidated damages[1]. The liquidated damages amount may be $25,000 per occurrence, and the continued or repeated failure to submit clean encounter data may result in the application of additional damages or sanctions, including possible forfeiture of the withhold, or result in the MCO being considered in breach of the contract.

[1] The amount of money specified in a contract to be awarded in the event that the agreement is violated. The fixed amount which a party to an agreement promises to pay to the other, in case he shall not fulfill some primary or principal engagement into which he has entered by the same agreement. http://www.lectlaw.com/def/l045.htm

## Overpayment Recoveries, Audit Activity, and Return on Investment

Per the state MCO contract, overpayment recoveries are to be tracked by the MCO and reported to the state. The MCO may not pursue the overpayment until the state directs the MCO to do so and approves the recovery of the overpayment by the MCO. The MFCU and AG review any cases of potential fraud or abuse and refer cases back to TennCare if further action is required. In general, overpayments not involving potential fraud or abuse are returned to the MCO and the MCO is approved to pursue the overpayment and correct the claims involved.

The CMS review team found all MCOs adhering to the contract and policy manual regarding all procedures for properly processing and managing all claims, and specifically provider overpayments.
The table below indicates the number of investigations by all TennCare MCOs and the overpayments identified and collected by each of the MCOs for the past four years.

**Table 3: Investigations and Overpayments collected by TennCare MCOs**

| SFY | Number of Preliminary Investigations | Number of Full Investigations | Amount of Overpayments Identified | Amount of Overpayments Collected |
|---|---|---|---|---|
| 2011 | 110 | 41 | * | $18,400,000* |
| 2012 | 152 | 64 | * | $30,000,000* |
| 2013 ** | 116 | 39 | * | $20,404,821.49*** |
| 2014 ** | 94 | 21 | * | $43,161,445.97*** |

*Overpayments identified are presently not captured for all cases where funds were collected. The MFCU and Attorney's General's office represents the State to collect funds they do not report amount of overpayments identified. Further, program integrity may not be notified of recoveries in some cases.
**Note: TennCare PIU recently developed a new case management system named T-Prime. This initial implementation did not break down investigations with multiple providers, but rather combined them together as one investigation. This design has been improved and the data is currently being updated. Therefore, the decrease in numbers is not a true representation of number of providers under preliminary and full investigation. Also SFY 2014 is not all inclusive.
*** These figures are generated from TennCare's fiscal office.

## Payment Suspensions

The TennCare contract with the MCOs does not specifically address 42 CFR 455.23; however the TennCare Policy Manual does have a provision that describes the process by which the Bureau of TennCare determines that there is a credible allegation of fraud and to explain the options available to providers.

The TennCare Policy Manual does require MCOs to suspend payments at the direction of the state Medicaid agency. Tips are reported to the state via the quarterly reports to the State Medicaid agency, prompting a review of the situation. Tips may also lead to a referral, which prompts a preliminary investigation to determine whether a credible allegation of fraud situation exists. As stipulated in the contract, referrals from the MCOs are submitted to the state and the MFCU simultaneously. The referrals do conform to the stipulations outlined in 42 CFR 455.23.

Therefore, within the TennCare program, the procedure is that payment suspensions are only initiated at the direction of the state. The state reports all credible allegations of fraud to the MFCU in accordance with the present Memorandum of Understanding (MOU) with the MFCU and the program integrity policy. The TennCare MOU along with their policy and procedure allows the state to effectively initiate payment suspensions and meet the full requirements of 42 CFR 455.23.

## Terminated Providers and Adverse Action Reporting

All MCOs are required to report changes in the provider network including voluntary and involuntary terminations to TennCare. All plans report terminated providers on the state's "Quarterly Managed Care Activity Report." In turn, the state will notify MCOs of any terminated providers from other plans, so that MCOs can ensure that terminated providers are not operating in another plan. The table below depicts the number of terminated providers reported by each of the plans.

