



**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**



**DIVISION OF TENNCARE
AND TENNCARE PHARMACY ADVISORY COMMITTEE**

Performance Audit Report

December 2018

Justin P. Wilson, Comptroller



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December 4, 2018

The Honorable Randy McNally
Speaker of the Senate
The Honorable Beth Harwell
Speaker of the House of Representatives
The Honorable Mike Bell, Chair
Senate Committee on Government Operations
The Honorable Jeremy Faison, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
Dr. Wendy Long, Deputy Commissioner
Division of TennCare
310 Great Circle Road
Nashville, Tennessee 37243

Ladies and Gentlemen:

We have conducted a performance audit of selected programs and activities of the Division of TennCare, including the TennCare Pharmacy Advisory Committee, for the period August 1, 2014, through September 30, 2018. This audit was conducted pursuant to the requirements of the Tennessee Governmental Entity Review Law, Section 4-29-111, *Tennessee Code Annotated*.

Our audit disclosed certain findings, which are detailed in the Audit Conclusions section of this report. Management of the division has responded to the audit findings; we have included the responses following each finding. We will follow up the audit to examine the application of the procedures instituted because of the audit findings.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the division and the committee should be continued, restructured, or terminated.

Sincerely,

A handwritten signature in black ink that reads "Deborah V. Loveless".

Deborah V. Loveless, CPA
Director

DVL/jw
18/043



Division of State Audit
Division of TennCare
Performance Audit
December 2018

Our mission is to make government work better.

AUDIT HIGHLIGHTS

Division of TennCare's Mission

Improving lives through high-quality cost-effective care.

We have audited the Division of TennCare and the TennCare Pharmacy Advisory Committee for the period August 1, 2014, through September 30, 2018. Our audit scope included a review of internal controls and compliance with laws, regulations, policies, procedures, and provisions of contracts or grant agreements in the following areas:

TennCare's Scheduled Termination Date:

June 30, 2019

**TennCare Pharmacy Advisory Committee's
Scheduled Termination Date:**

June 30, 2020

- follow-up on prior audit findings relating to Employment and Community First CHOICES and CHOICES programs;
- implementation of TennCare's payment reform initiatives;
- program integrity data matches for
 - member eligibility;
 - long-term care services;
 - provider screening; and
 - non-emergency medical transportation;
- eligibility redetermination;
- provider network accessibility;
- TennCare's strategies to combat Tennessee's opioid epidemic;
- the Drug Utilization Review Board and the TennCare Pharmacy Advisory Committee;
- information systems, including the TennCare Eligibility Determination System (TEDS) implementation; and
- TennCare's efforts to protect public records, including records disposition authorizations.

KEY CONCLUSIONS

Findings

- As noted in two prior audits, spanning eight years, TennCare did not develop formal policies to track registration processing times (page 12).
- TennCare could not provide sufficient documentation to support actual cost savings, did not set clear vendor contract expectations, and did not fully document and implement a formal monitoring plan, which calls into question whether the episodes of care strategy is positively changing the way healthcare is provided in Tennessee (page 24).
- TennCare did not recapture improper payments made on behalf of deceased, incarcerated, and duplicate members (page 38).
- TennCare did not ensure its managed care contractors established controls to prevent improper claims and to ensure that TennCare members received critical long-term care services (page 46).
- TennCare and its managed care contractors did not detect and terminate potentially ineligible providers (page 52).
- TennCare did not provide adequate internal controls in three specific areas (page 79).

For notes about TennCare's other areas that are not included within the scope of this audit, see the **Single Audit and Federal Reviews** section on page 4.

Observations

The following topics are included in this report because of their effect on the operations of TennCare and the citizens of Tennessee:

- TennCare and the managed care organizations should increase their education outreach to providers regarding payment calculations, commendable threshold methodology, and quality measurements (page 30).
- TennCare began implementing the primary care transformation strategy in fall 2016; however, by the end of audit fieldwork, management did not have sufficient data to evaluate the strategy's success (page 35).
- Greater oversight of the non-emergency medical transportation program could help TennCare detect improper claims (page 59).
- TennCare did not properly terminate, modify, and document member eligibility for Medicare Savings Program benefits; however, management believes the upcoming implementation of the Tennessee Eligibility Determination System will resolve these issues (page 62).
- Although the managed care contractors' networks met or exceeded TennCare's established network accessibility standards, TennCare's standards were set to permit the networks to retain fewer than 10 physicians per specialty, which could pose barriers to access should networks choose to operate at the minimum standard requirements (page 65).

- TennCare has implemented strategies to reduce opioid abuse among its members, but the effectiveness of those strategies cannot be measured currently (page 70).
- To achieve the required TennCare Drug Utilization Review Board and TennCare Pharmacy Advisory Committee representation, meet quorum requirements, and ensure all viewpoints are represented, all members should attend meetings and vacant positions should be quickly filled (page 75).
- After six years in development, TennCare's new eligibility determination system is anticipated to launch in spring 2019, at a total cost of \$475 million (page 80).
- Management is making strides to update records disposition authorizations (page 84).

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INTRODUCTION

AUDIT AUTHORITY

This performance audit of the Division of TennCare (TennCare), including the TennCare Pharmacy Advisory Committee, was conducted pursuant to the Tennessee Governmental Entity Review Law, Title 4, Chapter 29, *Tennessee Code Annotated*. Under Section 4-29-240, TennCare is scheduled to terminate June 30, 2019. Under Section 4-29-241, the TennCare Pharmacy Advisory Committee is scheduled to terminate June 30, 2020. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the entities and to report to the Joint Government Operations Committee of the General Assembly. This audit is intended to aid the committee in determining whether TennCare and the committee should be continued, restructured, or terminated.

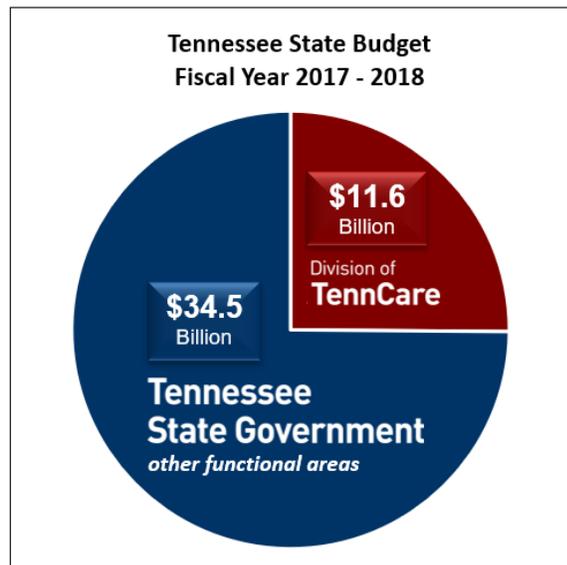
BACKGROUND

TennCare is Tennessee’s Medicaid program, a federally funded program¹ that provides health insurance coverage to certain groups of low-income individuals, such as pregnant women, children, caretaker relatives of dependent children and older adults, and adults with disabilities. TennCare has an annual budget of approximately \$11.6 billion and provides health coverage to approximately 1.4 million Tennesseans.

TennCare Membership

- 20% of Tennessee residents
- 50% of Tennessee’s births
- 50% of Tennessee’s children

Source: TennCare management, as of September 2018.



Established on January 1, 1994, TennCare is one of the oldest Medicaid managed care programs in the country. It is the only program in the nation to enroll all of its Medicaid population into managed care through contracts with managed care organizations (MCOs).² TennCare contracts with three MCOs and three benefits managers to manage and coordinate care and maintain a network of healthcare providers, including long-term care, for TennCare members. These contractors are

- AmeriGroup;
- BlueCare through Blue Cross Blue Shield of Tennessee;

¹ The Comptroller of the Treasury annually audits TennCare for compliance with federal program requirements as part of the Single Audit. For more information, see page 5.

² Throughout this report, managed care organizations will also be called managed care contractors or managed care plans.

- UnitedHealthcare Community Plan;
- TennCare Select through Blue Cross Blue Shield of Tennessee;
- Magellan Health (pharmacy benefits); and
- DentaQuest (dental benefits to children under age 21).

Led by the Deputy Commissioner/Director, TennCare is composed of different operational units to meet its mission of improving lives through high-quality, cost-effective care. The division’s organizational structure is described on the following pages.

See **Appendix 7** on page 103 for a glossary of TennCare-related terms used throughout this report.

Organizational Structure

Deputy Commissioner/Director’s Direct Reports

The Long-Term Services and Supports Unit offers long-term services and supports to individuals enrolled in TennCare. Long-term services and supports are medical and/or personal care and supportive services needed by individuals who have lost some capacity to perform activities that are essential to daily living. These activities include not only bathing, dressing, eating, and toileting but also completing housework, preparing meals, taking medications, shopping, and managing money. The unit also works with the Department of Intellectual and Developmental Disabilities to administer the Employment and Community First CHOICES (ECF CHOICES) program, which is a program for people of all ages who have an intellectual or developmental disability.

TennCare’s organizational chart is on page 7.

The Strategic Planning and Innovation Group takes on new TennCare initiatives by serving in a leadership role with special projects, taking these new initiatives and special projects to various TennCare divisions, and helping these divisions develop long-term strategies to successfully execute them.

In the Communications and Employee Relations Office, the Public Affairs Office coordinates TennCare’s communications with the General Assembly, other state agencies, healthcare associations, advocates, members, and the news media. The Office of Civil Rights Compliance and the Administrative Services Office coordinate employee relations by ensuring fair and consistent treatment to all employees.

Chief of Staff’s Direct Reports

The Fiscal Division includes accounting and budget personnel and purchasing functions, as well as a responsibility to monitor, review, and sign off on all contracts.

The Information Systems Division is responsible for the Medicaid management information system (known as interChange), which includes member eligibility and enrollment; claims processing; data analysis; data reporting; and other related systems functions. This division also handles all of TennCare's hardware, software, and system security needs.

The Policy Unit prepares program proposals for the federal Centers for Medicare and Medicaid Services (CMS) for Medicaid waiver agreements; files appropriate rules to support TennCare's programs; files Medicaid State Plan amendments; conducts research and writes policy statements to interpret programs; and submits reports required by the waiver agreements to CMS.

The Legislative Affairs Office monitors legislation affecting TennCare by reviewing filed legislation and coordinating activities of staff involved in the review and analysis of the legislation.

The Audit and Investigations Unit works with TennCare's staff to evaluate internal controls to ensure that assets are safeguarded; information is accurate and reliable; internal policies and procedures as well as external laws and regulations are followed; resources are used efficiently; operations and programs are carried out as designed; and prior audit findings are resolved.

The Project Management Office assists with a wide range of projects across TennCare. It works on a variety of projects, such as TennCare divisional work efforts, various Medicaid-related initiatives, process improvement plans, business-related endeavors, and information technology. The project managers often serve as a single point of contact between different groups and work to resolve problems and develop relationships at all levels. The office also serves as a key element in maintaining the proper relationship with outside vendors and contractors.

Chief Operating Officer's Direct Reports

The Medical Office provides medical direction for the TennCare program and provides oversight of the medical, pharmacy, and dental services delivered through a network of MCOs and benefits managers. The office is involved in developing medical policy and monitoring access to care, service quality, and health outcomes. The office also serves as the focal point for provider education.

The Pharmacy Division staff serve in an administrative role for the Drug Utilization Review Board and the TennCare Pharmacy Advisory Committee. See page 73 of this report for more information about both entities.

Managed Care Operations is responsible for managing and overseeing TennCare's MCOs. The office negotiates the contracts with the MCOs, monitors contract compliance, and refines MCO performance measures.

The Office of General Counsel provides TennCare's legal counsel. This includes legal oversight of the development, implementation, and monitoring of TennCare's contracts for its

MCOs, contractors, grantees, subcontractors, and vendors. The office works with other staff to ensure compliance with federal and state laws, regulations, court rulings, and consent decrees. The office assists in drafting TennCare rules and policies. The office is also involved in legal proceedings involving TennCare.

Member Services leads TennCare’s application process, eligibility redeterminations and terminations, and all other efforts involving TennCare’s members. Member Services also processes TennCare member’ eligibility, medical, pharmacy, and dental appeals and handles other related appeal issues.

TennCare’s Expenditures and Revenues

TennCare is funded by a combination of federal grant funds and state appropriations. Through its grants with the Centers for Medicare and Medicaid Services (CMS), the federal government covers 50% of TennCare’s administrative costs, approximately 65% of costs for medical services,³ and 90% of costs toward information system implementation. TennCare’s budget for fiscal year 2018 and expenditures and revenues (both federal and state) for fiscal year 2017 can be found in **Table 1**.

Table 1
Division of TennCare⁴
Fiscal Year 2017–2018 Recommended Budget and
Fiscal Year 2016–2017 Actual Expenditures and Revenues

Department of Revenue		FY 2017-2018 Recommended Budget*	FY 2016-2017 Actual Expenditures and Revenues**
Expenditures	Payroll	\$91,934,900	\$73,941,182
	Operational	11,491,186,400	10,928,559,790
	Total	\$11,583,121,300	\$11,002,500,972
Revenues	State	\$3,677,385,900	\$3,532,697,100
	Federal	7,163,104,200	6,701,051,000
	Other	742,631,200	840,067,400
	Total	\$11,583,121,300	\$11,073,815,500

*Source: Tennessee State Budget, Fiscal Year 2017–2018.

**Source: Tennessee State Budget, Fiscal Year 2016–2017 (Actual Revenues) and State Audit Information Systems (Actual Expenditures).

Single Audit and Federal Reviews

As part of the annual Single Audit of the State of Tennessee, the Comptroller of the

³ CMS adjusts federal financial participation rate annually based on federal fiscal year (October to September). For state fiscal year 2017, the rate from July 1 through September 30, 2016, was 65.05%; from October 1, 2016, through June 30, 2017, it was 64.96%.

⁴ TennCare’s Edison business unit code is 31865.

Treasury’s Division of State Audit performs a risk assessment and audits certain federal programs administered by state agencies. We review TennCare’s systems of internal control over federally funded programs and compliance with program regulations. The Single Audit’s objective is to determine the state’s compliance with federal requirements regarding how those funds were used. Given that TennCare’s operations are mostly funded by the federal government, we also include certain areas in the scope of our performance audit:

- member eligibility;
- allowable activities; and
- allowable costs.

Our focus for the current performance audit, for the period August 1, 2014, through September 30, 2018, was on TennCare’s processes and their effectiveness and efficiency. During the audit period, TennCare’s Medical Assistance and Children’s Health Insurance programs were included in the state’s fiscal year 2015, 2016, and 2017 Single Audits as described in **Table 2**. See **Table 2** for a summary of the expenditures associated with these programs and the numbers of findings reported.

Table 2
Single Audit Findings – Division of TennCare⁵

Federal Program	Average Federal Funds Expended During Fiscal Years 2015–2017	Findings by Fiscal Year		
		2015	2016	2017
Medical Assistance Program	\$6,538,987,010	1	2	3
Children’s Health Insurance Program ⁶	\$144,087,871	N/A	N/A	0
Total Findings		1	2	3

A summary of the TennCare’s results for fiscal year 2017 is presented in **Table 3**.

Table 3
Finding Summary for 2017 Single Audit

NEW FINDINGS	KNOWN QUESTIONED COSTS
3	\$39,736

⁵ Source: Single Audit reports for fiscal years 2015, 2016, and 2017:
http://www.comptroller.tn.gov/repository/SA/2015_TN_Single_Audit.pdf
http://www.comptroller.tn.gov/repository/SA/2016_TN_Single_Audit.pdf
http://www.comptroller.tn.gov/repository/SA/2017_TN_Single_Audit.pdf

⁶ The Children’s Health Insurance Program was not audited for fiscal years 2015 and 2016 Single Audits.

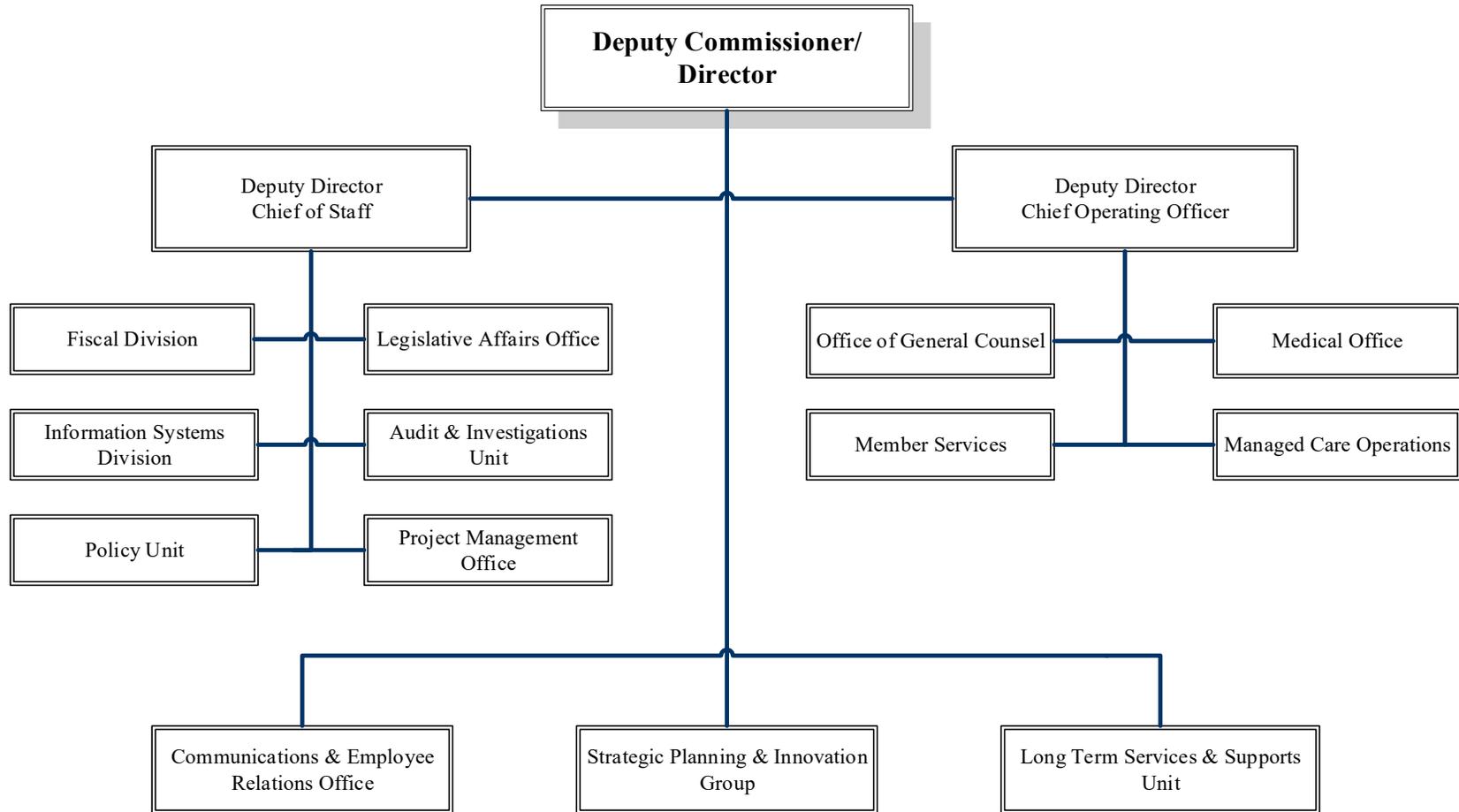
New Findings

- 2017-006 TennCare inappropriately overdrew \$37,923 of net federal reimbursements because it did not allocate indirect administrative expenses in accordance with its approved public assistance cost allocation plan
- 2017-007 TennCare paid two fee-for-service claims at incorrect amounts, resulting in federal questioned costs of \$1,813
- 2017-008 TennCare did not provide adequate internal controls in one specific area

In response to Single Audit findings and recommendations, TennCare must develop corrective action plans to submit to the appropriate federal awarding agency. The federal grantor is responsible for issuing final management decisions on TennCare's findings, including any directives to repay the federal grants. Our office is required to determine whether TennCare has taken full corrective action, partial corrective action, or no action.

We are currently auditing, for the 2018 Single Audit, the Medical Assistance Program. The audit results, including any uncorrected 2017 findings, will be reported by March 31, 2019.

Division of TennCare
Organizational Chart
 April 2018



Source: TennCare management.

AUDIT SCOPE

We have audited the Division of TennCare and the TennCare Pharmacy Advisory Committee for the period August 1, 2014, through September 30, 2018. Our audit scope included a review of internal controls and compliance with laws, regulations, policies, procedures, and provisions of contracts or grant agreements in the following areas:

- follow-up on prior audit findings relating to Employment and Community First CHOICES and CHOICES programs;
- implementation of TennCare’s payment reform initiatives;
- program integrity data matches for
 - member eligibility;
 - long-term care services;
 - provider screening; and
 - non-emergency transportation claims;
- eligibility redetermination;
- provider network accessibility;
- TennCare’s strategies to combat Tennessee’s opioid epidemic;
- the Drug Utilization Review Board and the TennCare Pharmacy Advisory Committee;
- information systems, including the TennCare Eligibility Determination System (TEDS) implementation; and
- TennCare’s efforts to protect public records, including records disposition authorizations.

TennCare’s management is responsible for establishing and maintaining effective internal control and for complying with applicable laws, regulations, policies, procedures, and provisions of contracts and grant agreements.

For our sample design, we used nonstatistical audit sampling, which was the most appropriate and cost-effective method for concluding on our audit objectives. Based on our professional judgment, review of authoritative sampling guidance, and careful consideration of underlying statistical concepts, we believe that nonstatistical sampling provides sufficient, appropriate audit evidence to support the conclusions in our report. Although our sample results provide reasonable bases for drawing conclusions, the errors identified in these samples cannot be used to make statistically valid projections to the original populations. We present more detailed information about our methodologies in **Appendix 1**.

We conducted our audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our

audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

PRIOR AUDIT FINDINGS

REPORT OF ACTIONS TAKEN ON PRIOR AUDIT FINDINGS

Section 8-4-109, *Tennessee Code Annotated*, requires that each state department, agency, or institution report to the Comptroller of the Treasury the action taken to implement the recommendations in the prior audit report. The December 2014 TennCare performance audit report contained two findings: one finding on the CHOICES application process and one finding on the provider database. TennCare filed its report with the Comptroller of the Treasury on July 15, 2015. The November 2017 performance audit of the Department of Intellectual and Developmental Disabilities contained one finding relevant to TennCare on Employment and Community First (ECF) CHOICES. TennCare filed its report with the Comptroller of the Treasury on January 12, 2018. We conducted a follow-up of the prior audit findings as part of the current audit.

RESOLVED AUDIT FINDINGS

The current audit disclosed that TennCare resolved the previous audit findings concerning the December 2014 report finding on the CHOICES application process and the November 2017 report finding on ECF CHOICES.

REPEATED AUDIT FINDING

The December 2014 performance audit report also contained a finding stating that “provider database completeness and accuracy have improved, but problems remain.” The current audit disclosed that this prior finding was partially resolved, and it is reported in the Prior Audit Findings section of this report.

Audit Conclusions



Prior Audit Findings



CHOICES AND EMPLOYMENT AND COMMUNITY FIRST CHOICES _____

General Background

In the December 2014 TennCare performance audit report, we identified a finding that involved the CHOICES application process. Tennessee's CHOICES program offers nursing home and home- and community-based services⁷ for adults (age 21 and older) with a physical disability and seniors (age 65 and older). Because Medicaid financial and medical eligibility rules and processes are inherently complex due to federal and other legal requirements, it is important to communicate this information to applicants and enrollees effectively and in a way that is easy to understand.

In the November 2017 Department of Intellectual and Developmental Disabilities (DIDD) performance audit report, a joint DIDD and TennCare finding involved the launch of a new program called Employment and Community First CHOICES (ECF CHOICES). ECF CHOICES is for people of all ages who have an intellectual or developmental disability. This program helps individuals gain as much independence as possible by providing support so that they can live with their families or in the community. This program also helps the individual explore the possibility of working. In the 2017 finding, we identified the following concerns:

- TennCare did not receive key information about potential members who expressed interest in applying for ECF CHOICES;
- TennCare's initial program correspondence confused members and their families; and
- ECF CHOICES did not reach its first-year enrollment target of 1,700 members enrolled.

Audit Results

1. Audit Objective: Did TennCare correct the December 2014 finding by distributing easy-to-understand information about the CHOICES application process?

Conclusion: We reviewed TennCare's applications, notices, and websites that explain the rules regarding eligibility for its CHOICES program and determined that they were easy to understand.

2. Audit Objective: Did TennCare address the concerns that emerged before, during, and after the launch of ECF CHOICES?

Conclusion: Based on our interviews with management and inspection of program documents, we determined TennCare addressed concerns that emerged before, during, and after the launch of ECF CHOICES.

⁷ This program offers services to help people live in their own homes or communities.

PROVIDER DATABASE

General Background

TennCare's Provider Services staff is responsible for establishing and managing the process for allowing Tennessee providers to register as TennCare providers and serve TennCare members' medical needs. In the December 2014 TennCare sunset performance audit report, we noted a finding concerning TennCare's provider registration process. The prior audit disclosed that Provider Services management did not have a formal process to track provider registration processing times. Our prior audit also noted that when we compared provider files to information in interChange, the files were confusing or needed corrections. For example, TennCare's provider files should have the providers' correct TennCare identification numbers and National Provider Identifiers (a unique provider identification number required by the federal Health Insurance Portability and Accountability Act).

In September 2012, Provider Services staff began using the Provider Database Management System to allow providers to register electronically. Provider Services staff review and approve provider registrations so that providers can obtain a Medicaid ID, which is used for claims processing and allows the providers to contract with any one of TennCare's managed care contractors.

Audit Results

- 1. Audit Objective:** Did TennCare resolve the problems with the provider data to improve completeness and accuracy?

Conclusion: We reviewed TennCare's Provider Database Management System, interChange, and the Department of Health's licensure verification database, and we determined that Provider Services improved completeness and accuracy of provider data.

- 2. Audit Objective:** Did TennCare develop a formal process to track registration processing times?

Conclusion: In TennCare's response to the prior audit finding dated July 15, 2015, TennCare stated that when management completed the system transition in 2015, it should resolve the remaining issues we identified; however, in the current audit, we determined that Provider Services did not have a formal process to track registration processing times (see **Finding 1**).

Finding 1 – As noted in two prior audits, spanning eight years, TennCare did not develop formal policies to track registration processing times

In our 2011 Department of Finance and Administration performance report, we first reported that TennCare did not have a way to accurately measure and track processing times for

provider applications. In 2014, we reported that TennCare did not complete regular reports to monitor how long it took staff to process provider registrations and did not establish a policy to track application processing times.

Management concurred in part with the 2011 finding and concurred in full with the 2014 finding. Management stated in its comments to the 2014 finding that when the transition to the Provider Database Management System (PDMS) was complete in 2015, the remaining issues identified should be resolved. In addition, in management’s report of action to implement the recommendations of audit findings submitted to the Comptroller of the Treasury on July 15, 2015, management stated that “in the next scheduled software release [of PDMS] is a new reporting functionality with export capabilities, which will facilitate tracking registration processing times.”

In the current audit, however, we confirmed with management that it did not use PDMS to create a report to track registration processing times. In addition, management has not developed a formal policy to address registration processing times. In our discussion with Provider Services management, staff use an informal 10-day standard to complete and approve applications, which we used as criteria for our audit work.

Results of Current Audit Work

Because Provider Services management did not track registration processing times, we requested a list of active providers to select a sample to determine the length of time it took Provider Services staff to approve applications. We requested a list of active providers from November 1, 2014, to May 30, 2018, which resulted in a population of 13,851 providers. From the population, we tested a nonstatistical, random sample of 25 provider registrations that Provider Services staff received and processed in PDMS. We found that for 14 applications (56%), Provider Services staff took an average of 147 days to approve the applications. See the results in **Table 4**.

**Table 4
Provider Application Processing Times**

Problem Identified	TennCare’s Explanation	Range of Days Late
7 applications – PDMS identified potential application errors, but we could not determine what the errors were. An application error occurs when a provider’s application has missing, incomplete, or deficient information. Minor errors (for example, a missing phone number) do not prevent TennCare from approving a provider’s registration. Major errors (for example, a missing medical license number) suspends the application process and requires corrective action, either from TennCare or the provider.	TennCare uses a contractor to develop and update the PDMS system. The PDMS contractor performed a system update at some point between late 2015 and early 2016, causing the potential errors to disappear.	Staff took 33 to 457 days to approve the applications.

7 applications – PDMS identified application errors. The applications were in the system’s queue waiting for staff to resolve the errors.	Upon application submission, PDMS displays a message that applications will be processed in 10 days. Management stated that the message is informational, not an agreement.	Staff took 19 to 288 days to approve the applications.
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The U.S. Government Accountability Office developed the *Standards for Internal Control in the Federal Government* (Green Book) to set standards for an effective internal control system for the federal government and serve as a best practice for states. Internal controls help entities like TennCare run their operations efficiently and effectively; report reliable information about their operations; and comply with applicable laws and regulations. According to Section 12.03 of the Green Book,

Management documents in policies for each unit its responsibility for an operational process’s objectives and related risks, and control activity design, implementation, and operating effectiveness. Each unit, with guidance from management, determines the policies necessary to operate the process based on the objectives and related risks for the operational process. Each unit also documents policies in the appropriate level of detail to allow management to effectively monitor the control activity.

Also, Section 12.04 states,

Those in key roles for the unit may further define policies through day-to-day procedures, depending on the rate of change in the operating environment and complexity of the operational process. Procedures may include the timing of when a control activity occurs and any follow-up corrective actions to be performed by competent personnel if deficiencies are identified. Management communicates to personnel the policies and procedures so that personnel can implement the control activities for their assigned responsibilities.

Provider Services management is responsible for providing customer service for providers that want to register and serve TennCare’s members. Such customer service could include reviewing errors in the application and answering questions from providers about the application process. The registration process allows members to have a choice of providers and services to meet their medical needs. By not implementing and monitoring registration efficiency, management increases the risk of delaying or limiting medical or service options for its members.

Recommendation

Provider Services management should analyze application processing times in order to develop policies that address the registration process. These policies should also include

procedures for meeting performance goals for prompt processing, and for regularly monitoring these process times to ensure staff resolve registration errors and promptly approve registrations.

Management's Comment

We concur in part. We agree that we did not develop a formal policy to track provider registration processing times. In response to the audit finding, TennCare will develop a written policy regarding the provider registration process detailing staff and system expectations and processing time goals. However, we do not agree that we do not use the Provider Database Management System (PDMS) to track provider processing times, and we strongly disagree with the assertion that staff took an average of 147 days to process 14 of 25 applications reviewed by the auditors.

The PDMS has a fully functioning reporting system, and Provider Services staff use PDMS reports daily for various monitoring and tracking purposes. For example, each Provider Services staff member responsible for processing provider applications has written job responsibilities that state “. . . PDMS provider errors generated from the interface with CAQH must be worked and monitored daily to enable providers to complete the registration and receive their Medicaid ID.” These provider errors are discovered through reviewing PDMS-generated reports.

In the case of each of the 14 applications cited by the auditors as exceeding TennCare's informal 10-day processing standard, the delay from the time the provider initially expressed interest in becoming a TennCare-registered provider until the date a Medicaid ID was assigned by Provider Registration staff was attributable to the provider (and/or the group the provider was attempting to affiliate with) not completing all required components of the application in a timely manner. Once a complete application was received, TennCare staff processed each of these 14 applications in less than 3 business days. TennCare currently has multiple processes in place to communicate with providers when additional information is required to complete their application, and we will evaluate whether there are additional steps we could take to promote timely completion of applications by providers; however, processing by state staff cannot and does not begin until the application is complete.

Payment Reform



By launching the Tennessee Health Care Innovation Initiative in February 2013, the Governor gave TennCare and its healthcare stakeholders (including providers, clinicians, and insurance companies) an opportunity to maintain a sustainable rate of growth in the state's healthcare costs while maintaining or improving quality of care. This initiative changes how insurance companies pay for healthcare by moving from paying for volume (traditional fee-for-service) to paying for value (quality-based care). The initiative rewards healthcare providers for providing high-quality, efficient medical treatment that enables patients to maintain their own health over time. To help facilitate this effort, TennCare received a \$65 million State Innovation Models grant from the federal Centers for Medicare and Medicaid Services (CMS), which was awarded February 1, 2015.⁸ According to TennCare management, TennCare's role is to coordinate with healthcare stakeholders and implement the initiative's three strategies:



1. Episodes of care is a value-based payment model that considers overall costs to treat members for certain conditions, such as knee replacement surgery or perinatal care. In addition to receiving their standard negotiated payments for services they provide, under the new episodes of care strategy, providers may earn rewards,⁹ have a withholding, or experience no change in pay based on whether they gave efficient and effective care.
2. Long-term services and supports focuses on improving respiratory care outcomes and providing a comprehensive training program to the direct support staff, such as nurses and nurse assistants, in the community or nursing facilities. This is also known as Quality Improvement in Long-Term Services and Supports (QuILTSS).
3. Primary care transformation helps members maintain their health over time by promoting higher-quality primary care, improving members' overall health, and reducing the cost of care.

EPISODES OF CARE

National Focus on Cost Containment Strategies

According to a National Conference of State Legislature issue brief on Health Cost Containment and Efficiencies, dated May 2010,¹⁰ episode-based payments are in the beginning stages of design and use. An episodes of care payment includes all the care a member receives in the course of treatment for a specific illness, condition, or medical event, which is different than the traditional fee-for-service reimbursement where providers are paid separately for each service. Some examples of episodes of care for which a single, bundled payment can be made

⁸ The State Innovation Models grant allows CMS to partner with states to advance multiple-player healthcare payment and delivery system reform models. Each state-led model aims to achieve better quality of care, lower costs, and improved health for the state's population.

⁹ TennCare uses the term "gain sharing payment" for bonuses or rewards and the term "risk sharing payment" for a withholding. In our report we will use the terms "bonuses" or "rewards" to describe gain sharing payments and the term "withholding" to describe risk sharing payments.

¹⁰ See the brief at <http://www.ncsl.org/research/health/episode-of-care-payments-health.aspx>.

include all physician, inpatient, and outpatient care for a knee or hip replacement or pregnancy and delivery. Cost savings can occur in three ways:

- negotiating a payment so the total cost will be less than fee-for-service reimbursement;
- agreeing with providers that any savings that result under the episode-based payments will be shared between the payer and providers; or
- improving quality of care to minimize medical complications and any related medical treatment.

TennCare’s Initiative Summarized

The episodes of care component of Tennessee’s Healthcare Innovation Initiative is an acute or specialist-driven strategy that seeks to reward providers who provide or facilitate the delivery of high-quality, cost-effective healthcare over the course of treating certain conditions. According to TennCare management, the episodes of care strategy focuses on multiple healthcare providers delivering services in association with acute healthcare events like surgical procedures, inpatient hospitalization, or other out-patient related procedures (such as a colonoscopy, respiratory infection, or congestive heart failure). After its initial implementation of the first wave of episodes in 2015, TennCare was able to analyze a full years’ worth of data in 2016 to determine whether the episodes were properly designed.

Originally, TennCare management planned to implement 75 different episodes by 2019. As of April 2018, TennCare designed 48 episodes, which are listed on **Appendix 4** on page 99. On May 30, 2018, TennCare released a statement informing the public that it was temporarily pausing the design of new episodes. TennCare stated that it will not design future episodes in order to concentrate on improving and maintaining the episodes already in place and improving provider engagement. At the end of our fieldwork in August 2018, management had not restarted expansion efforts.

General Description

 Provider payment methodology under the new episodes of care strategy differs from the payment methodology under the traditional fee-for-service model. Under episodes of care, providers are reimbursed for services in the same way they were in the past. The episodes of care strategy provides an opportunity to earn a bonus or pay a withholding at the end of the performance period. According to TennCare management, episodes of care will save the state money by

- coordinating all healthcare services related to a specific medical condition, procedure, or disability during the episode’s performance period;

- assigning a principal accountable provider, also known as a quarterback,¹¹ who is in the best position to ensure members receive quality care from all providers as cost efficiently as possible; and
- rewarding or withholding payments to quarterbacks based on achieving cost efficiencies and the quality of services provided during the episode performance period.

To coordinate a TennCare member’s care for each healthcare event (episode), a managed care organization (MCO) assigns the quarterback associated with the episode. The quarterback can be a physician, a group of physicians, or a facility (such as a hospital or a surgery center) that helps coordinate the member’s care with the different providers before, during, and after a procedure to ensure the member receives all needed care.

MCOs provide the quarterbacks with quarterly, interim, and final performance reports, which detail the members’ cost of services for the episode and whether the services met the episode’s quality metrics¹² throughout the performance period, which is based on calendar year. These reports contain the following information:

- an overall summary of the applicable episodes;
- a performance summary showing the quarterback’s payment calculations;
- an episode summary showing the total number of episodes treated and the number of episodes that were included or excluded in the report (for example, the member passed away or the episode diagnosis was not in the performance period);
- quality and cost details, which compare the quarterback’s performance to all other providers, and episode costs to the average costs of all providers; and
- a detailed list of excluded episodes.

Payment Methodology for Episodes

Although the episodes of care strategy introduces a new payment incentive, providers will continue to be paid their negotiated payment regardless of the cost efficiencies and quality outcome of the episode event. The payment is based on the contract arrangement between TennCare and the MCOs, which accept a set per member per month (capitation) payment. In addition to these payments, TennCare management created performance periods (defined as a calendar year) to capture the episode claims data in order to evaluate the new payment incentives for the quarterbacks. MCOs will analyze the claims data during a performance period so that they can establish whether quarterbacks fall within defined thresholds: acceptable, commendable, and gain sharing limit.

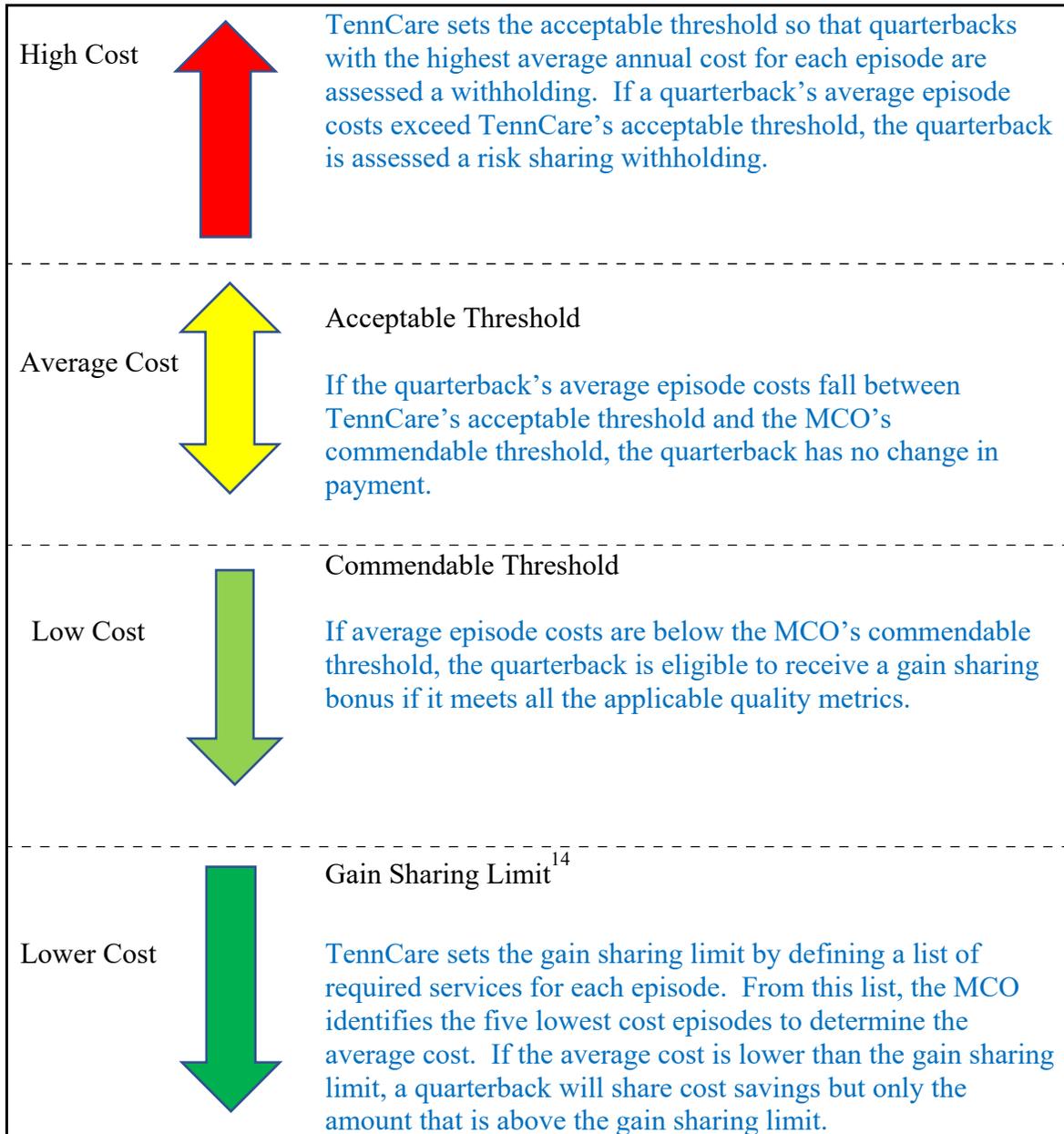
¹¹ In this report, the term “quarterback” refers to the provider who is responsible for coordinating the member’s care during the episode. The term “provider” refers to the individual who provides traditional medical care to the member.

¹² According to TennCare management, each episode has its own set of quality metrics that are selected based on clinical input and practice guidelines.

TennCare sets the acceptable threshold, the MCOs set the commendable threshold, and the gain sharing limit threshold is defined by TennCare and set by the MCO. These thresholds establish the quarterback's episode payment: a gain sharing payment (gain sharing bonus); risk sharing payment (risk sharing withholding); or no change in payment (no gain sharing bonus or no risk sharing withholding).

See **Figure 1** for an illustration of the different thresholds and their effect on quarterback payments for the 2016 performance period.

Figure 1
2016 Thresholds for Episode Payments¹³



Source: TennCare management.

¹³ See **Appendix 5** on page 101 for the 2018 episodes of care changes to the thresholds and payment calculations.

¹⁴ A quarterback can receive a bonus either by being between the commendable threshold and meeting all the applicable quality metrics or by being above the gain sharing limit.

TennCare’s 2016 Analysis of Episode Bonus and Withholding Results

To determine the total amount of quarterbacks’ gain sharing bonuses and risk sharing withholdings per MCO, we reviewed TennCare’s 2016 episodes results by MCO. The first wave of episodes (perinatal, asthma acute exacerbation, and total joint replacement—hip and knee) was designed in 2013 and implemented in 2015, and the second wave of episodes (screening and surveillance colonoscopy; chronic obstructive pulmonary disease acute exacerbation; outpatient and non-acute inpatient cholecystectomy; acute percutaneous coronary intervention; and non-acute percutaneous coronary intervention) was designed in 2014 and implemented in 2016. Our results showed that risk sharing withholdings exceeded gain sharing bonuses for episodes in both the first and second waves. In summer 2017, TennCare decided to make a one-time adjustment to the risk sharing withholdings because they were significantly higher than the gain sharing bonuses. For this reason, quarterbacks only had to pay one-third of the risk sharing withholding, rather than the entire amount. See **Table 5** for the 2016 episode results, which includes the one-time risk sharing adjustment.

Table 5
2016 Episode Results
Results Before and After the One-time 1/3 Adjustment

	Gain Sharing Bonus	Risk Sharing Withholding	
		Before One-time Adjustment	After One-time Adjustment
Total Results	\$936,893	(\$1,627,179)	(\$542,393)

Source: TennCare management.

TennCare management stated that it expects episodes in the first year of implementation to have the bonuses equal withholdings; however, results can vary based on quarterback performance. TennCare also has annual stakeholder feedback sessions, where providers come together to discuss what went well or did not go well for an episode. TennCare reviews this feedback to determine if any changes need to be made.

Provider Education

According to TennCare and MCO management, they are both responsible for educating TennCare providers about episodes of care and how this new payment model effects the providers’ payments. TennCare provided us with

- an *Introduction to Episodes of Care in Tennessee* PowerPoint presentation;
- a sample provider report;
- the *Guide to Reading Your Episode of Care Report*; and
- the *2016 Stakeholder Feedback Session* memo, which discussed the changes providers wanted and if those changes were accepted or not.

Each MCO provided us some examples of the different education methods used:

- Amerigroup provided Question and Answers (Q&As);
- BlueCare provided a link to the episodes of care section on TennCare’s website, newsletters, and emails to providers; and
- UnitedHealthcare provided in-person and telephone support.

The MCOs also help providers access their episode reports, review the quality metrics to ensure providers are meeting goals, and/or review costs to see if improvements can be made.

Monitoring of Episodes

According to TennCare management, it has contracted with three vendors to assist them with monitoring episodes of care. We focused our review on DXC Technology¹⁵ and the Tennessee Department of Commerce and Insurance (TDCI).



DXC Technology is responsible for testing the algorithm¹⁶ for the new episodes using MCOs’ claims against TennCare’s encounter data (similar to claims) before implementing an episode to determine if the current claims information is sufficient to properly analyze episodes for cost and quality after implementation. DXC tests new episodes based on claims data and tests existing episodes to determine if the episodes are working as intended.

TDCI is responsible for providing financial and compliance oversight of TennCare’s MCOs. TDCI’s TennCare Oversight Division does a quarterly review of episodes after implementation by selecting 25 TennCare members’ claim information from each MCO to determine if the episode mechanics are working correctly. For example, the trigger is the event, like a diagnosis, that initiates the episode. The episode trigger logic can include services, such as diagnostic imaging, procedures, and rehab, which include three different points in time:

- before (pre-trigger window);
- during (trigger window); and
- after (post-trigger window) the procedure (see **Appendix 6** on page 102 for an example of the different trigger windows involving the perinatal episode).