**Table 4: Provider Terminations in Managed Care**

| Selected MCOS | No. Providers Disenrolled or Terminated in Last 3 Completed FFYs | No. Providers Terminated for Cause in Last 3 Completed FFYs |
|---|---|---|
| Magellan | FY14 1<br>FY13 0<br>FY12 0 | FY14 1<br>FY13 0<br>FY12 0 |
| United | FY14 115<br>FY13 26<br>FY12 157 | FY14 9<br>FY13 14<br>FY12 16 |
| BlueCare | FY14 34<br>FY13 30<br>FY12 34 | FY14 23<br>FY13 26<br>FY12 12 |
| Amerigroup | FY14 863<br>FY13 1,499<br>FY12 1,583 | FY14 7<br>FY13 2<br>FY12 33 |
| Dentaquest | FY14 1<br>FY13 50<br>FY12 N/A | FY14 1<br>FY13 0<br>FY12 N/A |

## Effective Practices

1. ***TennCare Program Integrity Resource for Investigations and Management Exchange (T-Prime)***

   T-Prime is a centralized case management system for TennCare Program Integrity's provider investigations that allows extensive collaboration of resources and information between various divisions of State government. The system is the result of a corrective action taken by the state in response to an issue identified in the prior CMS comprehensive program integrity review in 2011.

   Among the benefits derived from T-Prime are (1) the ability to search current or archived investigations, and analyze and filter through all fields, including the meta-data; (2) supporting documentation for specific investigations is permanently stored here and is accessible by the MFCU or the Attorney General (AG) once they accept a referral from the TennCare PIU; (3) the secure transfer of large quantities of data; (4) the sharing of documents between the MFCU, the AG, and the PIU; and (5) the searching of keywords within the database to find links between investigations.

   Since going live in September 2014, T-Prime continues to evolve. TennCare is in the process of creating workflows to make processes operate more smoothly and aid in collection of information.

2. ***TennCare has robust managed care contract language***

   TennCare's standard MCO contract captures all of the elements of a strong program integrity program with the exception of the concern identified by this report. Furthermore, TennCare demonstrates a dedication to not only meeting all the minimum standards required of a program integrity program by federal regulations, but exceeds them.

   The 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 liquidated damages for failing to perform specific responsibilities or requirements as stipulated within the contract. This liquidated damages amount may be $25,000 per occurrence. The continued or repeated failure to submit clean encounter data may result in the application of additional damages or sanctions, including possible forfeiture of the withhold, or can result in the MCO being considered in breach of the contract.

   Notwithstanding the benefits of this robust contract language, the review team identified an issue with missing contract language in regards to the full requirements outlined in 42 CFR 455.23, as discussed in the potential risk area above.

*3. TennCare's Dual provider enrollment process*

Perspective Medicaid providers, including pharmacies, who want to contract with a medical or dental managed care plan must first register with the state in order to receive a Medicaid number. The perspective provider can then contact the MCO of their choice to complete a separate contract and credentialing application in addition to enrolling with TennCare.

During the MCO credentialing process the state has required by contract that all MCOs utilize a 16 page disclosure form that covers all the federal disclosure requirements as per 42 CFR 455. This is a corrected action taken by the state as a result of issues identified in the prior CMS comprehensive program integrity review in 2011.

Notwithstanding the benefits of this dual enrollment process, the review team identified an issue with one of the state's provider enrollment practices, as discussed in the potential risk area above.

## Summary Recommendations:

- The state should monitor MCOs' compliance with contractual requirements for checking the Social Security Administration's DMF when credentialing and re-credentialing providers.

- The state should ensure the TennCare managed care contract fully addresses the complete regulatory requirements specified at 42 CFR 455.23.

### Section 3: Status of Corrective Action Plan

Tennessee's last CMS program integrity report was issued in 2012 and contained six findings and one vulnerability. During the current on-site review, the CMS team conducted a thorough review of the corrective actions taken by Tennessee to address all issues reported in 2012. All CAP items from Tennessee's previous review have been satisfactorily addressed by TennCare.

- Issue 1 - **The state does not refer all cases of suspected provider fraud to the MFCU.** Corrective action taken by the state: All cases of suspected fraud are now referred to the MFCU per the MOU and Working Protocol.

- Issue 2 - **The state does not provide appropriate notice of withholding to providers.** Corrective action taken by the state: The state has added the appropriate language in its form withholding letter.

- Issue 3 - **The state does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)**
  Corrective action taken by the state: TennCare's 16-page disclosure form meets the requirements of 42 CFR-455.104, 105, and 106. All MCOs, and the dental and pharmacy contractors, are now required to collect disclosures forms. The disclosure form that is required to be collected now includes questions concerning family relationships between persons with ownership and control interests in the disclosing entity and subcontractors per the rule.