The risk adjustment factor is a score assigned to a member based on factors such as, but not limited to, gender, age, and medical conditions. TDCI examiners also review a sample of episode exclusions to determine if the MCOs correctly excluded them from counting against the provider in the episode payment calculations and quality metrics.

¹⁵ According to DXC Technology’s website, it is an independent, end-to-end Information Technology services company.

¹⁶ DXC Technology’s algorithm is an automated program based on a defined set of rules (e.g., include or exclude a member in the episode and the specific claim information needed to determine if quality metrics were met) that are used to design a new episode.

Audit Results

Audit Objective: Did TennCare’s episodes of care strategy for payment reform positively change the way healthcare is provided in Tennessee?

Conclusion: Based on our review of vendor contracts, monitoring documents, quarterback reports, budgets, and cost savings calculations, we are not able to determine the impact of this strategy and we recommend that TennCare should

- sufficiently support actual cost savings for the episodes of care strategy; and
- fully document and implement a formal monitoring plan to ensure MCOs are carrying out their responsibilities for the episodes of care strategy (see **Finding 2**).

Furthermore, TennCare and the MCOs should provide additional educational opportunities to providers about episodes of care (see **Observation 1**).

Finding 2 – TennCare could not provide sufficient documentation to support actual cost savings, did not set clear vendor contract expectations, and did not fully document and implement a formal monitoring plan, which calls into question whether the episodes of care strategy is positively changing the way healthcare is provided in Tennessee

The success of TennCare’s health care cost-savings initiative and payment reform requires management to effectively analyze and document the actual costs and make determinations and adjustments to achieve savings. Furthermore, TennCare must formally define expectations in vendor contracts for monitoring the episodes of care strategy, and management must ensure all parties fulfill those responsibilities under the new health care strategy.

Based on our discussions with management and our review of vendor contracts, monitoring documents, provider reports, budgets, and estimated cost savings calculations, we determined the following.

TennCare Could Not Provide Sufficient Documentation to Support Cost Savings Claims

In the state’s budget for fiscal years 2015 and 2016, TennCare’s budget was reduced by \$1.5 million and \$10 million, respectively, to account for projected future savings related to episodes of care. We requested the evidence to support these projections, but management did not document how these projections were developed. Because management could not provide sufficient supporting documentation, we could not verify the accuracy of management’s statements regarding savings. Furthermore, management stated that it did not have support for these numbers because the reductions were based on projections for the volume of services related to the episode that would be in place in



the future, instead of actual annual savings. At the time annual budgets were prepared, TennCare had just begun implementing episodes of care.

Based on discussions with and review of the documentation provided by TennCare's Director of Strategic Planning and Innovation, he estimated cost savings of approximately \$14.5 million for the 2016 episodes of care. We repeatedly asked for an explanation of the underlying data used in the cost savings calculation in order to determine if cost savings was achieved, which included the formula used to perform the calculation. We ended fieldwork on September 30, 2018. Management provided the actual, formula-based calculation on November 8, 2018, the date of the audit's field exit conference. Because we received the calculation at that time, we could not determine if cost savings was achieved without the calculation's underlying data.

TennCare Did Not Set Clear Contract Expectations and Did Not Document and Implement a Formal Monitoring Plan

Monitoring of New Episodes

TennCare contracted with DXC Technology to test the algorithm for the new episodes using both managed care organizations' (MCO) claims and TennCare's encounter data. We reviewed this contract and found that TennCare did not include specific contract terms or requirements to direct DXC Technology as to how to test the design of each episode, including criteria DXC Technology should use to evaluate and conclude on the quality assessment for an episode. The contract states,

Strengthen reporting of Episodes of Care to support the design of episode incentives and reward high-quality care, promote the use of clinical pathways and evidence-based guidelines, encourage coordination, and reduce ineffective and/or inappropriate care.

Based on our discussions with TennCare management, DXC Technology continually tests claims to determine if episode data is sufficient to measure costs and quality until such time that TennCare approves the quality assessments.¹⁷ As of August 9, 2018, TennCare approved 14 of 48 episodes' quality assessments. We reviewed DXC's analysis for 4 of 14 approved episodes (total joint replacement, perinatal, asthma, and ADHD) to determine if the quality assessments were met. We reviewed evidence, such as emails, that showed TennCare management and DXC Technology discussed the results of DXC's analysis; however, we were not able to determine TennCare management's basis for approving the episodes' quality assessments when DXC's analysis showed variances. In other words, TennCare did not have a formal process to describe how it evaluated variances once they were identified or how it ultimately determined when to accept or reject a variance.

At the end of audit fieldwork, we found that for the remaining 34 unapproved episodes awaiting quality assessments, DXC was actively reviewing 8 episodes and had not yet started its

¹⁷ According to TennCare management, DXC Technology performs a quality assessment by taking TennCare's claims data and each MCO's claims data and performing a comparison to identify any outliers in certain dimensions (e.g., number of valid episodes, number of valid quarterbacks, and certain quality metrics depending on the episode).

review of 26 episodes. Given the delay in the monitoring reviews, TennCare has not ensured the episodes of care are working as designed. During our discussions with the Director of Strategic Planning and Innovation, he stated that it takes time and sufficient resources from TennCare and DXC Technology to perform the quality assessments.

In addition, we determined that TennCare management had not developed any plans to perform ongoing testing of existing approved episodes; thus, TennCare may be at risk of future unforeseen and unacceptable changes in an episode.

Tennessee Department of Commerce and Insurance's Monitoring Efforts

TennCare's contract with the Tennessee Department of Commerce and Insurance's (TDCI) did not include language to examine MCOs' episodes of care procedures, and TDCI used a minimal sample selection methodology. Based on communication provided from the MCOs, the MCOs monitor the providers on a quarterly basis. They produce quarterly reports of the providers' cost and quality of care in an episode and submit them to TennCare and TDCI's TennCare Oversight Division. TennCare contracts with TDCI to provide financial and compliance oversight of its MCOs. Although the contract does not require TDCI to examine MCOs' episodes of care procedures, TDCI has incorporated this review into its scope of work for TennCare. Based on discussions with TDCI, the TennCare oversight examiners completed a review of the 2016-implemented episodes in August 2017 and completed a review of the 2017-implemented episodes in August 2018.



In the August 2018 review, TDCI examiners also reviewed a sample of gain sharing bonuses and risk sharing payments to ensure MCOs paid the bonuses and payments from the 2017-implemented episodes. At the time of the August 2017 review, TDCI reviewed less than 1% of approximately 1,400 provider reports for the 2016-implemented episodes. To provide a perspective on the TDCI review, each provider report can consist of a wide range of TennCare members, depending on the type of episode.

TDCI management stated that it developed its sample methodology by considering the limited staff resources as well as issues identified after analyzing its sample. As such, examiners stated they did not limit themselves to a 1% sample entirely, and if they did find an item that presented itself as a risk requiring further attention, they expanded their sample to further examine the risk; however, we did not see evidence that TDCI expanded the sample as stated to fully evaluate these concerns.

Criteria

According to "State Monitoring Requirements," Title 42, *Code of Federal Regulations*, Part 438, Section 66,

- (a) *General Requirement.* The State agency must have in effect a monitoring system for all managed care programs.

- (b) The State’s system must address all aspects of the managed care program, including the performance of each MCO . . . in at least the following areas: Administration and management[;] . . . Claims management[;] . . . [and] Quality improvement.

According to Section 16 of the U.S. Government Accountability Office’s *Standards for Internal Control in the Federal Government* (Green Book), “Monitoring Overview,”

monitoring of the internal control system is essential in helping internal control remain aligned with changing objectives, environment, laws, resources, and risks. Internal control monitoring assesses the quality of performance over time.

Furthermore, according to Section 6.06 of the Green Book,

Management evaluates and, if necessary, revises defined objectives so that they are consistent with these requirements and expectations. This consistency enables management to identify and analyze risks associated with achieving the defined objectives.

Finally, Section 3.09 of the Green Book states, “Management develops and maintains documentation of its internal control system.”

Effect

The episodes of care strategy is one of three strategies TennCare implemented to save the state money. By not documenting actual cost savings and by not designing and documenting effective monitoring to ensure the strategy is operating as intended and to identify any needed changes to ensure it is operating as intended, management cannot determine if this strategy is positively changing the way healthcare is provided in Tennessee, which ultimately affects TennCare members.

Recommendation

TennCare should develop a process to determine actual cost savings and maintain the documentation that supports the analysis.

TennCare management should document and implement a formal monitoring plan to ensure vendors are carrying out their responsibilities of the episodes of care strategy, including amending the contracts with DXC Technology and the Department of Commerce and Insurance to ensure the contracts clearly define the contractors’ monitoring responsibilities for the episodes of care strategy and address the issues noted in this finding. In addition, TennCare management should implement a schedule to continue testing episodes even after the quality assessments are approved.

Management's Comment

We do not concur.

TennCare has documented episodes savings

The auditors assert that TennCare could not provide sufficient documentation of episodes savings. We certainly did provide documentation of savings to the auditors, and went over those documents in detail on August 9 and August 28. During these meetings, we requested that the auditors tell us if they were unsatisfied by any of the materials we provided. We did not receive any indication from the auditors that the documents we provided were not acceptable to them until we received the draft audit report and met with the auditors in the field exit conference. We sent a new table to them the same day as the exit conference. This new table was identical to what we had provided to them previously, except for additional columns showing the calculations and formulas.

We have shared and discussed the same table we initially provided to the auditors showing the calculation of episodes savings on our website, in legislative hearings, and in many meetings with stakeholders.

Our method for calculating savings is straightforward. We compare the average risk-adjusted episode cost after episodes have been implemented with the average risk-adjusted episode cost before episodes were implemented, with an adjustment for medical inflation. We regret that the communication between us and the auditors did not lead to a better conversation about the results of episodes.

TennCare's scopes of work allow for effective monitoring of episodes

The auditors would like TennCare's scope of work with its vendor DXC and with TDCI to have more formal descriptions of the quality assurance processes they are carrying out, but the auditors do not find anything lacking in these processes. In fact the processes are functioning well to achieve their goals. DXC performs a quality assurance process where it runs the episodes algorithm and compares the results to the results from the MCOs. This process is intended to catch errors in algorithm programming. Starting in 2015, TennCare worked with TDCI to review each MCO's calculation of risk adjustment scores in episodes reports. Stakeholders were particularly concerned about the risk adjustment scores being calculated correctly and so TDCI's review was a way to address those concerns. As the auditors note, the work of TDCI has actually expanded beyond that initial scope to a review of many aspects of episodes reports.

The finding incorrectly implies that there has not been a quality assurance review of some episodes. In fact all episodes are reviewed prior to the start of the first preview report. In addition, many episodes have been reviewed a second time as part of a rolling process of review. We supplied the auditors with the date that each episode was reviewed on August 9. The finding should make clear that each episode has received at least one quality assurance review.

We agree with the auditors that TennCare should create a schedule of future quality assurance reviews of episodes by DXC, and have set that schedule since our discussion with the auditors.

The auditors imply that they want TDCI to review more episodes, but they do not state what their basis is for implying that the current amount of review is not enough or what amount of review would satisfy them. The auditors state that they did not see evidence that TDCI expanded its sample when an item required further attention. In fact, TDCI did not expand the sample because no deficiencies were found during the testing period that warranted an expansion.

We disagree with the auditor's recommendation that TennCare add more formal descriptions of processes to our agreements with DXC and TDCI. The current processes are working well, and the auditors did not find any problems with the processes. Further, too much specificity would just mean that the agreements would need to be changed every time the processes are enhanced. For example, TDCI is now reviewing much more content in the episodes report than the risk adjustment scores that were the initial focus.

Auditor Comment

TennCare Could Not Provide Sufficient Documentation to Support Cost Savings Claims

We asked TennCare management on multiple occasions during audit fieldwork to provide us the underlying support for the \$14.5 million cost savings achieved under the episodes of care strategy. We expected TennCare to provide specific information, including the costs of member services prior to episodes of care implementation, the actual episode costs related to the new strategy of care, and the related TennCare members' claim records, so that we could verify TennCare's calculations of cost savings based on the average episode costs and the total number of episodes involved. Despite our requests, the Director of Strategic Planning and Innovation did not provide evidence sufficient to support TennCare's claim of \$14.5 million cost savings.

TennCare Did Not Set Clear Contract Expectations and Did Not Document and Implement a Formal Monitoring Plan

In the finding, we did not state that monitoring was inadequate, but that the Director of Strategic Planning and Innovation did not provide us with sufficient evidence to demonstrate

- the vendor contracts clearly described episodes-of-care-related services to be provided;
- DXC Technology's quality assessments' criteria for acceptable variance; and
- that TDCI expanded work based on problems it identified.

Observation 1 – TennCare and the managed care organizations should increase their education outreach to providers regarding payment calculations, commendable threshold methodology, and quality measurements

Education Outreach Methods



During our review of the managed care organizations’ (MCO) education outreach methods, we found that the outreach methods fall short. The way the methods are written does not explain to providers the bonus and withholding methodology, the commendable threshold methodology, or how TennCare and the MCOs measure the providers’ performance. In response, as evidence of the MCOs’ educational outreach, TennCare provided us with provider engagement tracking spreadsheets for Amerigroup and UnitedHealthcare for quarter 3 of 2017 through quarter 2 of 2018. In these spreadsheets, which management provided on paper and in electronic form, we found notations of communication between the MCOs and providers concerning questions regarding episodes of care, such as how to access their provider reports. We also found notes describing the MCOs’ attempts to reach providers who were unresponsive to initial contact either through phone call or email. BlueCare, however, did not complete these provider engagement tracking spreadsheets correctly; therefore, we could not review them.

According to Section 6.06 of the Green Book,

Management evaluates and, if necessary, revises defined objectives so that they are consistent with these requirements and expectations. This consistency enables management to identify and analyze risks associated with achieving the defined objectives.

Commendable Threshold Methodology

During our review of a sample of 55 annual episodes of care reports that MCOs submitted in August 2017, we found that TennCare allowed each MCO to establish its own commendable level threshold, which the MCOs use to calculate a gain sharing payment to providers. For example, if a provider had a contract with each MCO, the provider could potentially receive different gain sharing payments even though the provider performed the same episodic services. Examples of MCO differences with the commendable threshold for the first- and second-episode waves are provided in **Table 6**.¹⁸

¹⁸ Episodes in the first and second waves include perinatal, asthma acute exacerbation, total joint replacement, chronic obstructive pulmonary disease acute exacerbation, colonoscopy, cholecystectomy, acute percutaneous coronary intervention, and non-acute percutaneous coronary intervention.

Table 6
2016 Quarterback Report – Episode Waves 1 and 2
Example of Differences of a Quarterback’s Commendable Threshold
Average Amount by MCO¹⁹

Quarterback Type	MCO	Commendable Threshold Average Amount
Imaging Provider	MCO 1	\$ 2,750
	MCO 2	\$ 5,000
	MCO 3	\$ 2,750
Major Regional Hospital	MCO 1	\$ 700
	MCO 2	\$ 1,000
	MCO 3	\$ 800

Source: Tennessee Department of Commerce and Insurance.

We interviewed 15 providers from various locations across Tennessee to assess their understanding of episodes of care. The providers were general surgeons, cardiologists, gastroenterologists, obstetricians/gynecologists, and orthopedic surgeons. Although TennCare describes on its website how thresholds are set, the providers expressed concerns about whether they were receiving the correct amount of gain sharing bonus or risk sharing withholding.

According to the Title 42, *United States Code*, Chapter 7, Section 1396a, “A State plan for medical assistance must provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . to assure that payments are consistent with efficiency, economy, and quality of care.”

According to the U.S. Department of Health and Human Services’ Centers for Medicare and Medicaid Services’ *Proposed Rule*, page 904,

With regard to value-based purchasing programs, commenters also cautioned to balance fair and equitable payment while avoiding payment penalties that mask health disparities or discouraging the provision of care to more medically complex patients.

Quality Metrics

Based on a review of a sample of 55 annual provider reports issued in August 2017, we found providers who are not meeting quality metrics. For several episodes, TennCare established quality metrics that must be met in order for a provider to receive a gain sharing bonus. Based on our discussions with TennCare management, MCOs are responsible for reaching out to providers who are not meeting quality metrics, which should be documented on the MCOs’ provider engagement tracking sheets. While we found instances of MCOs discussing quality metrics with the providers, the notes on the tracking sheets did not clearly state whether

¹⁹ The commendable threshold average amounts in Table 6 is presented for illustrative purposes only. They do not represent real numbers.

providers failed to meet quality metrics or whether the MCOs discussed the corrective actions so the providers could meet them in the future.

In addition, at the end of our fieldwork, we found that 3 of 48 episodes did not have quality metrics assigned. Those episodes are total joint replacement, respiratory infection, and esophagogastroduodenoscopy. By not having quality metrics assigned to all episodes, TennCare management cannot determine if providers are giving quality care to its members. In addition, establishing quality metrics is an important part of the episodes of care strategy.

TennCare management stated that the MCOs' provider engagement tracking sheets consisted of typed comments in spreadsheet cells from where the MCOs discussed quality metrics with a provider. However, the spreadsheet did not document the corrective actions needed to meet quality metrics in the future or document that all providers who did not meet their quality metrics were contacted.

According to the National Quality Forum (NQF)²⁰

NQF evaluates and endorses tools for standardized performance measurement, including: performance measures that assess structure, process, outcomes, and patient perceptions of care; preferred practices that suggest a specific process that, when executed effectively, lead to improved patient outcomes; and frameworks that provide a conceptual approach to organizing practices. These performance standards can be used by institutions, providers, and healthcare consumers to: Create reliable, comparative performance information on which consumers can rely to make informed decisions about their care; Ensure practitioners and provider organizations are held accountable for the quality and efficiency of their performance; and Support quality improvement activities.

Quarterback and Provider Discussions

From our interviews with the 15 providers from across Tennessee, the providers also expressed the following concerns with episodes of care:

- The quarterback is being held accountable for expenses made for an emergency room visit that does not relate to the episode (for example, if a TennCare member who is pregnant goes to the emergency room for a sinus infection).
- The quarterback is being held accountable for postpartum issues when the TennCare member has not had any prenatal care.
- Providers did not understand the way their practice was being measured, and it appears unequal.

²⁰ The NQF is one of the many organizations working to improve the quality of healthcare in the United States. The NQF is a standard-setting organization whose efforts center on evaluating and endorsing standardized performance measurement. The NQF works to improve the quality of American healthcare by infusing daily health practices with higher standards and routine measures of how and when patients' needs are being effectively and efficiently met.

To help increase the quarterbacks' and providers' understanding of the episodes of care strategy, TennCare and the MCOs should provide additional training or reassess the education they are currently providing to determine the effectiveness of the educational outreach. Specifically, they should ensure the training thoroughly describes the gain and risk sharing calculations, the commendable threshold methodology, and how a provider is measured. In addition, TennCare should ensure BlueCare is completing its provider engagement tracking sheets, which document its discussions with providers about episodes of care. TennCare should also periodically review these tracking sheets to determine if training efforts should be revised or added.

LONG-TERM SERVICES AND SUPPORTS AND PRIMARY CARE TRANSFORMATION

Long-Term Services and Supports

TennCare created the Quality Improvement in Long-Term Services and Supports (QuILTSS) based on data collected during stakeholder meetings and online provider and consumer surveys in 2013 and 2014. QuILTSS rewards providers that improve the member's care experience and promote a person-centered care delivery model, which focuses on what the member wants his or her life to be. TennCare plans to save money with the long-term services and supports strategy by



- having a higher quality of care measured by a quality metrics²¹ process through QuILTSS,
- reducing the total cost of care by having better medical technology,
- decreasing the number of hospitalizations, and
- decreasing the number of infections.²²

To determine cost savings for the enhanced respiratory care procedures, TennCare management tracked expenditures and utilization (units) for fiscal years 2015 through 2017 for the following procedures: vent weaning, chronic vent, tracheal suctioning, and secretion management. TennCare management demonstrated that enhanced respiratory care spending decreased by 25% from fiscal year 2016 to fiscal year 2017. See **Table 7**.

²¹ According to TennCare management, quality metrics for the long-term services and support strategy involve standards for measuring quality in the following areas: satisfaction (member, family, and staff); quality of life (respectful treatment, member choice, member or family input, and meaningful activities); staffing and competency (registered nurse hours per day, certified nurse assistant hours per day, staff retention, consistent staff assignment, and staff training); and clinical performance (antipsychotic medication and urinary tract infection).

²² There are three pieces to the long-term services and support strategy: quality; enhanced respiratory care; and workforce development. For the quality piece, we read the survey results that had positive feedback. For the workforce development piece, we read the training materials and watched a video on the changes to training for the direct support staff. We focused on the enhanced respiratory care piece because it involved direct cost savings and improving quality of life.

Table 7
Enhanced Respiratory Care Savings²³
Fiscal Year 2016 to Fiscal Year 2017

Enhanced Respiratory Care	FY 2016 Expenditures	FY 2017 Expenditures
Total Spending	\$23,229,090	\$17,377,628
Cost Savings %	25%	

Source: TennCare management.

Primary Care Transformation

According to TennCare management, the primary care transformation strategy focuses on the primary care provider promoting the delivery of preventive services and managing chronic illnesses over time. This strategy is based on developing an aligned model for care coordination that includes



- patient-centered medical homes (for example, pediatric, adult, and family practices) that involve a provider or a group of providers who take ownership to coordinate a member’s care;
- Tennessee Health Link, which is for TennCare members with the highest behavioral health needs and involves creating a care team that includes medical and nonmedical treatments (such as therapy or a support system); and
- the care coordination tool, which serves as a centralized database of members’ medical information, which allows providers to identify, track, and close gaps in care linked to quality measures (for example, schedule a follow-up visit with the primary care doctor, obtain needed immunizations, or have a diabetic screening).

TennCare plans to save money with this strategy by

- measuring higher-quality care through a quality metrics process and claims data reviews developed by the National Committee for Quality Assurance’s Healthcare Effectiveness Data and Information Set;²⁴
- reducing the total cost of care by decreasing the use of specialty care through better management of chronic conditions and decreasing the use of unnecessary procedures and visits (such as emergency room visits) and using more cost-conscious referrals; and
- shifting the system toward more coordination and information sharing.



²³ We obtained the enhanced respiratory care expenditures and re-performed management’s cost savings calculation to verify its accuracy.

²⁴ According to its website, the National Committee for Quality Assurance measures and accredits health plans. The measures include six domains of care: effectiveness of care; access and availability of care; experience of care; utilization and risk-adjusted utilization; health plan descriptive information; and measures collected using electronic clinical data systems.

Audit Results

1. Audit Objective: Did TennCare’s long-term services and supports’ payment reform strategy positively change the way healthcare is provided in Tennessee?

Conclusion: Based on our review of the spending and data tracking documentation, TennCare management demonstrated that enhanced respiratory care spending decreased by 25% from fiscal year 2016 to fiscal year 2017.

2. Audit Objective: Did TennCare’s primary care transformation strategy positively change the way healthcare is provided in Tennessee?

Conclusion: We determined that TennCare began implementing the primary care transformation strategy in fall 2016, but management does not have enough data available to evaluate the success of its efforts at this time (see **Observation 2**).

Observation 2 – TennCare began implementing the primary care transformation strategy in fall 2016; however, by the end of audit fieldwork, management did not have sufficient data to evaluate the strategy’s success

The primary care transformation strategy’s goal is to assist primary care providers in promoting higher-quality, team-based primary and behavioral healthcare; improving population health; and reducing the cost of care by coordinating with other providers. This strategy includes

- patient-centered medical homes (PCMH) – TennCare’s three managed care organizations launched a statewide aligned PCMH program with 29 organizations²⁵ on January 1, 2017;

²⁵ According to the 2017 *TennCare Patient Centered Medical Home: Provider Operating Manual*, to be eligible to participate as a PCMH, an entity must

1. be a participating TennCare practice with one or more primary care practitioners;
2. have at least 500 attributed TennCare members under a managed care organization;
3. attest to commit to the goals of value-based payments (e.g., increase care coordination, focus on improving quality);
4. designate a PCMH Director to serve as a point of contact; and
5. commit to following PCMH activities (e.g., participate in two years of practice transformation and support, sign up and use the care coordination tool, and share best practices with other organizations in the program).

- Tennessee Health Link – this program began statewide on December 1, 2016, with 21 eligible health link organizations;²⁶ and
- care coordination tool – this online tool rolled out to PCMHs and health link providers in February 2017.



To encourage quality and efficiency of care, TennCare management measures provider performance against preset quality and efficiency metrics²⁷ determined by the National Committee for Quality Assurance’s Healthcare Effectiveness Data and Information Set. A provider receives a larger payment for services rendered per member based on how well a provider performs against these metrics.

At the end of our fieldwork, TennCare was in the process of collecting data to determine if the primary care transformation strategy will meet its objective. Management will use claims data to evaluate the cost savings. While TennCare has completed the first year of implementation, providers have up to six months after services are rendered to submit claims. Due to this lag, TennCare will not have a full year of data available to evaluate until August 2018. Based on discussion with the Director of Strategic Planning and Innovation, TennCare does not anticipate seeing a significant change or a large savings in the first year. In the next audit, we will review TennCare’s data collection methodologies and the results of its evaluation.

²⁶ According to the 2017 *TennCare Patient Centered Medical Home: Provider Operating Manual*, to be eligible to participate as a health link organization, an entity must

1. be a community health center or another type of qualified organization (e.g., mental health clinic);
2. be in the process of obtaining a stated commitment to collaborate with a TennCare primary care provider for each health link location;
3. commit to adopt the care coordination tool;
4. have a documented plan to meet CMS e-prescribing requirements within one year of joining;
5. employ a designated point of contact (Health Link Administrator) and a care team;
6. have the capability to provide behavioral health services onsite;
7. be committed to providing training to employees; and
8. be capable of providing all required health link activities, which are comprehensive care management, care coordination, referral to social supports, patient and family support, transitional care, health promotion, and population health management.

²⁷ According to TennCare management, the primary care transformation strategy has five efficiency metrics: causes for hospital readmissions, emergency department (ED) visits, inpatient admissions, mental health inpatient utilization, and avoidable ED visits. The quality metrics are different for the three different PCMH types. For example, pediatric practices are measured on well child visits, immunizations, and weight assessments; family practices are measured on well visits, immunizations, weight assessments, diabetes care, and asthma management; and adult practices are measured on well visits, diabetes care, and weight assessments.

Program Integrity



The federal government considers the Medicaid program vulnerable to improper payments due to fraud, waste, abuse, mismanagement, inefficiencies, and ineffectiveness.²⁸ Furthermore, Medicaid expenditures account for a significant proportion of state and federal budgets, and program spending is projected to increase 66% by 2025. TennCare is responsible for safeguarding the integrity of the state's Medicaid program to ensure its sustainability for beneficiaries and accountability to taxpayers.

We focused our audit work on four areas of program integrity: member eligibility, long-term care services, provider screening, and non-emergency medical transportation.

MEMBER ELIGIBILITY

In general, TennCare incurs two types of payments on behalf of its members: managed care and fee-for-service. TennCare supports most members through a managed care plan. Under this model, TennCare pays three private managed care organizations a monthly premium, known as a capitation payment, to provide medical and behavioral health coverage for members. TennCare makes capitation payments regardless of whether a member uses services during the month covered by the payment.

Although TennCare serves most members through managed care, some members receive medical care on a fee-for-service basis. In the fee-for-service model, members still belong to a managed care plan, but TennCare reimburses the plan for services rendered instead of making monthly capitation payments. TennCare also contracts with two benefit management companies to coordinate members' prescription coverage, as well as dental coverage for certain eligible populations,²⁹ and reimburses those companies for pharmacy and dental services rendered to members.

To avoid improper capitation and fee-for-service payments, TennCare verifies member eligibility upon initial application and on an ongoing basis. At the initial application, TennCare determines the applicant's eligibility based on household and income criteria and also ensures the applicants have not already obtained a membership to prevent duplicate memberships. TennCare's ongoing eligibility verification activities include regularly checking for members who have lost eligibility or who are duplicate members and recouping overpaid or improper capitation payments and fee-for-service claims payments made on behalf of those members. We focused our audit work on TennCare's processes for detecting and stopping coverage for members who are deceased, incarcerated, or who hold multiple active TennCare memberships.

²⁸ U.S. Government Accountability Office Report to Congressional Committees: *CMS Has Taken Steps to Address Program Risks but Further Actions Needed to Strengthen Program Integrity* (August 2018). <https://www.gao.gov/assets/700/694029.pdf>

²⁹ TennCare members eligible for dental coverage include children and members of the Employment and Community First CHOICES program for individuals with intellectual and developmental disabilities.

Audit Results

1. Audit Objective: Did TennCare make improper payments for deceased Medicaid members?

Conclusion: Based on data analysis, we determined that TennCare made improper payments totaling approximately **\$17,036** for deceased Medicaid members between July 1, 2016, and December 31, 2017 (see **Finding 3**).

2. Audit Objective: Did TennCare make improper payments for incarcerated Medicaid members?

Conclusion: Based on data analysis, we determined that TennCare made improper payments totaling approximately **\$628,775** for incarcerated Medicaid members between July 1, 2016, and December 31, 2017 (see **Finding 3**).

3. Audit Objective: Did TennCare make duplicate payments for Medicaid members with multiple identification numbers?

Conclusion: Based on data analysis, we identified **\$60,598** in duplicate payments TennCare made between July 1, 2016, and December 31, 2017, for Medicaid members with multiple identification numbers (see **Finding 3**).

Finding 3 – TennCare did not recapture improper payments made on behalf of deceased, incarcerated, and duplicate members

TennCare did not recoup³⁰ improper capitation and fee-for-service payments, totaling approximately \$706,409, that it made on behalf of deceased, incarcerated, and duplicate members between July 1, 2016, and December 31, 2017. According to Title 42, *Code of Federal Regulations* (CFR), Part 438, Section 2, overpayments are payments for costs not allowed in the Medicaid program and include payments made for ineligible members, such as deceased, incarcerated, and duplicate members. Generally, TennCare must refund the federal share of Medicaid overpayments to the Centers for Medicare and Medicaid Services. **Table 8** summarizes unrecouped improper payments we identified based on our data analysis.

³⁰ Based on our review of the managed care contracts, TennCare can recoup up to 12 months of capitation payments and claims for payments made on behalf of members after their date of death. For incarcerated members, however, the managed care contract and TennCare policies are silent on this issue.

Table 8
Unrecouped Improper Capitation and Claim Payments for Ineligible TennCare Members
July 1, 2016, Through December 31, 2017

	Managed Care	Fee for Service			Total
	 Capitation	 Medical	 Pharmacy	 Dental	
Deceased Members	\$4,004 (estimated) ³¹	-	\$12,913	\$119	\$17,036
Incarcerated Members	\$575,230 (estimated) ³¹	\$3,945 (estimated) ³¹	\$49,483 (estimated) ³¹	\$117	\$628,775
Duplicate Members	\$60,598	-	-	-	\$60,598
Total	\$639,832	\$3,945	\$62,396	\$236	\$706,409

Deceased Members

TennCare Policy 005.045, “Death,” states, “Eligibility for TennCare Medicaid and CoverKids will be terminated once an enrollee’s death has been verified. Advance notice of action is not required if [TennCare] has factual information confirming the death of a beneficiary.”

The U.S. Department of Health and Human Services’ Office of Inspector General published an audit report in December 2017 that disclosed TennCare made an estimated \$2.7 million in improper capitation payments for deceased members during the period July 1, 2009, through March 4, 2016. In response to this finding, TennCare refined its monthly and quarterly death reviews of its member repository, effective April 2017. The review process compares TennCare’s membership repository to the Social Security Administration’s Death Master File to identify deceased members. Upon establishing a member’s death, TennCare terminates coverage and recoups improper payments made on behalf of that member. The unrecouped capitation payments we identified occurred before TennCare changed its process in April 2017, but all of the unrecouped fee-for-service pharmacy and dental claims we found were for services provided after TennCare implemented the new process.

³¹ We identified numerous capitation payments that TennCare made on behalf of deceased and incarcerated members, and numerous medical and pharmacy fee-for-service claims paid on behalf of incarcerated members. We tested a sample of payments in each of these categories to determine whether TennCare recouped the improper payments. Based on our sample results, we estimated the total amount of unrecouped payments.

The Director of Information Systems and the Director of Claim and Encounters explained that because TennCare implemented refinements to the review process during our audit scope, our capitation results contained items subject to the older and less reliable review. For the fee-for-service claims, they noted instances where information from the Death Master File did not align with Tennessee Department of Health's vital statistics records, causing TennCare to establish the wrong date or no date of death for an individual. In those cases, TennCare lacked an accurate trigger to terminate coverage timely and recoup improper payments for the appropriate timeframe. As noted in the Office of the Inspector General's audit report, TennCare must identify and resolve inconsistencies in date of death information among its various sources of death data.

Incarcerated Members

TennCare Policy 200.112, "Eligibility of Inmates of Public Institutions," stipulates, "Applicants/enrollees involuntarily confined in a public institution are placed in a temporary suspended status to prevent inappropriate payments." Furthermore, 42 CFR 431.213(c) exempts state Medicaid agencies from providing advance notice to members prior to stopping coverage if the member is incarcerated and is no longer eligible for services.

TennCare's policy is to suspend members who have been incarcerated for more than 90 days, rather than to terminate benefits entirely. TennCare receives incarceration data from the Tennessee Department of Correction and a private contractor. If the sources report conflicting information about a member, TennCare's Eligibility Audit and Compliance Division must investigate further to resolve the discrepancy. TennCare suspends membership based on the first piece of incarceration data it receives from either of the sources.

The data TennCare received from the Department of Correction and from the private contractor did not always match what the Department of Correction reported to the auditors. Furthermore, TennCare did not always recoup improper payments made on behalf of incarcerated members because management believes that TennCare must furnish advance notice prior to suspending a member's benefits. Federal regulations, however, exempt state Medicaid agencies from this requirement if the suspension is due to the member's incarceration.

Duplicate Members

Under TennCare Policy 200.020, "Prohibition Against Concurrent Receipt of Benefits," individuals are "prohibited from receiving Medicaid from two or more state programs and from two or more Tennessee Medicaid categories simultaneously," except under limited circumstances. TennCare uses an enrollee identification process to prevent creating duplicate individuals in its membership repository. TennCare also employs the same monthly and quarterly review process to identify duplicate memberships and deceased members. The Director of Information Systems explained that TennCare refined its monthly and quarterly duplicate review process in April 2017 to capture more months of improper payments. Under the redesigned process, TennCare's monthly review searches up to nine months of improper payments, and the quarterly review searches up to five years. All but nine of the unrecouped

duplicate capitation payments we identified occurred before TennCare changed its process in April 2017.

TennCare is entrusted with a limited public budget to serve the healthcare needs of low-income, elderly, and disabled Tennesseans. Improper payments waste taxpayers' money and diminish TennCare's capacity to serve its target population. The impact of these losses magnifies as TennCare's enrollment continues to grow.

Recommendation

Overall Recommendation

TennCare should recoup improper payments identified through this analysis and return the federal share to the Centers for Medicare and Medicaid Services. TennCare should investigate providers who billed for services that took place after a member's date of death or during a member's incarceration to determine if fraud occurred.

Deceased Members

TennCare should evaluate its current process for identifying deceased individuals and consider supplementing or corroborating Master Death File information with vital statistics data compiled by the Tennessee Department of Health.

Incarcerated Members

TennCare should work with the Tennessee Department of Correction and its incarceration data contractor to establish a more effective process for identifying and verifying TennCare members who are incarcerated and suspending those members immediately. TennCare should also establish a process for retroactively recouping any payments made on behalf of the incarcerated TennCare members, as it does for duplicate members and deceased individuals.

Duplicate Members

TennCare should continue to use its duplicate member check upon initial application and the monthly and quarterly review processes to identify improper payments made on behalf of members with multiple TennCare identification numbers.

Management's Comment

We concur in part. We agree with the portion of the finding dealing with fee-for-service claims noted as issues for deceased members. However, we do not agree with the portion of the finding dealing with capitation payments noted as issues for deceased members, nor do we agree with the issues noted for incarcerated or duplicate members.

Deceased Members

TennCare receives a monthly file from the Department of Health's Vital Statistics, which contains date of death information. The data is then run through TennCare's seven match criteria to identify exact matches in TennCare's Medicaid Management Information System (MMIS), which systematically loads the Vital Statistics date of death. The MMIS also reports suspect matches, which are manually reviewed, and if verified through the Social Security Administration's (SSA) On Line Query (SOLQ) system, the date of death is manually uploaded to the MMIS. As a secondary source to identify date of death information, TennCare has access to the SSA's Limited Death Master File (DMF) through a subscription with the U.S. Department of Commerce, National Technical Institute Service (NTIS). Matches from this monthly process with TennCare's MMIS eligibility data are reported and reviewed through SOLQ, and if verified through SSA's SOLQ, the date of death is manually updated to the MMIS.

Regarding the improper payments noted by the Comptroller's Office on behalf of deceased enrollees:

Capitation payments – We do not concur with this payment being an issue. Our MCO capitation process performs a monthly nine-month lookback as well as a quarterly five-year lookback to determine if payments were made for deceased enrollees and takes action to recoup such payments, when necessary. Only one capitation issue was noted by the auditors, and this payment was recovered in line with our normal business process.

Fee-for-service claims – We concur with this portion of the finding. One dental claim and one DCS claim were paid by TennCare before the date of death was uploaded in our MMIS but were not subsequently recouped prior to audit. These claims have since been voided, and new processes have been implemented both within TennCare and with our dental benefits manager (DBM) to prevent these situations from recurring. After investigating the pharmacy claims provided to us by the auditors, TennCare noted that the pharmacy benefits manager (PBM) was deviating at times from the clear protocols we require that they follow for identifying and recouping claims paid after the date of death. The result was a lack of uniformity regarding both recoupment of funds and referral to the state Office of Inspector General. TennCare has since issued a directive to the PBM to research the claims noted in this finding as well as ensure they are in full compliance going forward.

Incarcerated Members

We do not concur. In accordance with TennCare policy, upon receiving information that indicates a member may be incarcerated, TennCare sends a 10-day advance notice informing the member that their benefits will be placed in suspended status unless the member files an appeal to dispute the information TennCare received. Of the numerous claims cited by the Comptroller's Office as being paid in error, only one crossover claim was paid while the enrollee was in a suspended status, and that claim has since been recouped. The business rule for this type of claim was originally coded to not pay crossover claims for incarcerated enrollees, but a defect was introduced by a work request in 2017. This defect was corrected in production on

July 24, 2018, and future crossover claims will not be paid if a member is in a suspended eligibility status.

The auditors cite the other claims as improper payments because they do not think TennCare should give enrollees a 10-day advance notice that their coverage is being suspended. We respectfully disagree with the auditors, as federal language allows the state to choose not to send advance notice when a beneficiary has been admitted to a correctional institution, but it does not require it. We are well within federal guidelines in administering this aspect of the program as we do and believe our approach is prudent and appropriate given concerns regarding incarceration data quality and due process protections for our enrollees.

We will continue to encourage improvements in correctional data quality, though we have no direct control over the collection of this data, and we will consider changes to the process at some point in the future if we develop greater confidence in the quality of the data.

Duplicate Members

We do not concur. TennCare receives eligibility data from multiple sources, and it takes time to process changes to the MMIS eligibility data and match the criteria to determine if enrollees are truly duplicates or not. Our MCO capitation process performs a monthly nine-month lookback as well as a quarterly five-year lookback to determine if we made improper payments for duplicate enrollees and take corrective action, if necessary. Enrollees fall into one of three categories:

- (1) They are automatically linked through a seven match criteria. Any capitation payments made for the inactive link are recouped, if necessary, through our monthly capitation cycle. The active link is not recouped because there is no need to.
- (2) If the enrollees cannot be automatically linked through the seven match criteria, they go into a queue to be manually processed. If determined that the enrollee is a duplicate, then we recover capitation payments through the lookback, if necessary.
- (3) If the manual process determines that the enrollees are truly separate people, then everything remains the same with regard to these enrollees.

All of these issues presented by the auditors were recovered through our normal process. None of these duplicate enrollees were unaccounted for prior to the auditor's notification. We either already recouped the capitation payment or the capitation payment was already scheduled to be recouped prior to audit notification. Therefore, we do not believe this is an issue.

Auditor Comment

Deceased Members

TennCare did not recoup the deceased member's capitation payment until after the auditors brought this overpayment to management's attention and, as such, the recoupment was not part of the normal business process.

Incarcerated Members

Our finding clearly states our condition is that management has paid benefits for incarcerated members and has not recouped the overpayments when it should have. We have no issue with TennCare providing advance notice to the members even though this notice is not federally required. In this situation, TennCare did not retroactively recover payments made for members while incarcerated. Payments for incarcerated individuals are improper because their health care needs are already covered by a correctional institution.

Duplicate Members

TennCare did not recoup the duplicate capitation payments until the date the auditors brought these items to management's attention. These capitation payments ranged from seven months to two years old as of the date we brought the issue to management's attention, which suggests to us that the normal process did not work sufficiently to promptly identify and recover overpayments.

LONG-TERM CARE SERVICES

TennCare administers programs to provide long-term services and supports to targeted member populations. These programs include

- **CHOICES**, a program of nursing facility care and home- and community-based services for adults age 21 and older with a physical disability and seniors age 65 and older; and
- **Employment and Community First (ECF) CHOICES**, a program with an employment and independent community living focus for members of any age who have an intellectual or developmental disability.³²

As of August 31, 2018, the CHOICES program had 12,312 members in home- and community-based services, and the ECF CHOICES program had 2,548 members.

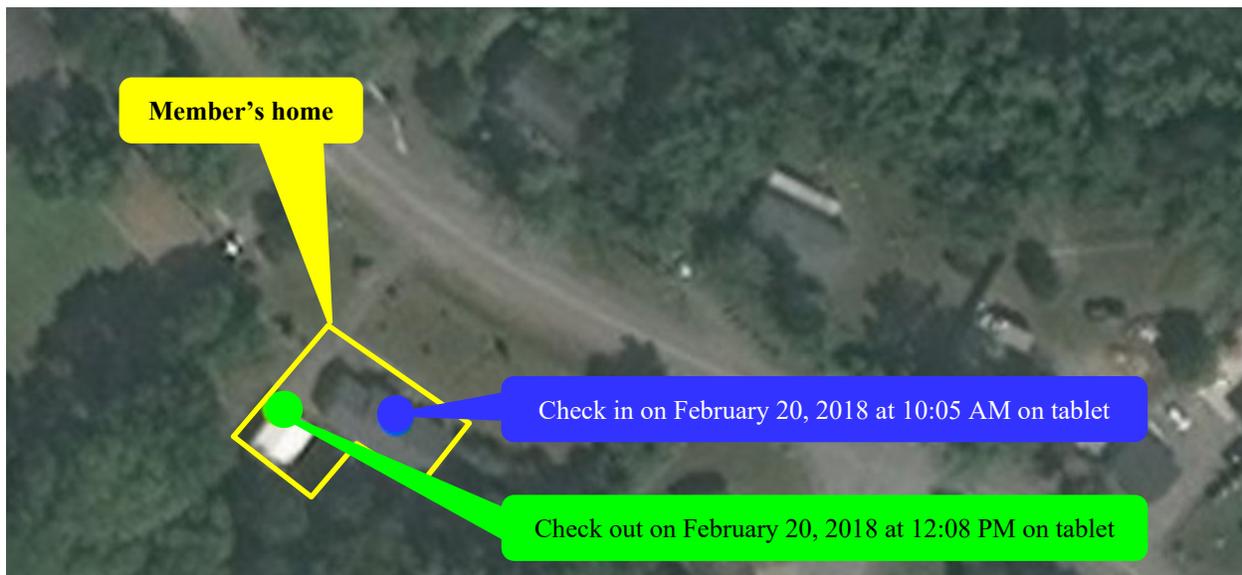
Members enrolled in CHOICES and ECF CHOICES have access to home-based personal care and attendant care services. These services assist the member with activities of daily living, such as eating, bathing, and getting dressed. TennCare limits personal care to a maximum of four hours per visit and at least four hours between each visit, whereas members may use attendant care for longer than four hours at a time and with fewer than four hours between each visit. TennCare's managed care organizations contract with private providers to deliver the personal care and attendant care services to members. Providers are responsible for employing and scheduling care workers, and for billing managed care organizations for services furnished.

³² A developmental disability is a physical and/or mental impairment that begins before age 22 and inhibits an individual's capacity to perform activities of daily living. An intellectual disability manifests before age 18 and is characterized by an intelligence quotient (IQ) of 70 or below, along with significant limitations in the ability to adapt and carry on everyday life activities.

Home-based care service delivery presents unique program integrity challenges. A November 2016 report released by the U.S. Government Accountability Office (GAO) classified in-home personal care services as high risk for Medicaid improper payments due to providers billing for services not rendered. The GAO also noted that certain home care situations could jeopardize members' safety, such as a personal care worker missing a scheduled appointment.

To monitor home-based care services, since 2011 TennCare has required its managed care contractors (MCCs) to use an electronic visit verification system to record when care workers start and finish providing care at a member's residence. Upon arriving at a member's home, workers must check in to the system using a dedicated tablet kept in the member's home, or via an application on the worker's own mobile phone. Upon leaving, the worker must check out the same way. The electronic visit verification system captures the date, time, and the worker's geographic location upon check-in and check-out (see example in **Figure 2**).

Figure 2
Example of Home Care Visit Date, Time, and Location Data Captured by Electronic Visit Verification System



Source: Auditor-prepared based on MCCs' electronic visit verification system records.