- Issue 4 - **The state does not conduct complete searches for individuals and entities excluded from participating in Medicaid.**
  Corrective action taken by the state: The state now checks the list of providers against the EPLS upon enrollment, reenrollment, and monthly.

- Issue 5 - **The state does not report all adverse actions taken on provider participation to the HHS-OIG. (Uncorrected Partial Repeat Finding)**
  Corrective action taken by the state: The state and HHS-OIG have discussed how MCOs, PBMs, and DBMs accept, reject, renew, and deny providers in their respective programs. TennCare received guidance from HHS-OIG on when it would be necessary, and under what circumstances, they should report these regarding providers to HHS-OIG. The state will follow 42 C.F.R. § 1002.3(b) (3) along with the guidance from HHS-OIG as to how to report various scenarios.

- Issue 6 - **The state does not provide notice of exclusion consistent with the regulation.**
  Corrective action taken by the state: Providers that are terminated by the state are now listed on the State Agency's, TennCare, website under Fraud and Abuse, Terminated Providers List. http://www.tn.gov/tenncare/topic/terminated-provider-list

- Issue 7 - State Vulnerability: **The state had two databases, which were used to track all cases and one to track cases that were under preliminary investigation by the state. The two tracking systems did not match completely. The MOU between the MFCU and State Agency did not include a clear process for reporting on the status of cases.**
  Corrective action taken by the state: All cases and matters are now referred to the MFCU per the MOU and working protocol. There is now only one tracking system for all cases. The MOU has been revised to require the MFCU and other signatories on it to update cases at least once every ninety days.

The CMS review team approved and closed all corrective actions taken by TennCare to completely address all 2012 comprehensive program integrity review report issues.

## 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:

- 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 RISS for information provided by other states including best practices and managed care contracts.
- 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 based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- 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.
- Access the annual program integrity review summary reports on the CMS's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that Tennessee review the effective and noteworthy practices in program integrity and consider emulating these practices as appropriate.
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

## Conclusion

CMS supports Tennessee's efforts and encourages it to look for additional opportunities to improve overall program integrity. The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

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 the deficiencies will not recur. 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 plan should identify those corrections as well.

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

**Official Response from Tennessee**
**January 2016**

Division of
Health Care
Finance & Administration

January 7, 2016

Letitia Leaks
Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop AR-21-55
Baltimore, Maryland 21244-1850

Re: Tennessee's Response to Focused Program Integrity Review Report

Dear Ms. Leaks:

Tennessee appreciates the opportunity to respond to the Focused Program Integrity Report. In the Report two concerns were raised:

(1) Federal database checks -- The State should monitor MCOs' compliance with contractual requirements for checking the Social Security Administration's DMF when credentialing and re-credentialing providers.

(2) Suspension of payments in cases of fraud – The State is in partial compliance with this regulation, but lacks a complete written policy or procedure that covers the complete regulatory citation.

Tennessee agrees with the two areas of concern identified by the review team.

In way of background, Tennessee requires all providers to register with TennCare in order for them to contract with a Manage Care Contractor. During this registration process with TennCare the provider is now compared with the Social Security Master Death (SSMD) file prior to a Tennessee Medicaid number being issued. This check will insure that no Medicaid number is assigned to someone that is matched against the SSMD. Without a Medicaid number issued by TennCare no provider can be contracted with or paid by an MCO. *See Attachment 1.* TennCare and all MCOs presently check the SSMD monthly after the provider registers or contracts.

The MCO's are now required to report monthly their findings on any SSMD matches within their credentialing/re-credentialing process.

For the second concern, TennCare has updated its policy on Federal regulation 42 CFR 455.23(a) concerning allegations of fraud that are credible. TennCare's policy now covers the complete regulatory citation. *See Attachment 2.*

All necessary changes to or creation of policies and standard operating procedures are completed and fully implemented at this time. The SOP for checking the SSMD will be added to the risk assessment of program integrity so that the process is audited annually.

Tennessee found the focused review by CMS to be a good check on the business practices of the Program Integrity division within TennCare. If there are any questions or concerns regarding our proposed corrective action plans, please let us know.

Sincerely,

Darin J. Gordon
Director

Attachments