TennCare's MCCs have adopted procedures to address contingencies such as technical malfunctions or missed visits. If a worker cannot access a tablet or mobile phone application, he or she may call a hotline to check in and check out. If that method is also unavailable, the worker may prepare a written timesheet and manually key the information into the electronic visit verification system at a later date. If a worker fails to check in for a scheduled visit, the system alerts the worker's employer and the member's MCC to engage a backup plan of care for the member.

Providers of personal and attendant care services use data from the electronic visit verification system to claim payment from the MCCs for services rendered. In addition, TennCare requires its MCCs to use data from the system to monitor and report on whether members received these services.

We focused our audit work on TennCare and its MCCs' use of this system to oversee in-home personal care and attendant care services.

Audit Results

Audit Objective: Did TennCare ensure the electronic visit verification system was designed to mitigate risks relating to members receiving long-term care services?

Conclusion: Based on data analysis, we determined that TennCare's electronic visit verification system did not prevent providers from claiming payment for services rendered to different members in different locations by the same worker at the same time. We also noted that approximately 30% of records were manually entered into the system rather than generated by workers' electronic check-in and check-out activity (see **Finding 4**).

Finding 4 – TennCare did not ensure its managed care contractors established controls to prevent improper claims and to ensure that TennCare members received critical long-term care services

Based on our analysis of electronic visit verification system records and reports for the period July 1, 2016, through March 31, 2018, we found that two managed care contractors (MCCs) lacked controls to prevent an individual worker from claiming to care for two different members at the same time. We also noted that for approximately 30% of personal and attendant care visits, rather than using the electronic visit verification system check-in and check-out process, the providers manually recorded their check-in and check-out times, thus introducing greater risks of error and fraud.

Lack of Controls to Prevent Overlapping Claims of Care

Two of TennCare's MCCs' lacked controls to prevent workers from claiming to care for different members at the same time. We analyzed Amerigroup, BlueCare, and UnitedHealthcare's electronic visit verification personal and attendant care records for the period July 1, 2016, through March 31, 2018, to identify potentially overlapping claims, where a worker checks in to provide personal or attendant care services to two or more different members at the same time, for a duration of 15 minutes³³ or more.

We organized our analysis results into groups of visits to different members with the same worker name, date, and time. We identified

- 2,131 groups containing 4,317 potentially overlapping visits in the Amerigroup data; and

³³ We chose a minimum visit duration of 15 minutes because providers claim payment for personal and attendant care visits in increments of 15 minutes.

- 5,485 groups containing 11,768 potentially overlapping visits in the UnitedHealthcare data.

Our analysis alone was not sufficient to conclude whether the groups of potentially overlapping visits we identified resulted in improper payments. For example, TennCare permits a worker to care for two or more members who share a home in a single visit, if the worker prorates the duration of the visit among the members. In addition, two different workers may share the same name, which gives the false appearance of overlapping visits by the same person. Consequently, we tested a sample of 60 groups each from Amerigroup and UnitedHealthcare to determine whether providers improperly claimed payment for overlapping visits. Based on our testwork, we found

- in 7 of 60 groups tested (12%), Amerigroup providers claimed a total of \$899 for 14 overlapping visits; and
- in 11 of 60 groups tested (18%), UnitedHealthcare providers claimed a total of \$1,687 for 22 overlapping visits.

Based on our testwork results, we estimated that Amerigroup and UnitedHealthcare providers claimed approximately \$127,741, in total, for overlapping personal and attendant care visits between July 2016 and March 2018.

Pursuant to Title 42, *Code of Federal Regulations*, Part 455, Section 1(a)(2), state Medicaid agencies must “have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients.”

TennCare’s managed care contract also requires its MCCs to

monitor and use information from the electronic visit verification system to verify that services are provided as specified in the plan of care or [person-centered support plan], and in accordance with the established schedule, including the amount, frequency, duration, and scope of each service, and that services are provided by the authorized provider/worker; and to identify and immediately address service gaps, including late and missed visits.

The Director of Long-Term Services and Supports explained that Amerigroup and UnitedHealthcare have used the same electronic visit verification system vendor since 2015. During our audit period, the vendor’s system lacked sufficient business rules to identify and reject overlapping claims. In February 2016, the managed care plans requested system enhancements to prevent overlapping visits. The vendor deployed an enhancement in April 2016. In May 2017, the vendor discovered that the enhancement did not always work as intended. According to TennCare’s Chief Information Officer, the vendor tested and deployed a fix in May 2018. We will test the effectiveness of this fix in the next audit, but in the meantime, TennCare management should analyze data from Amerigroup’s and UnitedHealthcare’s electronic visit verification system to verify that the edit check prevents a worker from checking in for two or more members at the same time.

Manually Created Visit Records

Our analysis of the managed care plans’ electronic visit verification system data disclosed that providers created approximately 30% of personal care and attendant care visit records manually rather than electronically through a tablet, mobile phone application, or hotline call. **Table 9** presents our results of workers’ personal and attendant care visit check-in and check-out methods by MCC. Manual entries are not as reliable as real-time system entries because the worker may not accurately and truthfully enter the date, time, and location of rendered services. In contrast, when a worker logs in to the system in real-time with a tablet or mobile application, the electronic visit verification system automatically captures the date, time, and geographic location from the device.

**Table 9
Methods Used to Record Personal and Attendant Visits in the
Electronic Visit Verification System
July 2016 Through March 2018**

	Method Electronically Captures Date, Time, and Location		Method Electronically Captures Date and Time	No Electronic Data Capture
	 Tablet	 Mobile App	 Hotline	 Manual
Amerigroup	60%	4%	36%*	
BlueCare	17%*		53%	30%
UnitedHealthcare	53%	4%	14%	30%

* Amerigroup’s system classifies records created by hotline and manual entry into a single category. Consequently, we could not determine the number of manually created records in Amerigroup’s electronic visit verification system. BlueCare’s system classifies records created by tablet and mobile application into a single category. This is not a concern, however, because the tablet and mobile application methods both collect the same check-in and check-out data.

In its managed care contracts, TennCare stipulates that contractors

shall monitor all manual confirmations to ensure compliance with the [electronic visit verification] requirements, overall program integrity and that members are receiving necessary services. At minimum . . . the contractor shall monitor and take appropriate remedial action against providers and workers who repeatedly fail to use the [electronic visit verification] system when required to do so.

The Chief of Long-Term Services and Supports explained that providers create manual entries when a worker is not able to automatically attach himself or herself to a specific visit for a member with a tablet, mobile application, or hotline for multiple reasons, such as

- user error,
- technical error,
- poor cellular coverage,
- insufficient training, and
- lost devices.

When a worker cannot log in to the electronic visit verification system, he or she must prepare a manual log of hours worked and services performed. The worker's employer enters information from the manual log into the electronic visit verification system to claim payment for service. TennCare requires its MCCs to approve all manual entries in the electronic visit verification system prior to billing TennCare by reviewing the supporting log. Based on this requirement, we calculated that the MCCs would have had to approve up to 2.8 million manual entries between July 2016 through February 2018.

Lack of preventative edits in the electronic system resulted in improper payments to providers. In failing to detect and reject overlapping visits, the system allowed providers to represent that the same worker was in two places at the same time. Since this is not possible, groups of overlapping visits represent cases where at least one member missed scheduled services while the system gave the false impression that all the members received care. In addition, if TennCare does not insist on greater worker compliance with use of the electronic visit verification system and a reduction in manually created records, the risk increases that dishonest providers will submit false claims supported by fabricated manual entries. These control gaps threaten the safety and well-being of vulnerable TennCare members who rely on home care services to live, and the lack of controls increases the risk of improper payments, which escalate state and federal costs of providing healthcare to vulnerable populations.

Recommendation

TennCare should recoup improper payments identified through this analysis and investigate providers who billed the same worker for different members at the same time to determine if fraud occurred. TennCare should test the newly implemented edit check to ensure Amerigroup's and UnitedHealthcare's electronic visit verification system now prevents the same worker from checking in for two or more members at the same time. TennCare management may wish to consider implementing a unique worker identification number to distinguish workers with the same name. A unique identifier would also help TennCare detect providers that are recording and billing overlapping visits by the same worker for members of different managed care plans.

TennCare, in conjunction with the MCCs, should develop and implement strategies for encouraging workers to check in and check out of the electronic visit verification system via tablet, mobile phone application, or hotline call.

Management's Comment

TennCare concurs in part and does not concur in part.

We concur that two MCOs contracted EVV [electronic visit verification] systems failed to function as required for a time period during the audit review period, and permitted overlapping claims to be billed in certain instances, which resulted in a limited number of claims that appear to have been paid in error. These claims, when extrapolated to the pool identified by the auditors as potentially overlapping, represent less than 0.06% of the over 5 million visits provided through the three MCOs.

Both Amerigroup and UnitedHealthcare identified that their newly contracted EVV system was not performing as required and took steps to correct this deficiency, requesting enhancements in February 2016. While enhancements were made, the MCOs were not aware that the requested “fix” still permitted overlapping visits in certain instances—primarily related to manual confirmations. As of May 2018 (prior to identification of this issue by the Comptroller's Office), the problem has been corrected and documentation provided to each MCO to demonstrate that their contracted system is working as expected.

We do not concur that the failure of two MCOs' newly contracted EVV system in permitting billing of overlapping claims necessarily means that TennCare members did not receive critical long-term care services. There is not sufficient evidence to conclude that *“Groups of overlapping visits represent cases where at least one member missed scheduled services while the system gave the false impression that all the members received care.”* In fact, evidence strongly suggests otherwise. As explained by management to the auditors, when a visit is manually confirmed, the worker completes a paper timesheet, which must be signed by the worker **and the member** and uploaded into the EVV system by the provider who keys the manual confirmation. Only then can a manually confirmed visit be paid. This means that in instances where a visit has been manually confirmed but billed and paid, **the member signed a timesheet stating that the visit in fact occurred.** This could mean that the service was provided, but provided at a time other than that specified on the signed timesheet, or that the visit was not provided for the full duration of time specified on the timesheet. When MCOs followed up with members regarding these visits, members typically had a hard time remembering past dates of service, but **members reported that they believed the visits had, in fact, occurred.** Members did not report failing to receive these services.

TennCare appreciates the auditors' recommendations and will develop a corrective action plan encompassing recovery of these overpayments when appropriate, review of potential fraud, and additional testing and validation of the EVV system to confirm functionality to prevent overlapping visits. In addition, we will begin actions to implement a unique worker identification number and to reduce the number of manually confirmed visits.

PROVIDER SCREENING

TennCare and its managed care contractors (MCCs) are responsible for TennCare’s program integrity efforts—specifically, for ensuring that only eligible healthcare providers are permitted to serve TennCare/Medicaid members. To ensure program integrity and to prevent improper payments to ineligible healthcare providers, TennCare and its MCCs conduct initial and ongoing provider screenings including

- professional licensure verifications;
- criminal background checks; and
- federal database checks, such as the Social Security Administration’s Death Master File and the U.S. Department of Health and Human Services’ List of Excluded Individuals and Entities.

To ensure sufficient healthcare provider screening, TennCare requires each MCC to maintain and submit monthly a provider enrollment file, which contains information on all active medical, behavioral, and long-term care service providers enrolled in TennCare’s program. These provider enrollment files are the basis of MCCs’ network directories, which members depend on to find the eligible TennCare healthcare providers who serve TennCare members. TennCare also relies on these files to verify MCCs’ compliance with TennCare’s network accessibility standards.³⁴

We focused our audit work on reviewing TennCare’s MCCs’ active provider enrollment files to identify providers with invalid physical service addresses; providers with expired, suspended, or revoked licenses; providers excluded from Medicaid participation by the U.S. Department of Health and Human Services’ Office of Inspector; and deceased providers.

Audit Results

1. Audit Objective: Did TennCare or its managed care contractors (MCCs) make improper payments to providers with invalid service addresses?

Conclusion: We identified 56 providers using private mailbox addresses (a potential fraud indicator) and 8,606 providers with unknown addresses; we did not have enough information to determine whether payments to those providers were improper (see **Finding 5**).

2. Audit Objective: Did TennCare or its MCCs make improper payments to providers with expired, inactive, or revoked licenses?

Conclusion: We identified 4,286 physicians with missing, unverifiable, expired, inactive, or revoked licenses who were listed as active providers (see **Finding 5**).

³⁴ See the Provider Network Accessibility section of this report on page 63.

3. **Audit Objective:** Did TennCare or its MCCs make improper payments to providers excluded from participation in Medicaid?

Conclusion: We did not identify any providers excluded from participation in Medicaid in TennCare's provider network.

4. **Audit Objective:** Did TennCare or its MCCs make improper payments to deceased providers?

Conclusion: We identified 44 deceased physicians listed as active providers (see **Finding 5**).

Finding 5 – TennCare and its managed care contractors did not detect and terminate potentially ineligible providers

Based on our analysis of TennCare's managed care contractors' (MCC) active provider enrollment files, we identified

- physicians with missing, expired, inactive, revoked, or unknown medical license numbers;
- deceased physicians; and
- providers with invalid service addresses.

Invalid and Questionable Licenses

We compared physicians in the MCCs' provider enrollment files to the Tennessee Department of Health's professional licensure database and identified 4,286 physicians with license deficiencies or questionable validity. Our results consisted of the following:

- **531 physicians with no license number recorded**
We manually located all but 23 of these providers' licenses in the Department of Health's database; however, they were not all licensed physicians. Instead, some were other medical professionals such as nurses.
- **246 physicians with an expired license**
Physician license expiration dates ranged from March 31, 2007, to April 30, 2018.
- **11 physicians with an inactive license**
None of the physicians with an inactive license billed for services to TennCare patients during our audit period.
- **1 physician with a revoked license**
This physician did not bill for services to TennCare patients during our audit period.
- **3,474 physicians whose license number did not match the Department of Health's professional licensure database**

Of these, 2,130 physicians' license numbers on file with the MCCs did not exist in the Department of Health's database. A further 1,344 physicians' license numbers existed in the Department of Health's database, but the physician's name did not match the name associated with that license number in the database. Consequently, we could not determine whether these providers were appropriately licensed to practice medicine in Tennessee and whether payments to these providers were improper.

Table 10 summarizes the number of invalid and questionable licenses by MCC.

Under Title 42, *Code of Federal Regulations* (CFR), Part 455, Section 412, state Medicaid agencies must

- a) Have a method for verifying that any provider purporting to be licensed in accordance with the laws of any State is licensed by such State.
- b) Confirm that the provider's license has not expired and that there are no current limitations on the provider's license.

Under state law, no person may practice medicine in Tennessee unless licensed by the state's Board of Medical Examiners or Board of Osteopathic Examination. Furthermore, TennCare requires its MCCs to ensure that providers are licensed to provide services in the state in which they are furnished.

According to our interviews with the Director of Provider Services, the Assistant Director of Provider Services, and the Director of Program Integrity, both TennCare and its MCCs monitor provider licensure. Our results indicate, however, that this monitoring was not effective. TennCare's Program Integrity unit checks the Department of Health's database monthly to identify and terminate TennCare providers with suspended or revoked licenses. These checks failed to identify providers with expired, missing, or unverifiable licensure information.

Based on analysis of our testwork results, we noted that the MCCs sometimes classified non-physician health professionals as physicians, which could hinder their efforts to verify physician licenses. Our analysis also disclosed that the MCCs recorded one license number per physician, even if the physician practiced medicine in multiple states. Without recording all of a physician's license numbers, TennCare and its MCCs lack the data needed to ensure all physicians hold active licenses in every state they practice in. This is important because Tennessee borders eight other states, and some providers serve TennCare members at multiple practice locations—both in Tennessee and in neighboring states. Furthermore, a physician may have disciplinary actions or restrictions on his or her license in one state yet hold an unrestricted license in another state. By only monitoring one license number per physician, the MCCs are not able to identify and respond to license changes in the physician's other states of practice.

Table 10
Missing, Out-of-status, and Unverifiable Physician Licenses by Managed Care Contractor

	Amerigroup	BlueCare	DentaQuest ³⁵	TennCare Select	UnitedHealthcare	Total
Totals						
Physicians in provider enrollment file	6,990	13,755	988	13,183	10,745	45,661
Missing						
No license number on file	162	147	-	142	80	531
No license number on file and not found by name in the Department of Health's records	4	9	-	9	1	23
Expired, Inactive, and Revoked						
Expired license	38	78	1	75	54	246
Inactive license	2	4	-	4	1	11
Revoked license	1	-	-	-	-	1
Unknown						
License number did not exist in the Department of Health's records	185	109	7	627	1,202	2,130
License number existed in the Department of Health's records, but the name did not match	225	177	4	197	741	1,344

Source: Auditor analysis of TennCare's provider enrollment files.

³⁵ DentaQuest is TennCare's dental benefits manager. We evaluated both physicians (medical doctors and osteopathic doctors) and dentists in DentaQuest's provider enrollment file.

Deceased Providers

We compared TennCare’s MCCs’ provider enrollment files to the Tennessee Department of Health’s vital statistics records and identified 44 deceased individuals who were listed as active providers. **Table 11** summarizes deceased providers by MCC.

Table 11
Deceased Providers by Managed Care Contractor

Managed Care Contractor	Number of Deceased Providers Listed as Active
Amerigroup	7
BlueCare	15
DentaQuest	2
TennCare Select	15
UnitedHealthcare	5
Total:	44

Source: Auditor analysis of TennCare’s provider enrollment files.

Under 42 CFR 455.436, state agencies must check the Social Security Administration’s Death Master File upon provider enrollment and reenrollment. TennCare Policy PRO 16-001, “Provider Screening Requirements,” requires ongoing checks for provider deaths. Furthermore, TennCare requires its MCCs to screen their provider enrollment files monthly against the Social Security Administration’s Death Master File to detect deceased providers.

Based on our discussion with the Director of Provider Services, TennCare’s and the MCCs’ monthly checks of the Death Master File failed to capture the deceased providers we identified. As noted in **Finding 3** related to deceased members, information in the Death Master File does not always align with the Tennessee Department of Health’s vital statistics records, which creates the potential for TennCare to establish the wrong date or no date of death for an individual. In those cases, TennCare and its MCCs lacked an accurate trigger to remove deceased providers timely. The Director of Provider Services also found an instance where a deceased provider shared the same name as another provider, causing confusion as to which one was deceased.

Invalid Service Addresses

TennCare and its MCCs did not monitor providers’ service addresses to verify that they were legitimate places of business. We performed our own analysis and identified 56 TennCare providers with private mailbox addresses and 8,606 TennCare providers with addresses unknown to the United States Postal Service (USPS).

Private Mailbox Addresses

In a common Medicaid billing fraud scheme, a perpetrator will establish a fraudulent healthcare provider and register a private mailbox address as his or her official place of business. A private mailbox address looks like a legitimate street address, but it belongs to a Commercial

Mail Receiving Agency that accepts mail on behalf of customers. USPS licenses Commercial Mail Receiving Agencies and maintains records of addresses associated with these agencies in its Address Management System. We compared TennCare’s MCC provider enrollment files to the Address Management System and found 56 providers with private mailbox addresses associated with Commercial Mail Receiving Agencies.

A private mailbox address does not necessarily indicate that a provider is fraudulent. A provider could operate from a genuine street address but use a private mailbox for convenience, privacy, or security. Based on the private mailbox address alone, however, we could not determine whether the 56 providers with private mailbox addresses were legitimate businesses.

Unknown Addresses

USPS’ Address Management System is a comprehensive database of all mailing addresses in the nation. We compared TennCare’s MCC provider enrollment files to the Address Management System and identified 8,606 provider addresses that were not in the database.

Table 12 summarizes private mailbox and unknown provider service addresses by MCC.

**Table 12
Invalid Provider Service Addresses by Managed Care Contractor**

Managed Care Contractor	Private Mailbox Addresses	Unknown Addresses
Amerigroup	15	1,370
BlueCare	8	2,519
DentaQuest	-	45
TennCare Select	8	2,366
UnitedHealthcare	25	2,370
Total:	56	8,670

Source: Auditor analysis of TennCare’s provider enrollment files.

Data matching alone is not sufficient to determine whether these addresses involve fraud. The private mailbox addresses could indicate that a legitimate provider mistakenly enrolled with his or her mailing address instead of service address. The unknown addresses may have errors due to inaccurate data entry or differences in the ages of the USPS data and the provider enrollment file data. Although the Director of Provider Services explained that TennCare validates provider enrollment file addresses as part of its monthly network accessibility compliance tests, neither TennCare nor the MCCs follow up on addresses that did not pass validation. Consequently, TennCare did not have the information necessary to determine whether address deficiencies occurred due to error, fraud, or data age differences. Furthermore, TennCare’s address validation process does not identify private mailbox addresses, which appear to be legitimate street addresses but are not.

TennCare’s provider screening process mandates site visits for certain providers, which would help determine whether a provider’s service address is authentic. Under 42 CFR 455.432,

TennCare must conduct pre- and post-enrollment site visits of providers who are designated as moderate or high risk, based on factors such as the type of services offered and years in business. The providers we identified with private mailbox addresses were mostly physician and non-physician practitioners and clinics, which TennCare ordinarily designates as low risk and therefore not subject to mandatory site visits.

Effective provider screening is necessary to prevent fraud and control Medicaid costs. By not detecting and following up on license deficiencies; deceased providers; and providers with unknown and private mailbox addresses, TennCare increases the risk of improper payments to providers who are not eligible to serve its members. These problems also frustrate members' efforts to select and locate available healthcare services. Furthermore, inaccurate provider data increases the risk that TennCare cannot inaccurately and readily determine the number of the active providers in TennCare's managed care plans and prevents TennCare from precisely measuring the availability, geographic distribution, and density of covered services.

Recommendation

Invalid Licenses

TennCare's MCCs should ensure that the providers we identified are actively licensed in Tennessee and correctly classified in the provider enrollment files. TennCare should implement a process to periodically identify and suspend providers whose licenses have expired.

Deceased Providers

TennCare should implement a process to check both the Tennessee Department of Health's vital statistics records and the Social Security Administration Death Master file to timely remove deceased providers from the active provider enrollment files.

Invalid Service Addresses

TennCare should update its provider enrollment process to include address verification. TennCare should return addresses that do not pass data validation for the network accessibility tests to the MCCs. The MCCs should then obtain accurate address information for these providers.

Management's Comment

We concur. Although TennCare has extensive processes in place to validate provider reported data, terminate ineligible providers, and recoup claims paid to ineligible providers, TennCare will explore improvements and additions to these processes as recommended by the auditors. In addition, TennCare will follow up on each of the providers identified in the audit to confirm that they are correctly classified and actively licensed.

NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES

Federal regulations require TennCare to offer non-emergency medical transportation to convey members to and from routine medical appointments and other TennCare-covered services. TennCare members who have Medicare coverage may also use this benefit to access Medicare-covered services. TennCare accounts for the cost of non-emergency medical transportation in its capitation payments to its managed care contractors (MCCs), who subcontract a transportation broker to administer the benefit. Transportation brokers' responsibilities include

- maintaining a statewide network of transport providers;
- screening and training drivers;
- scheduling, assigning, and dispatching rides; and
- monitoring transport providers' performance.

Based on the transportation brokers' claims data, an average of 31,683 TennCare members per month received 1.6 million rides between July 2017 and February 2018. Members use public buses, multi-passenger vans, wheelchair vans, and ambulances (when medically necessary). Members may also provide their own transportation and seek mileage reimbursement from their managed care plan's transportation broker.

In a February 2016 report, the U.S. Government Accountability Office identified non-emergency medical transportation services as a high-risk area for Medicaid fraud and abuse. Common non-emergency medical transportation fraud schemes include Medicaid members using transportation for non-medical purposes and providers billing for trips that never occurred. In August 2017, the U.S. Department of Justice reported that one Nashville-based transportation provider paid \$550,000 to settle allegations that it submitted false claims for transportation services not rendered to TennCare members.

TennCare has established compliance requirements in its managed care contracts to promote the integrity of non-emergency medical transportation services. For example, TennCare's MCCs must post-validate³⁶ at least 2% of all transportation claims each month to ensure each claim corresponds to a valid TennCare medical, pharmacy, dental, or behavioral health claim for the same date.

We focused our audit work on determining whether TennCare members used non-emergency medical transportation services for allowed purposes.

Audit Results

Audit Objective: Did TennCare members use non-emergency medical transportation services to access covered services?

³⁶ Managed care contractors post-validate by matching billed transportation claims to billed healthcare provider claims to ensure that the TennCare member had a legitimate medical reason for the transportation.

Conclusion: We determined that non-emergency medical transportation services did not always accompany a claim for covered services, and greater oversight of the program could help TennCare detect improper payments (see **Observation 3**).

Observation 3 – Greater oversight of the non-emergency medical transportation program could help TennCare detect improper claims

TennCare did not regularly analyze non-emergency medical transportation claims to monitor program standards and detect potentially improper payments. We performed our own analysis of 5,267,524 non-emergency medical transportation claims filed between July 1, 2016, and June 30, 2017, and identified 28,721 claims with no associated medical claim on the date of the transportation. We identified an additional 271,790 non-emergency medical transportation claims with no associated TennCare medical claim for members with both TennCare and Medicare coverage. Neither we nor TennCare had access to Medicare claims to determine whether those members appropriately used TennCare-provided transportation to access Medicare-covered services. **Table 13** summarizes these claims by MCC.

Table 13
Non-Emergency Medical Transportation Claims
Without an Associated TennCare Medical Claim
July 1, 2016, Through June 30, 2017

	Trips by Members With TennCare Coverage Only	Trips by Members With TennCare and Medicare Coverage	Total Potentially Improper Trips Paid
Amerigroup	8,891	93,536	102,427
BlueCare	15,463	142,597	158,060
UnitedHealthcare	4,367	35,657	40,024
Total	28,721	271,790	300,511

Source: Auditor analysis of TennCare’s non-emergency medical transportation claims.

We considered these claims potentially improper because our analysis alone did not provide sufficient information to conclude on their legitimacy. For example, a transportation claim would have no associated TennCare medical claim if the provider billed Medicare instead of TennCare for the service. Also, providers may not bill at all for some services, such as orientation visits. Consequently, we tested a sample of 60 potentially improper non-emergency medical transportation claims for each MCC. Our testwork identified the following:

- Eight of 60 Amerigroup non-emergency medical transportation claims tested (13%) had no supporting TennCare claim from a TennCare provider and no provider record to support that the member saw a provider on the day transportation was provided. Three of these claims lacked documentation, such as driver logs, to prove the trip occurred.
- Eleven of 60 BlueCare non-emergency medical transportation claims tested (18%) had no supporting TennCare claim from a TennCare provider and no provider record to support that the member saw a provider on the day of transportation service. One of these claims lacked documentation to prove the trip occurred.

- One of 60 UnitedHealthcare non-emergency medical transportation claims tested (2%) had no supporting TennCare claim from a TennCare provider and no provider record to support that the member saw a provider on the day of transportation service.

TennCare’s non-emergency medical transportation claims data from Amerigroup and BlueCare did not include the amount the transportation broker paid each provider for the claim. As a result, TennCare could not provide us with enough information to estimate the dollar amount of improper non-emergency medical transportation claims associated with those MCCs. Based on our testwork, we estimated UnitedHealthcare non-emergency medical transportation claims with no associated medical claim totaled approximately \$51,053.

According to Title 42, *Code of Federal Regulations*, Part 431, Section 53, “A State plan must (a) Specify that the Medicaid agency will ensure necessary transportation for beneficiaries to and from providers.” Furthermore, Section A.4.2.3 of TennCare’s managed care contract requires the MCC to screen all requests for non-emergency medical transportation services to confirm that members request transportation for a TennCare-covered service.

Based on discussion with TennCare’s Director of Managed Care Compliance/Non-Emergency Medical Transportation Program Manager, TennCare does not routinely validate non-emergency medical transportation claims. TennCare delegates this responsibility to the MCCs. TennCare requires the MCCs to pre-validate 2% and post-validate 2% of trips per month. The MCCs provide summaries of their validation results to TennCare in quarterly Pre-Transportation and Post-Transportation Validation Check reports. Our analysis of these reports for July 2016 through September 2017 disclosed that, on average, the MCCs could not substantiate the medical purpose for 11% of trips selected for pre-validation and 11% of trips selected for post-validation audit each month.

The Director of Managed Care Compliance/Non-Emergency Medical Transportation Program Manager further explained that when a member’s trip fails a post-validation audit, the transportation broker must pre-validate that member’s next three trips by verifying in advance that the trip is for a legitimate medical purpose. TennCare does not mandate that the MCC and the transportation broker place limitations on providers who repeatedly fail post-validation audits.

When TennCare services are not adequately monitored, there is a greater risk for improper payments due to fraud, waste, or abuse of these services. Improper payments in the non-emergency medical transportation program increases managed care costs for TennCare, resulting in wasted taxpayer funds.

Recommendation

TennCare should routinely analyze non-emergency medical transportation claims to monitor the program, detect potentially improper payments, and identify high-risk providers and members.

Eligibility Redetermination



General Background

Redetermination Process

Federal regulations require TennCare to redetermine members' eligibility for Medicaid benefits annually. Since 2015, TennCare has contracted with a vendor to assist with this process. TennCare sends the vendor a monthly list of members due for eligibility redetermination; the vendor, in turn, sends renewal applications to those members. Members must complete and return the application, providing updated demographic and financial information. The vendor processes returned applications and reviews each member for modified adjusted gross income (MAGI) eligibility based on the information it has received.³⁷ If approved for MAGI and not potentially eligible for other non-MAGI categories that provide higher benefits, then the vendor sends a transaction to TennCare indicating reapproval. If not approved for MAGI or potentially eligible for other categories, the vendor then refers the renewal packet to TennCare staff to determine eligibility for a non-MAGI category. Following TennCare's determination, the member is either approved for continued benefits or sent a termination letter with information about the member's appeal rights. TennCare terminates the eligibility of members who do not meet the conditions of any eligibility category, or who fail to return the renewal application or respond timely to requests for additional information. The vendor maintains copies of renewal applications, supporting documentation, and associated case notes in its information system.

Medicare Savings Programs

TennCare's redetermination process includes reviewing the eligibility of Medicare Savings Program members. This program helps certain groups of members who qualify for Medicare pay for Medicare premiums. There are four different program categories, which offer varying levels of assistance with Medicare costs:

- the Qualified Disabled and Working Individuals category pays a member's Medicare Part A (hospital insurance) premiums only;
- the Qualifying Individual and the Specified Low-Income Medicare Beneficiary categories pay a member's Medicare Part B (medical insurance) premiums only; and
- the Qualified Medicare Beneficiary category pays for a member's Medicare Part A and Part B premiums, as well as deductibles, coinsurance, and copays.

To qualify for Medicare Savings Program benefits, a member's income and resources (assets such as checking and savings accounts, stocks, and bonds) may not exceed specified limits.

In December 2017, the Tennessee Comptroller of the Treasury issued a review report of TennCare eligibility redeterminations.³⁸ The report offered several suggestions for improving communications and processes for the renewals of Medicare Savings Program members.

³⁷ According to TennCare management, TennCare is also required to verify information provided by the individual using electronic data sources and interfaces, such as the Social Security Administration, whenever possible.

³⁸ The review report is accessible online at <http://www.comptroller.tn.gov/repository/SA/TennCareMemoandReport.pdf>.

TennCare has now implemented most of those suggestions. During our audit fieldwork, the Comptroller's Office received an allegation that TennCare disregarded its redetermination findings and intentionally allowed ineligible individuals to retain Medicare Savings Program benefits, to avoid litigation and reduce the agency's appeals caseload. Because of this allegation, we expanded our audit work to include TennCare's redetermination of Medicare Savings Program member eligibility.

Audit Results

Audit Objective: Did TennCare appropriately redetermine members' eligibility for Medicare Savings Program benefits?

Conclusion: We determined that for 30 of 60 of members tested (50%), TennCare did not appropriately redetermine or document eligibility for Medicare Savings Program benefits (see **Observation 4**).

Observation 4 – TennCare did not properly terminate, modify, and document member eligibility for Medicare Savings Program benefits; however, management believes the upcoming implementation of the Tennessee Eligibility Determination System will resolve these issues

In violation of its policy, TennCare did not terminate Medicare Savings Program benefits of members who no longer met eligibility requirements and members who failed to complete a renewal application or supply requested documentation. In addition, TennCare did not assign members to the appropriate Medicare Savings Program eligibility category based on income.

From a population of 737 Medicare Savings Program members, we tested a sample of active Medicare Savings Program members and found that TennCare did not appropriately redetermine the eligibility of 14 of 60 (23%) of the members tested. Based on the documentation we reviewed in TennCare's redetermination vendor's system, we identified the following:

- **5 members who either failed to disclose income or reported income over Medicare Savings Program eligibility limits**

TennCare notified these members that they no longer qualified for Medicare Savings Program benefits and set a coverage termination date. TennCare then either failed to terminate coverage or reversed the termination decision, even though members' income exceeded eligibility limits or was not disclosed at all. TennCare may have based these decisions on its independent verification of members' Social Security income with the Social Security Administration but did not consider other sources of income, such as retirement benefits.

- **1 member who failed to submit proof of resources, such as checking account balances**

TennCare requested the missing proof of resources from this member and, when the member did not respond, scheduled a coverage termination date. TennCare then failed to terminate coverage or reversed the termination decision, despite the missing information.

- **1 member without a properly completed renewal application on file**
TennCare had no redetermination application on file for this member, though case notes indicated that TennCare had processed the member's application. Without a redetermination application on file, we could not conclude whether the member still met Medicare Savings Program eligibility criteria.
- **5 members whom TennCare did not assign to the appropriate Medicare Savings Program category based on income**
We identified 5 members who remained eligible for the Medicare Savings Program but who TennCare should have assigned to a different benefit category based on income. One of the 5 members received less benefits than she qualified for, and 3 members received more benefits than their income allowed. One member would have received the same level of benefits. TennCare may have based these decisions on its independent verification of members' Social Security income with the Social Security Administration but did not consider other sources of income, such as retirement benefits.
- **1 member who was improperly terminated from the program**
We identified 1 member who qualified for Medicare Savings Program benefits, but TennCare improperly terminated the member's eligibility. The member did not appeal timely, so TennCare did not reactivate the member's benefits. After we brought this error to management's attention, the individual's benefits have been reactivated with no break in their coverage.

Title 42, *Code of Federal Regulations*, Part 435, Section 916 requires TennCare to determine the eligibility of Medicaid every 12 months. Part 8 of TennCare's Policy 200.030 states, "Applicants must provide complete and accurate information regarding their individual circumstances within specified time limits." According to TennCare's Policy 200.040, TennCare will record in an individual's electronic case file all pertinent information, documentation, and verifications obtained or used in the eligibility determination process.

We discussed the deficiencies we identified with TennCare's Chief Operating Officer, the Director of Member Services, and the Director of Internal Audit. Management explained that the state was working through outstanding renewals in preparation for implementation of the new Tennessee Eligibility Determination System (TEDS), and there was a group of Medicare Savings Program members who were still in a pending status. The state has been prioritizing those individuals most likely to be included in the first pilot of TEDS, which does not include Medicare Savings Program members.

Management stated that it uses the State On-Line Query System (SOLQ), an application provided by the Social Security Administration, to verify the individual's Social Security income; however, this information is not always documented in the member's redetermination file. Furthermore, we could not always determine whether employees considered other income sources in their redetermination decisions. Management stated that it expects the launch of TEDS in spring 2019 to streamline the redetermination process. During the fiscal year 2019 Single Audit of TennCare, auditors will perform redetermination testwork to ensure that the new

system has corrected these issues. For more information regarding the TEDS system, see **Observation 8**.

When TennCare does not appropriately redetermine eligibility for Medicare Savings Program benefits, it increases the risk of ineligible members receiving benefits to which they are not entitled and increases the risk of eligible members not receiving the benefits they should be receiving. The Director of Member Services should ensure that redetermination staff are following procedures to appropriately determine a member's eligibility.

Provider Network Accessibility



Accessibility (or access to healthcare) is the ease with which an individual can reach services that preserve or improve his or her health. As one of its program goals, TennCare strives to “assure appropriate access to care” for its members. To receive care, a TennCare member must generally see a provider that participates in his or her managed care contractor’s (MCC) network. TennCare requires its MCCs to develop provider networks with sufficient number, variety of specialties, and geographic distribution to satisfy accessibility standards that TennCare developed. These standards include requirements for

- the maximum distance that a TennCare member should travel to see different types of providers, both in rural and urban areas;
- the maximum number of TennCare patients per physician; and
- the maximum amount of time a TennCare member should wait for primary, specialist, and urgent care appointments.

TennCare employs three strategies to ensure its MCCs comply with network accessibility standards. The MCCs must analyze their networks and report their compliance to TennCare annually. In addition, TennCare conducts its own monthly analysis of MCCs’ provider networks. Finally, TennCare contracts with an external quality review organization to test and verify annually the MCCs’ adherence to network accessibility standards.

We focused our audit work on TennCare members’ access to physician specialists. Physician specialists are doctors who have advanced education and training in a specific area of medicine, such as neurology, orthopedics, or cardiology.

Audit Results

Audit Objective: Did TennCare’s managed care contractors (MCCs) meet network accessibility standards for physician specialists?

Conclusion: Although TennCare’s MCCs met network accessibility standards for physician specialists, our analysis disclosed that these standards were not stringent enough to ensure members had appropriate access to care (see **Observation 5**).

Observation 5 – Although the managed care contractors’ networks met or exceeded TennCare’s established network accessibility standards, TennCare’s standards were set to permit the networks to retain fewer than 10 physicians per specialty, which could pose barriers to access should networks choose to operate at the minimum standard requirements

TennCare’s network accessibility standards currently allow managed care contractors (MCCs) to operate networks with a fewer number of physician specialists relative to the size of TennCare’s member population as compared to the federal accessibility standards. We evaluated TennCare’s specialist-to-member ratio standards, which specify the maximum number of

members per physician specialist. For example, TennCare's standards require all MCCs to have at least 1 cardiologist per 20,000 members.

Based on our analysis, TennCare has set the maximum number of members per specialist such that for some specialties (including allergy and immunology, oncology and hematology), networks can retain only 2 specialists to serve as many as 188,000 members. **Table 14** presents TennCare's specialist-to-member ratio standards compared to the same standards the federal Centers for Medicare and Medicaid Services requires of Medicare Advantage plan³⁹ networks.

When we evaluated TennCare's provider networks, we found that the MCCs have exceeded the standards set by TennCare, and, based on our analysis, we determined that each specialty had an average of 60 times the number of physicians in the network than TennCare's standards required. TennCare's Director of Provider Services explained that the MCCs have a financial interest in maintaining robust specialist networks, because members with good access to physicians are more likely to seek routine and preventive care in cost-effective office settings rather than in a hospital.

Title 42, *Code of Federal Regulations* (CFR), Part 438, Section 206(a) requires state Medicaid agencies to develop standards to ensure members have timely access to covered services. Furthermore, 42 CFR 438.68(c) specifies that states' standards must reflect factors such as anticipated enrollment, expected utilization of services, and the numbers and types of providers required to furnish services. In its *Promoting Access in Medicaid and CHIP Managed Care* toolkit, the Centers for Medicare and Medicaid Services recommends states use historical and projected encounter data and provider productivity estimates to develop ratio standards. The toolkit also recommends states should revise and update ratio standards when access issues arise or improve.

³⁹ Medicare Advantage plans are health insurance plans operated by private companies that contract with Medicare.

Table 14
Comparison of Specialist-to-Member Ratio Requirements – TennCare and Medicare Advantage Plans

Specialty	Maximum Number of Members per Each Physician Specialist		
	TennCare	Medicare Advantage Plans ⁴⁰	
		Metropolitan Areas	Rural Areas
Allergy and immunology	100,000 ↓	20,000	25,000
Cardiology	20,000 ↓	3,704	4,348
Dermatology	40,000 ↓	6,250	7,143
Endocrinology	25,000 ↑	25,000	33,333
Gastroenterology	30,000 ↓	8,333	10,000
General Surgery	15,000 ↓	3,571	4,167
Nephrology	50,000 ↓	11,111	12,500
Neurology	35,000 ↓	8,333	10,000
Neurosurgery	45,000 ↑	100,000	100,000
Oncology and hematology	80,000 ↓	16,667	20,000
Ophthalmology	20,000 ↓	4,167	5,000
Orthopedic surgery	15,000 ↓	5,000	5,882
Otolaryngology	30,000 ↓	16,667	20,000
Psychiatry (adult)	25,000 ↓	7,143	8,333
Psychiatry (child and adolescent)	150,000 ↑	No standard	No standard
Urology	30,000 ↓	8,333	10,000
Comparison			
↓ TennCare’s standard is less stringent than the Medicare Advantage Plan standard.			
↑ TennCare’s standard is more stringent than the Medicare Advantage Plan standard.			

Source: TennCare managed care contracts; Centers for Medicare and Medicaid Services’ Health Service Delivery Reference File, effective January 1, 2018.

Based on our review of the managed care contracts dating back to 2006, TennCare has not updated its specialist-to-member ratio requirements in at least 12 years. When we inquired with management to determine whether it had considered raising the ratio standards to reflect the reality of the managed care networks and members’ needs, the Director of Provider Services said management had not considered changing the ratio requirements and that making this change could increase the MCCs’ administrative burden in monitoring and reporting compliance—which TennCare already requires its contractors to do. The Chief Operating Officer said the Centers for Medicare and Medicaid Services does not specifically require TennCare to have a ratio standard. He added that physician-to-member ratios are the least useful indicator of member access compared to TennCare’s other network accessibility metrics, such as driving distance and appointment wait time. When we asked why TennCare keeps a standard that is not useful, the Chief Operating Officer told us that removing the ratio standards would involve revising managed care contracts that are hundreds of pages long.

⁴⁰ The Centers for Medicare and Medicaid Services prescribes different specialist-to-member ratio standards based on the population size and density of the geographic area in which a plan operates.

The purpose of network accessibility standards is to strengthen members' access to care. When these standards are not monitored and revised based on members' actual and expected utilization of benefits, members could face substantial difficulties and delays in receiving care. Furthermore, by requiring MCCs to measure and monitor standards that TennCare management does not consider useful, TennCare has placed an unnecessary administrative burden on itself and its MCCs.

Opioid Epidemic



TENNCARE'S OPIOID STRATEGY

General Background

According to the U.S. Department of Health and Human Services, in the late 1990s, many pharmaceutical companies reassured the medical community that patients would not become addicted to opioid pain relievers, and healthcare providers began to prescribe them at greater rates. Increased prescriptions of opioid medications led to widespread misuse of both prescription and non-prescription opioids before it became clear that these medications could indeed be highly addictive. According to the U.S. Centers for Disease Control and Prevention, from 1999 to 2016, more than 200,000 people in the United States died from overdoses related to prescription opioids.

The Opioid Crisis in Tennessee

According to the Tennessee Department of Health, opioid overdose deaths in Tennessee rose from 698 in 2012 to 1,186 in 2016, an increase of 70%, and Tennessee remains in the top 15 states in drug overdose deaths.

Tennessee's Opioid Prescriptions

According to the Office of the Governor's *Tennessee Together*, a plan introduced in January 2018, each year more opioid prescriptions are written for Tennessee residents than there are people living in the state, with 1 million more prescriptions than residents. Although Tennessee has the third highest opioid prescribing rate in the United States, the rate has steadily decreased from 2014 to 2016 because of the medical community's continued efforts to self-regulate prescriptions and reduce initial opioid dosage and supply.

According to the Tennessee Medical Association, an April 2018 report published by the IQVIA Institute for Human Data Science shows nearly a 9% drop in Tennessee of filled opioid prescriptions in 2017 compared to 2016, and a 21.3% drop from 2017 to 2013.

Effect on TennCare Members

According to the Information and Statistics section of TennCare's website, during 2016, medical professionals treated 1,349 of 42,039 TennCare newborns for neonatal abstinence syndrome, a drug withdrawal syndrome that occurs primarily among opioid-exposed infants shortly after birth and often manifests in central nervous system irritability, overactivity, and gastrointestinal tract dysfunction.⁴¹ The total cost of medical care for these infants in their first year of life was \$54,191,165 in calendar year 2016, which was 8 times higher than the average cost of care for normal birthweight infants.

⁴¹ Source: The Centers for Disease Control and Prevention.

Audit Results

Audit Objective: Has TennCare addressed the state’s opioid epidemic for its members?

Conclusion: We determined that TennCare developed and implemented strategies to address the state’s opioid epidemic as it relates to TennCare’s members. Management has measurement strategies for prevention in place; however, due to the recent implementation of some strategies, we were unable to determine the current overall effectiveness (see **Observation 6**).

Observation 6 – TennCare has implemented strategies to reduce opioid abuse among its members, but the effectiveness of those strategies cannot be measured currently

In coordination with its managed care organizations (MCOs), TennCare has implemented the following strategies:

- instituting opioid prescription quantity and dosage limits;
- tracking providers who are the most frequent prescribers of opioids;
- increasing access to non-opioid pain relievers; and
- requiring that providers conduct patient risk assessments before prescribing opioids to chronic users.

Abuse Prevention Strategies

TennCare separates its opioid abuse prevention strategies into three categories: primary prevention, secondary prevention, and tertiary prevention.

1. Primary Prevention

TennCare’s main goals for primary prevention are to prevent members from becoming newly dependent or addicted to opioids by

- improving access to non-opioid pain medication therapies;
- establishing strict opioid day limits and dosage limits for non-chronic users; and
- increasing the number of prior authorization forms providers must complete to prescribe all opioid refills.

TennCare implemented the following steps in January 2018:

- removing prior authorization requirements for some medication therapies;
- establishing minimum and maximum day limits, as well as reducing the daily maximum dosage limits; and

- requiring prior authorization forms approved by TennCare’s pharmacy benefits manager for all non-chronic user opioid prescription refills beyond an initial five-day supply.

2. Secondary Prevention

This strategy focuses on provider intervention by educating providers about

- appropriate prescribing habits and tapering of chronic opioid use;
- increasing access to long-acting reversible contraceptives for women (such as injections, intrauterine devices [IUDs], or contraceptive implants); and
- increasing outreach to pregnant women and women of childbearing age who have used or are currently using opioids.

TennCare has implemented the following steps:

- Around 2009, TennCare started using the top prescribers report card to rank providers that were among the most frequent prescribers of opioids based on a comparison of the provider’s prescribing levels within the same region and across the state.⁴²
- Around 2014, MCOs started using seminars, webinars, and written materials to provide opioid use data to providers and promote alternative pain medications and therapies.
- In November 2017, TennCare collaborated with its MCOs to provide financial incentives to physicians and hospitals to inform mothers of long-term reversible birth control devices immediately after giving birth.
- In December 2017, TennCare collaborated with its MCOs to develop provider-conducted risk assessments for pregnant women and women of childbearing age who have used or currently use opioids to determine if they are a high-risk user. MCOs have care coordinators who contact and meet with this high-risk group to provide counseling and education regarding the dangers of opioid addiction.

3. Tertiary Prevention

This strategy focuses on supporting active recovery for severe opioid dependence and addiction by

- lowering the TennCare-allowed maximum dosage for chronic users;
- increasing outreach to the highest-risk members; and

⁴² From 2009 to 2016, TennCare prepared the high-prescriber reports based on paid and denied pharmacy claims to release a report card to providers highlighting their opioid prescribing patterns. If a provider was consistently above the prescribing medians, TennCare would contact the MCO to determine if the provider needed additional education and to make any network decisions (such as removing the provider from the network or taking disciplinary action). In 2017, TennCare’s MCOs began compiling high-prescriber reports to send to providers to identify opportunities for provider education, to educate providers, and to make any network decisions.

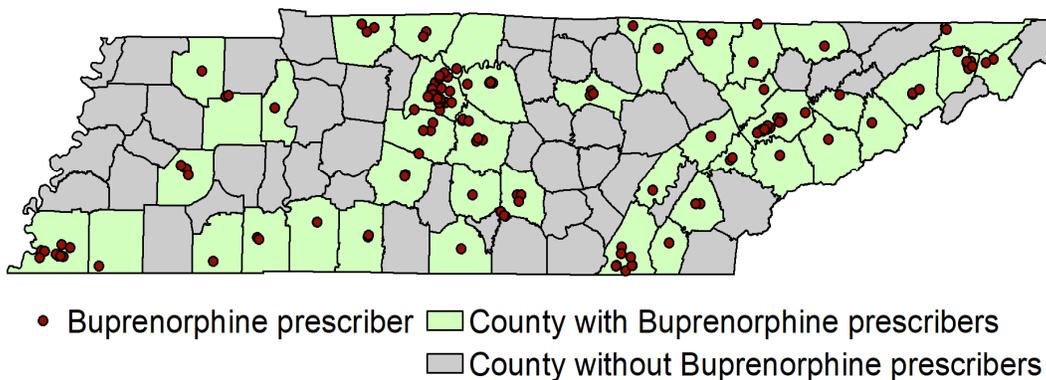
- defining opioid addiction treatment standards and developing treatment networks.

TennCare has implemented the following steps:

- In July 2004, TennCare implemented the Pharmacy Lock-In Program, which restricts either a high-risk member or a member suspected of doctor shopping to one pharmacy where they must fill all their prescriptions.
- In September 2017, TennCare implemented a daily dose limitation for chronic opioid users.
- In January 2018, TennCare began requiring providers to complete a substance abuse risk assessment form and document patient behavior or characteristics that may indicate risk of addiction before prescribing opioids to a chronic user.
- As of June 2018, TennCare is collaborating with its MCOs to develop updated Medication-Assisted Treatment (MAT) provider standards based on the U.S. Department of Substance Abuse and Mental Health Services’ guidelines. These guidelines recommend the use of medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to treating substance use disorders. Buprenorphine, which suppresses opioid withdrawal symptoms, is the primary medication used by MAT providers in TennCare’s network.

TennCare’s goal is for each MCO to contract with a MAT provider that is within 45 minutes’ travel time for at least 75% of its non-dual members⁴³ and within 60 minutes’ travel time for 100% of its non-dual members. According to TennCare data, as of November 2017, the TennCare network includes 180 licensed buprenorphine prescribers, but 44 counties in Tennessee do not have a TennCare network provider who is licensed to prescribe buprenorphine. See **Figure 3**.

Figure 3
Licensed Buprenorphine Prescribers in the TennCare Network as of November 2017



Source: TennCare management.

⁴³ A non-dual TennCare member is a member that does not carry both Medicare and TennCare coverages.

Based on discussions with the Chief Medical Officer, TennCare has measurement methods in place to gauge the strategies' effectiveness (for example, a measurement method for the tertiary prevention strategy is to measure outreach to chronic members who have entered a MAT recovery program). However, due to the recent implementation of some strategies, we were unable to determine the overall effectiveness. Furthermore, TennCare has not set specific numeric measurement goals for reducing member opioid use, but TennCare defines success as a steady decline in user rates.

Currently, TennCare is collaborating with Magellan, the pharmacy benefits manager, to implement Performance Improvement Projects (PIPs), which will involve Magellan performing data analysis of member opioid use based on member-filled prescriptions. The Chief Medical Officer stated that the first PIP was completed in July 2018 and analyzed opioid usage data from 2017 and prior. Due to the timing of our fieldwork, however, we did not review this analysis. Magellan will analyze the 2018 opioid data during the July 2019 PIP. In the next audit, we will review TennCare's measurement methods and results to determine their effectiveness.

TENNCARE DRUG UTILIZATION REVIEW BOARD AND TENNCARE PHARMACY ADVISORY COMMITTEE

General Background

The TennCare Drug Utilization Review (DUR) Board and the TennCare Pharmacy Advisory Committee were created to monitor prescription drug use of TennCare members across the state and to make recommendations for prescription drugs to be added to TennCare's preferred drug list. While the board and committee have similar requirements and duties, each one was created for a specific purpose.

TennCare Drug Utilization Review Board⁴⁴

Pursuant to Title 42, *Code of Federal Regulations*, Part 456, Section 716, TennCare created the DUR Board, which is responsible for

1. discussing and making recommendations related to prescriptions for outpatient drugs;
2. monitoring the dispensing of clinically appropriate outpatient drugs;
3. reviewing, evaluating, and ensuring enrollees' appropriate drug usage; and
4. assuring medical quality.

TennCare's DUR Board has 11 members. Federal regulations do not specify a required membership number but do specify board membership as follows:

⁴⁴ Section 71-5-190, *Tennessee Code Annotated*, mentions a TennCare drug utilization review committee. Because Title 42, *Code of Federal Regulations*, Part 456, Section 716 had created the TennCare Drug Utilization Review Board, it was not necessary to create the TennCare drug utilization review committee. Our audit results are based on the TennCare Drug Utilization Review Board (under the federal regulations). We did not look at the TennCare drug utilization review committee (under *Tennessee Code Annotated*).

- at least one-third but not more than 51% of members must be licensed and actively practicing physicians; and
- at least one-third must be licensed and actively practicing pharmacists.

The federal regulations also require that the DUR Board must meet at least quarterly.

The DUR Board advises TennCare management of appropriate dosages, uses, and potential issues of prescription drugs and makes recommendations to the TennCare Pharmacy Advisory Committee.

TennCare Pharmacy Advisory Committee

Section 71-5-2401, *Tennessee Code Annotated*, established the TennCare Pharmacy Advisory Committee (TPAC) to make recommendations regarding TennCare's preferred drug list (PDL) and to provide oversight for all state expenditures for prescription drugs under the program. The committee is governed by 15 members; however, during our initial review, the committee had 2 vacancies. The membership must represent the following stakeholders, who must be enrolled as TennCare providers:

- psychiatrists;
- nurse practitioners or physician assistants;
- practicing physicians representing geriatric groups;
- pediatricians;
- family practitioners;
- cardiologists;
- general internists; and
- pharmacists.

In addition, the following members also serve on the committee:

- a pharmacy director from a managed care organization under contract with TennCare;
- a member of an advocacy organization that represents TennCare members;
- TennCare's Pharmacy and Medical Directors (ex-officio);
- the Chair of the House Health Committee (ex-officio); and
- the Chair of the Senate Health and Welfare Committee (ex-officio).

Initial appointments made by the Governor, Speaker of the Senate, and Speaker of the House will serve either a one-, two-, or a three-year term, depending on their role (for example, a psychiatrist will serve a three-year term, a nurse practitioner will serve a one-year term, and a physician will serve a two-year term). Any members not appointed serve three-year terms.

Although state statute does not specify how often the committee should meet, the committee meets quarterly.

Section 71-5-2404, *Tennessee Code Annotated*, requires the committee to focus on

- submitting to TennCare both specific and general recommendations for drugs to be included on any state PDL adopted by TennCare using evidence-based research;
- listening to public presentations regarding a drug or classes of drugs under consideration for the TennCare PDL; and
- reviewing the clinical and economic research and utilization information as requested on drugs and drug classes provided by TennCare or its designee.

Audit Results

1. Audit Objective: Did the DUR Board and TPAC fulfill the required duties specified in the respective regulation or statute?

Conclusion: We determined that the DUR Board and TPAC fulfilled their required duties.

2. Audit Objective: Did the DUR Board and TPAC meet the membership composition requirements?

Conclusion: Based on our audit work, the DUR Board members met the specified membership composition requirements; however, we determined that TPAC had two vacant positions. One vacancy has been unfilled for five years. The second position was vacant for one year but was recently filled in August 2018 (see **Observation 7**).

3. Audit Objective: Did the DUR Board and TPAC satisfy the meeting frequency requirement?

Conclusion: While the DUR Board and TPAC convened quarterly, some members did not attend at least half of the scheduled meetings in any one-year period between 2015 and 2017. The board did not have a quorum at three meetings (see **Observation 7**).

Observation 7 – To achieve the required TennCare Drug Utilization Review Board and TennCare Pharmacy Advisory Committee representation, meet quorum requirements, and ensure all viewpoints are represented, all members should attend meetings and vacant positions should be quickly filled

TennCare Drug Utilization Review Board

When we examined board meeting minutes for meetings held during calendar years 2015, 2016, and 2017, we found that on three occasions, the board did not have a quorum, resulting in

a delayed approval of the previous meeting’s minutes and the board’s recommendations to the TennCare Pharmacy Advisory Committee. The meeting dates were

- March 8, 2016,
- September 13, 2016, and
- December 5, 2017.

We also found that some board members did not attend at least half of the scheduled meetings in a one-year period. See **Tables 15** and **16**.

Table 15
Overview of DUR Board Members Who Failed to Attend at Least Half of the Scheduled Meetings

Year	Total Members	Number in Noncompliance	Percentage in Noncompliance
2015	8	4	50%
2016	8	6	75%
2017	10	4	40%

Source: Auditor’s analysis of Drug Utilization Review Board attendance records.

Table 16
Details of Board Members’ Average Attendance

Year	Member	Member Specialty	Average Attendance
2015	Member 4	Advanced Practice Nurse	0%
	Member 5	Physician	0%
	Member 6	Pharmacist	25%
	Member 7	Physician	50%
2016	Member 2	Physician	50%
	Member 4	Advanced Practice Nurse	25%
	Member 5	Physician	0%
	Member 6	Pharmacist	25%
	Member 7	Physician	50%
	Member 8	Pharmacist	25%
2017	Member 3	Physician	50%
	Member 5	Physician	0%
	Member 7	Physician	50%
	Member 8	Pharmacist	25%

Source: Auditor’s analysis of Drug Utilization Review Board attendance records.

TennCare Pharmacy Advisory Committee

During our review, we noted that two of the TPAC’s member positions had been vacant for some time:

- One House of Representatives appointment (general internist) has been vacant since March 20, 2013. According to management, TennCare planned to fill it by May 17, 2018. As of June 8, 2018, this position has not been filled. TennCare management did not know this position was vacant until we brought it to their attention.
- One Governor appointment (patient advocate) had been vacant since July 2017; it was finally filled in August 2018. TennCare management knew the position was vacant and was actively trying to fill it but had difficulty finding someone to volunteer.

When we examined records for committee meetings conducted during calendar years 2015, 2016, and 2017, we found that some committee members did not attend at least half of the scheduled meetings in a one-year period. See **Tables 17** and **18**.

Table 17
Overview of Committee Members Who Failed to Attend At Least Half of the Scheduled Meetings

Year	Total Members	Number in Noncompliance	Percentage in Noncompliance
2015	10	2	20%
2016	14	2	14%
2017	15	5	33%

Source: Auditor’s analysis of Pharmacy Advisory Committee attendance records.

Table 18
Details of Committee Members' Average Attendance

Year	Member	Member Specialty	Appointing Authority	Average Attendance
2015	Member 6	Tennessee Chain Drug Council Pharmacist	Governor	25%
	Member 9	Practicing Pharmacist	Speaker of the House of Representatives	50%
2016	Member 6	Tennessee Chain Drug Council Pharmacist	Governor	50%
	Member 9	Pharmacist in the Distribution of Prescription Drugs in Long-Term Care Setting	Speaker of the House of Representatives	50%
2017	Member 5	Family Practitioner	Governor	50%
	Member 6	Tennessee Chain Drug Council Pharmacist	Governor	50%
	Member 9	Pharmacist in the Distribution of Prescription Drugs in Long-Term Care Setting	Speaker of the House of Representatives	50%
	Member 13	Ex-Officio Chair of Health Committee of the House of Representatives	Speaker of the House of Representatives	0%
	Member 14	Ex-Officio Chair of the Senate Health and Welfare Committee	Speaker of the Senate	25%

Source: Auditor's analysis of Pharmacy Advisory Committee attendance records.

Vacant positions, low meeting attendance, and the lack of quorum impact the board's and committee's abilities to provide TennCare management with timely recommendations based on full representation of appointed or volunteer members. The DUR Board's and TPAC's appointing authorities should ensure members appointed to serve are willing and able to attend the quarterly meetings. Furthermore, they should contact the consistently absent members to determine their continued interest in serving. If attendance issues persist, the appointing authorities should initiate the removal process.

TennCare Operations



INFORMATION SYSTEMS

TennCare relies on information systems to support its critical business functions, including member management and claims processing. TennCare's Information Systems Division is responsible for systems development, operations, and maintenance. We focused our audit work on TennCare's information systems controls and operations, including management's measures to ensure the security, accuracy, and reliability of its hardware and software; controls over systems development; and efforts to replace an obsolete mainframe with a new eligibility determination system.

Audit Results

1. Audit Objective: Did TennCare follow state information systems security policies regarding information systems controls?

Conclusion: We determined that TennCare did not provide adequate internal controls in three specific areas (see **Finding 6**).

2. Audit Objective: Did TennCare make adequate progress in implementing its Tennessee Eligibility Determination System (TEDS)?

Conclusion: As of July 2018, TennCare's TEDS project was on schedule and within budget (see **Observation 8**).

Finding 6 – TennCare did not provide adequate internal controls in three specific areas

TennCare did not provide adequate internal controls in three specific areas related to two of its systems. Ineffective implementation of internal controls increases the likelihood of errors, data loss, and inability to continue operations. The details of this finding are confidential pursuant to Section 10-7-504(i), *Tennessee Code Annotated*. We provided TennCare with detailed information regarding the specific conditions we identified, as well as the related criteria, causes, and our specific recommendations for improvement.

Recommendation

Management should remedy these conditions by promptly developing and consistently implementing internal controls in these areas. Management should implement effective controls to ensure compliance with applicable requirements; assign staff to be responsible for ongoing monitoring of the risks and mitigating controls; and take action if deficiencies occur.

Management's Comment

We concur. Controls have been developed and described within existing policy and procedure documents. Management will ensure all current policies, and controls described therein, are strictly enforced.

Observation 8 – After six years in development, TennCare’s new eligibility determination system is anticipated to launch in spring 2019, at a total cost of \$475 million

TennCare has traditionally relied on a disjointed and resource-heavy array of systems and manual processes to determine eligibility for Tennessee’s Medicaid health coverage program. The federal Affordable Care Act of 2010 introduced new Medicaid eligibility determination rules, changing the way states must assess and verify most applicants’ household income and composition, effective January 2014. TennCare determined that the state’s legacy eligibility system, ACCENT,⁴⁵ could not be updated to accommodate the changes. Since 2012, TennCare has collaborated with multiple vendors to develop and implement a new system, Tennessee Eligibility Determination System (TEDS), with project costs expected to reach approximately \$475 million by September 2020. As of June 2018, TennCare was conducting user acceptance testing on TEDS and was planning to implement the system later in the year. Management expects to fully implement TEDS in spring 2019.

Timeline

See **Table 19** for a timeline of key events in the TEDS development lifecycle below.

**Table 19
TEDS Timeline**

Date	Event
March 2010	U.S. Congress enacted the Affordable Care Act. The Act included new rules for income-based Medicaid eligibility determination, effective January 2014. The state determined that it would not be possible to update ACCENT, the legacy eligibility determination system, to comply with the new standards.
December 2012	TennCare contracted Northrop Grumman to coordinate, design, develop, and implement a new eligibility determination system known as TEDS.
January 2014	Effective date of the Affordable Care Act’s income-based Medicaid eligibility determination rules. Because its existing eligibility system did not comply with the new rules and the new system was not yet complete, TennCare began relying on the federal healthcare marketplace to determine eligibility for income-based Medicaid in Tennessee.
August 2014	Due to management’s concerns about contractor performance, TennCare contracted KPMG, LLC, to review Northrop Grumman’s progress on TEDS.
January 2015	KPMG issued its review report that documented numerous problems. KPMG’s findings included TEDS performance problems, insufficient project management, inadequate staff training, inadequate testing, and missing or imprecise key requirement

⁴⁵ ACCENT stands for Automated Client Certification and Eligibility Network for Tennessee and is operated by the Tennessee Department of Human Services.

Date	Event
	definitions. TennCare and Northrup Grumman agreed to terminate their contract early. TennCare paid Northrup Grumman \$6.4 million for its work on the project.
September 2015	TennCare contracted KPMG to provide technical advisory services to support the completion of TEDS. KPMG's role included crucial startup and monitoring activities, such as helping TennCare request and review proposals from software developers.
January 2016	In a report to the federal Centers for Medicare and Medicaid Services, TennCare projected full implementation of TEDS in September 2020.
October 2016	TennCare contracted Deloitte Consulting to design, develop, implement, and maintain TEDS.
March 2017	To reduce program risk, TennCare decided to change from a multi-phase release to a single release schedule and projected a new TEDS implementation date of January 2019.
April 2018	TennCare began user acceptance testing of TEDS.
May 2018	Due to changes to pilot testing plans, TennCare changed TEDS' expected implementation date to spring 2019.
Fall 2018	TennCare's anticipated start of pilot testing.
Spring 2019	TennCare's anticipated full implementation of TEDS. Based on our June 18, 2018, interviews with personnel from the state's Business Solutions Delivery group and the project's independent verification and validation contractor, TEDS is on schedule to meet this target.

Source: TennCare management.

Budget

TennCare funds the TEDS project with a combination of federal and state funds. In **Table 20**, we present the TEDS budget for federal fiscal years 2015 through 2020.

Table 20
TEDS Design, Development, and Implementation Budget

Federal Fiscal Year	Federal Share	State Share	Total
2015	\$4,266,284	\$474,032	\$4,740,316
2016	23,782,784	2,684,198	26,466,982
2017	72,753,143	8,083,683	80,836,826
2018*	122,267,676	13,585,297	135,852,973
2019*	153,861,818	17,095,758	170,957,575
2020*	50,953,587	5,661,510	56,615,097
Total	\$427,885,292	\$47,584,477	\$475,469,769

* Budget amounts for federal fiscal years 2018 through 2020 are projected.

Source: TennCare management.

The design, development, and implementation budget does not include operations and maintenance costs for TEDS after implementation. Based on our review of the budget projections TennCare submitted to the Centers for Medicare and Medicaid Services, projected costs increased \$164 million between January 2016 and February 2018. According to the Information System Director and our review of the budget projections, the increased projected costs relate to

- a longer pilot period established for the combined single release;
- extended contracts with redetermination and call center vendors;
- Strategic Technology Solutions' infrastructure support;
- implementation of an asset verification system;
- additional systems testing support; and
- additional post-implementation maintenance and operation costs due to the accelerated projected TEDS start date.

The Centers for Medicare and Medicaid Services approved the increased budget. The state's share was approved at the Governor's and legislative budget hearings.

Conclusion

TennCare has worked to implement a new eligibility determination system since December 2012. During our current audit, we discovered that the original vendor did not meet the division's performance and implementations standards. In January 2015, the original vendor was replaced by the current vendor. Despite this setback, TennCare has made adequate progress in implementing TEDS. As of June 2018, projected costs for federal fiscal years 2015 through 2020 are \$475,469,769. According to TennCare management, TEDS will provide a single eligibility system based on uniform rules to ensure consistency in eligibility determinations, provide member self-service options, and allow TennCare to better identify duplicate applications and enrollees.

PUBLIC RECORDS MANAGEMENT

General Background

The Public Records Commission is required by state law to determine and order the proper disposition of the state's public records and to direct the Tennessee Department of State's Records Management Division to initiate any action necessary to establish the regulation of record holding and management in any state agency. Section 10-7-301(6), *Tennessee Code Annotated*, defines public records as

all documents, papers, letters, maps, books, photographs, microfilms, electronic data processing files and output, films, sound recordings, or other material, regardless of physical form or characteristics made or received pursuant to law or

ordinance or in connection with the transaction of official business by any governmental agency.

Public officials are legally responsible for creating and maintaining records that document the transactions of government business. These records provide evidence of government operations and accountability to citizens. Public officials must maintain this information according to established records disposition authorizations (RDAs). According to Section 10-7-509, *Tennessee Code Annotated*,

The disposition of all state records shall occur only through the process of an approved records disposition authorization. Records authorized for destruction shall be disposed of according to the records disposition authorization and shall not be given to any unauthorized person, transferred to another agency, political subdivision, or private or semiprivate institution.

RDAs describe the public record, retention period, and destruction method for each record type under an agency's authority. Upon destructing a public record, an agency must submit a certificate of destruction to the Records Management Division.

In March 2013, the division developed an online application to catalog and maintain RDAs. The Public Records Commission asked all state agencies to amend or retire RDAs that existed at that time, and to create new ones for public records currently in use.

TennCare's Records Management Process

Beginning in August 2017, in addition to having a Records Officer, TennCare executive-level staff identified at least one person in each unit to serve as a records contact. Currently, TennCare has approximately 30 staff members at all levels of the organization who meet quarterly to receive updates on records management practices, RDA progress, and other records developments. TennCare is currently pursuing plans to review all records-related policies and make changes as needed; it is also considering physical space changes that will facilitate more effective records management and storage. Once management revises records management policies, employees at all levels will be trained on the revised policies at the level and depth of records management knowledge that is appropriate for their position and job responsibilities. According to management, it will ensure that policies align with the governing Public Records Commission guidelines and that management takes proper actions agency-wide to retain and protect records that TennCare creates or stores.

In November 2017, the Records Management Division completed a records assessment at TennCare. The purpose of the assessment was to

- examine TennCare's records management process;
- identify the RDAs used and if new ones were needed; and
- assess the volume of records for each RDA.

The division issued the assessment on November 17, 2017, and noted 18 recommendations.

Audit Results

1. Audit Objective: Did TennCare management comply with the Public Records Commission’s 2013 request to review all RDAs?

Conclusion: While TennCare management did not fully comply with the commission’s 2013 request, by the end of audit fieldwork, management had updated 50% of the RDAs and submitted an additional 12 RDAs to the commission for review at its October 2018 meeting (see **Observation 9**).

2. Audit Objective: Did TennCare management implement the Records Management Division’s assessment recommendations?

Conclusion: While TennCare management had not implemented all the recommendations, management completed 17% of the recommendations and had partially completed the remaining 83% of the recommendations by the end of fieldwork on August 2018 (see **Observation 9**).

Observation 9 – Management is making strides to update records disposition authorizations

TennCare’s Records Disposition Authorizations (RDAs)

During our review of TennCare’s process to manage its public records, we determined that management did not have 15 of 30 RDAs (50%) approved by the Public Record Commission (PRC) as of May 30, 2018. After early discussions with management, TennCare made progress to address its outstanding RDAs. As of May 30, 2018, near the end of fieldwork, 12 RDAs have been updated and are scheduled to be reviewed by the PRC in October 2018. Management has not submitted the remaining 3 RDAs to the PRC for approval. See **Table 21**.

Table 21
Status of Outstanding RDAs as of May 2018

Item #	RDA #	Title	Status
1	673	Medicaid Recipients Correspondence	Management Action Pending
2	1047	Utilization Control Independent Professional Reviews and Medical Reviews for Long-Term Care Facilities	Scheduled for PRC Review
3	1201	Retired: Medicaid Quality Control Records (records series merged with RDA 2016)	Scheduled for PRC Review
4	2035	Independent Laboratory Files	Scheduled for PRC Review
5	2036	Community Health Files	Scheduled for PRC Review

Item #	RDA #	Title	Status
6	2037	Home- and Community-based Services Waiver Program Records	Scheduled for PRC Review
7	2038	Third-party Liability Recovery Files	Management Action Pending
8	2039	Patient Care Review Files	Scheduled for PRC Review
9	2040	Provider Integrity Files	Scheduled for PRC Review
10	2041	Recipient Case Files	Scheduled for PRC Review
11	2045	Legal Appeal Files	Scheduled for PRC Review
12	2578	Retired: TennCare Appeals (records series is now covered under RDA 2045)	Scheduled for PRC Review
13	2852	TennCare Reports	Management Action Pending
14	2909	Medicaid Overpayment Claims (PA68)	Scheduled for PRC Review
15	2977	Home- and Community-based Services Medicaid Waiver Records	Scheduled for PRC Review

Source: TennCare management.

Status of Implementing Public Records Assessment Recommendations

In November 2017, the Records Management Division performed a public records assessment and made 18 recommendations to TennCare. As of May 30, 2018, management indicated it had implemented 3 recommendations and had partially implemented the remaining 15. We did not verify their statement since management was still in the process of implementing all recommendations. We will include management’s corrective actions in the next audit. See **Table 22**.

Table 22
Partially Implemented Records Management Division Assessment Recommendations
As of May 2018

Item #	Recommendation
1	Recommend the Long-Term Services and Support Division review the records that is stored [<i>sic</i>] under the [Statewide RDA] SW17 to determine which records can be safely purged, which records should be sent to the Tennessee State Library & Archives, and which records should be classified under a different RDA.
2	Recommend the RDA 2040 be updated to reflect any changes in business practices or legal statute. [See Item 9 in Table 21.]
3	Recommend the Program Integrity change their labeling to reflect that the investigation files are not kept under SW41 [SW41 is the statewide RDA for fraud investigation files] .
4	Recommend a new RDA that governs the retention for financial change requests.
5	Recommend a new RDA that governs the retention of consultation records that meets the business practices and legal needs for the Health Care Information Division.
6	Recommend the RDA 2578 be updated to match the current business practices. [See Item 12 in Table 21.]
7	Recommend a new RDA to govern the retention of legislative records that are produced by the Legislative Division.

Item #	Recommendation
8	Recommend the Long-Term Services and Support Division review and purge all working papers that no longer have administrative value and that are past the mandated retention.
9	Recommend the RDA 2852 be revised to meet the current standards and business practices. [See Item 13 in Table 21.]
10	Recommend the Medical/Medical Oversight Division review their training and reference materials to determine if any of them can be destroyed.
11	Recommend the Medical/Technical Solutions Unit complete the sorting and organizing of the divisional working papers that were involved in the legal hold which has expired.
12	Recommend a new RDA to govern TennCare legal records that are not covered under any agency RDA.
13	Recommend the Office of the General Counsel destroy records that were involved in the legal holds that have expired.
14	Recommend a determination be made on the legal liability and business needs as to how long Pharmacy pricing records should be kept.
15	Recommend the files on the 4th Floor file room be reviewed to determine which records can be safely purged, which records should be sent to the Tennessee State Library & Archives, and which records need to be sorted and properly filed or sent to Richards & Richards.

Source: TennCare management.

Management should continue to work toward updating the three outstanding RDAs and should implement the remaining recommendations from the Records Management Division's public records assessment as soon as practical.

APPENDICES

APPENDIX 1 Methodologies to Achieve Audit Objectives

PRIOR AUDIT FINDINGS

CHOICES AND EMPLOYMENT AND COMMUNITY FIRST CHOICES

1. **Audit Objective:** Did TennCare correct the December 2014 finding by distributing easy-to-understand information about the CHOICES application process?
2. **Audit Objective:** Did TennCare address the concerns that emerged before, during, and after the launch of ECF CHOICES?

To determine whether TennCare corrected the December 2014 finding by distributing easy-to-understand information about the CHOICES application process, and whether TennCare addressed the concerns that emerged before, during, and after the launch of ECF CHOICES, we interviewed TennCare's Deputy Chief of Long-Term Services and Supports; the Assistant Deputy Chief of Policy, Contracts and Compliance; the Assistant Deputy Chief of Clinical Operations; and the Deputy Director of Member Services for the Compliance and Policy Group.

We reviewed program policies, contracts, forms, and benefit information; correspondence to applicants and enrollees; education and outreach materials; enrollment and outcome data and reports; and quality monitoring tools.

We measured correspondence relayed to CHOICES and ECF CHOICES applicants and enrollees using the Gunning Fog and Flesch-Kincaid readability tests to determine if they were easy to understand.

We obtained communication logs and outreach outcomes for the 14 individuals potentially eligible for ECF CHOICES noted in the November 2017 sunset performance audit. We compared the logs to communication requirements prescribed in the contract between TennCare and the managed care organizations.

PROVIDER DATABASE

1. **Audit Objective:** Did TennCare resolve the problems with the provider data to improve completeness and accuracy?
2. **Audit Objective:** Did TennCare develop a formal process to track registration processing times?

We interviewed the Provider Services Director and the Assistant Director to gain an understanding of the Provider Database Management System (PDMS) and the registration process.

From a population of all 13,099 active providers (who registered using paper or PDMS) from November 1, 2014, to March 27, 2018, we tested a nonstatistical, random sample of 60 providers and reviewed each provider's information in PDMS, interChange, and the Tennessee Department of Health's licensure verification database to determine if the data in the three systems was complete and accurate.

From a population of 13,851 active providers that staff processed in PDMS from November 1, 2014, to May 30, 2018,⁴⁶ we tested a nonstatistical, random sample of 25 active providers to determine if management approved the registration within a reasonable time.

PAYMENT REFORM

EPISODES OF CARE

- 1. Audit Objective:** Did TennCare's episodes of care strategy for payment reform positively change the way healthcare is provided in Tennessee?

To gain an understanding of TennCare's episodes of care strategy, we interviewed TennCare's Director of Strategic Planning, management staff at the managed care organizations, and TennCare providers. We obtained and reviewed five other states' (Colorado, Maine, Minnesota, Ohio, and Vermont) Medicaid State Innovation Models Initiative; Tennessee's State Innovation Models Grant award; vendor contracts; monitoring documents; provider reports, which were reviewed for withholdings and bonuses; quality metrics; budgets; and estimated cost savings calculations to determine if TennCare developed and implemented a strategy to address payment reform, including a process to measure strategy effectiveness.

LONG-TERM SERVICES AND SUPPORTS AND PRIMARY CARE TRANSFORMATION

- 1. Audit Objective:** Did TennCare's long-term services and supports' payment reform strategy positively change the way healthcare is provided in Tennessee?
- 2. Audit Objective:** Did TennCare's primary care transformation strategy positively change the way healthcare is provided in Tennessee?

To gain an understanding of TennCare's long-term services and supports strategy, we interviewed TennCare's Chief of Long-Term Services and Supports. We obtained and reviewed the Quality Improvement in Long-Term Services and Supports nursing facility quality framework; stakeholder nursing facility quality surveys; TennCare's Plan for Improving Enhanced Respiratory Care Quality; the Enhanced Respiratory Care Operations Manual; and the spending and utilization expenditures for fiscal year 2015 and 2016 for vent weaning, chronic vent, tracheal suctioning, and secretion management to determine if TennCare developed and implemented a strategy to address payment reform and if TennCare developed a process to measure strategy effectiveness.

⁴⁶ The difference in population sizes for the active provider lists was due to the timing of our testwork.

To gain an understanding of TennCare’s primary care transformation strategy, we interviewed TennCare’s Director of Strategic Planning. We obtained and reviewed the 2017 and 2018 *TennCare Patient Centered Medical Home: Provider Operating Manual* and the 2017 and 2018 *Tennessee Health Link Provider Operating Manual* to determine if TennCare developed and implemented a strategy to address payment reform and if TennCare developed a process to measure this strategy’s effectiveness.

PROGRAM INTEGRITY

MEMBER ELIGIBILITY

- 1. Audit Objective:** Did TennCare make improper payments for deceased Medicaid members?
- 2. Audit Objective:** Did TennCare make improper payments for incarcerated Medicaid members?
- 3. Audit Objective:** Did TennCare make duplicate payments for Medicaid members with multiple identification numbers?

For use in all our member eligibility objectives, we obtained TennCare’s membership repository as of January 25, 2018. We also obtained TennCare’s payment records comprising capitation and fee-for-service (institutional, physician, dental, and pharmacy) claims data for the period July 1, 2016, to December 31, 2017.

To determine whether TennCare made improper payments for deceased Medicaid members, we cross-matched TennCare’s membership and payment records to the Tennessee Department of Health’s vital statistics records. When the records contained conflicting dates of death, we obtained death certificates and researched obituaries to establish the correct date. Our match identified 3,058 capitation payments, totaling \$4,815,553; 100 fee-for-service physician claims, totaling \$868; 1 dental claim, totaling \$119; and 93 pharmacy claims, totaling \$12,959, paid on behalf of members after their date of death. We selected a stratified sample of 60 capitation cross-match results, totaling \$249,483, and the entire population of fee-for-service physician, dental, and pharmacy cross-match results. We reviewed the selected payments in TennCare’s interChange⁴⁷ system and interviewed management to determine whether TennCare recouped the improper payments. Our capitation testwork disclosed that TennCare did not recoup 1 of 60 payments sampled (2%). We projected the 2% error rate from our testwork to our overall capitation cross-match results to estimate total unrecouped capitation payments for deceased members.

To determine whether TennCare made improper payments for incarcerated Medicaid members, we cross-matched TennCare’s membership and payment records to the Tennessee Department of Correction’s inmate population and movement data for the period July 1, 2016, through December 31, 2017. When incarceration dates conflicted between sources, we contacted

⁴⁷ interChange is TennCare’s system for managing members and claims.

the Department of Correction's Detainer Administrator to validate the correct dates. Our match identified 8,736 capitation payments, totaling \$1,425,373; 996 fee-for-service physician claims, totaling \$9,702; 456 fee-for-service institutional claims, totaling \$97,189; 5 dental claims, totaling \$1,609; and 1,485 pharmacy claims, totaling \$129,144, paid on behalf of members during their incarceration.

We selected random samples of

- 60 capitation cross-match results, totaling \$17,358;
- 25 members with 240 fee-for-service physician cross-match results, totaling \$2,725; and
- 25 members with 166 pharmacy cross-match results, totaling \$19,396.

In addition to the random samples specified above, we also tested the entire population of fee-for-service institutional and dental cross-match results. We then reviewed the payments in TennCare's interChange system and interviewed management to determine whether TennCare recouped the improper payments. Our testwork disclosed that TennCare did not recoup 22 of 60 capitation payments (37%), 43 of 240 fee-for-service physician claims (18%), and 102 of 166 pharmacy claims sampled (61%). We projected the error rates from our testwork to our overall capitation, fee-for-service physician, and pharmacy cross-match results to estimate total unrecouped payments for incarcerated members.

To determine whether TennCare made duplicate payments for Medicaid members with multiple identification numbers, we analyzed Social Security numbers in TennCare's membership repository to find members with more than one active identification number. We cross-matched those members to the payment records and located 705 duplicate payments, totaling \$221,809, that TennCare made on behalf of those members during the period July 1, 2016, through December 31, 2017. We reviewed the payments in TennCare's interChange system and interviewed management to determine whether TennCare identified and recouped the duplicate payments.

LONG TERM CARE SERVICES

Audit Objective: Did TennCare ensure the electronic visit verification system was designed to mitigate the risks relating to members receiving long-term care services?

To determine whether TennCare ensured the electronic visit verification system was designed to mitigate risks relating to members receiving long-term care services, we interviewed TennCare's Chief of Long-Term Services and Supports; Deputy Chief of Long-Term Services and Supports; Assistant Deputy Chief of Long-Term Services and Supports; and Director of Long-Term Services and Supports and Dual Eligible Initiatives and Operations. We administered an email questionnaire to Amerigroup's Director of Special Program Operations; BlueCare's CHOICES Program Manager; and UnitedHealthcare's Executive Director of Long-Term Services and Supports. We also interviewed 13 TennCare members who received home-based care services.

We reviewed federal and state laws, regulations, policies, and procedures pertaining to personal and attendant care services for TennCare members.

We obtained the population of late and missed visit reports for CHOICES for the period January 1, 2014, through February 28, 2018, and for ECF CHOICES for the period June 1, 2017, through February 28, 2018. We tabulated the report data and calculated overall and average on-time, late, and missed personal and attendant care visits in each program.

We obtained from TennCare's managed care contractors (MCCs) the population of electronic visit verification records associated with Current Procedural Terminology codes⁴⁸ S5125 (attendant care services) and T1019 (personal care services) for the period July 1, 2016, through March 31, 2018. The population consisted of 949,069 Amerigroup records; 2,064,204 BlueCare records; and 1,511,052 UnitedHealthcare records. We summarized the records by check-in type and by check-out type.

We added calculated fields to the data to flag groups of records with the same date, same worker, and different members. Within each group, we calculated the duration of each visit and the number of minutes from the end of one visit to the start of the next visit. We then identified visits longer than 15 minutes that also overlapped the same worker's next visit by at least 15 minutes.

Our data analysis disclosed 2,131 groups with 4,317 potentially overlapping visits in the Amerigroup data; 5,485 groups with 11,768 potentially overlapping visits in the UnitedHealthcare data; and 13,270 groups with 34,142 potentially overlapping visits in the BlueCare data.

We selected a random nonstatistical sample of 60 groups of potentially overlapping visits from each MCC for testwork. We examined interChange, TennCare's Medicaid management information system, to determine whether providers claimed payment for services to different members attributed to the same worker at overlapping times. We provided our results to TennCare's Long Term Services and Supports unit to research the potential causes of the overlapping visits.

PROVIDER SCREENING

- 1. Audit Objective:** Did TennCare or its managed care contractors (MCCs) make improper payments to providers with invalid service addresses?
- 2. Audit Objective:** Did TennCare or its MCCs make improper payments to providers with expired, inactive, or revoked licenses?
- 3. Audit Objective:** Did TennCare or its MCCs make improper payments to providers excluded from participation in Medicaid?

⁴⁸ Current Procedural Terminology codes are the standard for documenting and billing healthcare services in the United States.

4. Audit Objective: Did TennCare or its MCCs make improper payments to deceased providers?

For use in all our provider screening objectives, we obtained active provider enrollment files as of April 24, 2018, for each of TennCare’s managed care contractors. The files consisted of 66,404 Amerigroup providers; 102,042 BlueCare providers; 2,047 DentaQuest providers; 98,184 TennCare Select providers; and 101,612 UnitedHealthcare providers.

To determine whether TennCare or its MCCs made improper payments to providers with invalid service addresses, we combined the provider enrollment files for each MCC into one file. In this file, we summarized the data by street address, city, state, and zip code in a pivot table, to produce a list of unique street addresses for validation. We cross-matched the list of unique addresses to a United States Postal Service Coding Accuracy Support System-certified address data validation tool. We analyzed the cross-match output to identify addresses that did not pass validation and those assigned to a Commercial Mail Receiving Agency.⁴⁹

To determine whether TennCare or its MCCs made improper payments to providers with expired, inactive, or revoked licenses, we filtered the provider enrollment files to show only physicians (and dentists, for DentaQuest) and removed duplicate records. We analyzed the file to identify physician records with an empty license number data field. We also filtered physician records to only include those with a Tennessee service address and matched the physicians’ license numbers and names to the Tennessee Department of Health’s Health Professional Licensing Reports for the Boards of Medical Examiners, Osteopathic Examination, and Dentistry. If the cross-match identified physicians with expired, inactive, or revoked licenses, we searched TennCare’s interChange system for claims filed for each physician while his or her license was not in good standing.

To determine whether TennCare or its MCCs made improper payments to deceased providers, we cross-matched the physician records to the Tennessee Department of Health’s vital statistics records. When dates of death conflicted between TennCare’s records and the Tennessee Department of Health’s data, we obtained death certificates and researched obituaries to establish the correct date of death. When our cross-match identified deceased physicians, we searched TennCare’s interChange system for claims filed for each physician for services rendered after his or her date of death.

To determine whether TennCare or its MCCs made improper payments to providers excluded from participation in Medicaid, we cross-matched the physician records to the U.S. Department of Health and Human Services, Office of Inspector General’s List of Excluded Individuals and Entities as of April 18, 2018. Our cross-match did not identify any physicians in TennCare’s provider network that had been excluded from participation in Medicaid.

⁴⁹ A Commercial Mail Receiving Agency is a private mailbox operator. The agency provides customers with a mailing address and accepts mail and other deliveries on behalf of those customers.

NON-EMERGENCY MEDICAL TRANSPORTATION

Audit Objective: Did TennCare members use non-emergency medical transportation services to access covered services?

To determine whether TennCare members used non-emergency medical transportation services to access covered services, we interviewed both the Director of Managed Care Compliance/Non-Emergency Medical Transportation Program Manager and the Compliance Administrator. We reviewed contracts, policies and procedures, provider monitoring plans, and quality assurance plans relating to non-emergency medical transportation services.

We reviewed and analyzed the managed care contractors' (MCC) non-emergency medical transportation reports for January 2016 through February 2018. These reports included issues such as transportation broker call centers, claims payment accuracy, member complaints, pick-up and delivery standards, post-payment reviews, post-transportation validation checks, pre-transportation validation checks, prompt payment, and utilization.

We obtained all paid managed care and fee-for-service medical, behavioral, pharmacy, and dental claims for the period July 1, 2016, through December 31, 2017. We also obtained the population of 5,267,524 non-emergency medical transportation claims the MCCs received from their transportation brokers for services provided between July 1, 2016, and June 30, 2017.

We cross-matched the population of non-emergency medical transportation claims to the managed care and fee-for-service medical, behavioral, pharmacy, and dental claims. Our match yielded 300,511 transportation claims that did not match to a corresponding healthcare claim for the same date of service:

- 102,427 for Amerigroup,
- 158,060 for BlueCare, and
- 40,024 for UnitedHealthcare.

We compared the claims to TennCare's membership repository to identify claims filed by members with dual Medicaid and Medicare coverage. We also tested a nonstatistical, random sample of 60 claims for each MCC and reviewed the claims in interChange to manually verify whether a healthcare claim existed for the same date of service as the non-emergency medical transportation claim. For claims we could not validate, we contacted the relevant MCC for an explanation.

ELIGIBILITY REDETERMINATIONS

Audit Objective: Did TennCare appropriately redetermine members' eligibility for Medicare Savings Program benefits?

To determine if TennCare appropriately redetermined members' eligibility for Medicare Savings Program benefits, we interviewed the Eligibility Administrator and reviewed working papers from a prior audit interview with the Director of Eligibility Audit and Compliance. We also reviewed the TennCare redetermination vendor contract and associated amendments, and TennCare's Medicare Savings Program eligibility and appeal policies and procedures.

We obtained a list of 460,684 members TennCare submitted to its redetermination vendor between July 1, 2017, and August 9, 2018. We also obtained a list of 126,231 member appeal requests recorded in TennCare's Tennessee Eligibility Appeals Management System (TEAMS) between July 1, 2017, and August 8, 2018, and matched these two files and filtered on eligibility category and date to identify 737 Medicare Savings Program members subject to redetermination between July 1, 2017, and August 9, 2018, who filed an appeal with TennCare between May 1, 2018, and August 9, 2018. From this list, we haphazardly selected a sample of 60 Medicare Savings Program members for testwork. We reviewed the members' documentation in the vendor's system and in TennCare's interChange system, and the members' appeals documentation in TEAMS.

PROVIDER NETWORK ACCESSIBILITY

Audit Objective: Did TennCare's managed care contractors (MCCs) meet network accessibility standards for physician specialists?

To determine whether TennCare's MCCs met network accessibility standards for physician specialists, we reviewed the standards and interviewed the Director of Provider Services and the Assistant Director of Provider Services. We obtained active provider enrollment files as of April 24, 2018, for each MCC. We counted the number of physicians in each healthcare specialty in each managed care network. We then obtained TennCare's active membership repository as of March 31, 2018, and counted the adult non-dual⁵⁰ members and child non-dual members in each managed care health plan. We divided the number of physicians in each specialty by the number of members to determine the ratio of TennCare members to specialist providers in each managed care plan. We compared our results to TennCare's accessibility standards and the results reported in the external quality review organization's 2017 report. We also analyzed TennCare's physician specialist accessibility standards to determine the minimum number of physicians needed in each specialty to satisfy the requirements.

Using Esri ArcGIS geospatial software, we mapped the addresses of TennCare members and each managed care plan's physician specialists. We used the Network Analyst extension in ArcGIS to generate 60-mile and 90-mile travel distance perimeters around each specialist. For every managed care plan and every specialty, we calculated the percentage of plan members located outside the 60-mile and 90-mile travel distance perimeters. We analyzed our results to determine whether the maximum travel distance to a physician specialist was 60 miles for at least 75% of non-dual members and 90 miles for all non-dual members, as required by

⁵⁰ A non-dual member has TennCare coverage only, whereas a dual member has both TennCare and Medicare coverage.

TennCare’s accessibility standards. We also compared our results to those reported in the external quality review organization’s 2017 report.

OPIOID EPIDEMIC

TENNCARE’S OPIOID STRATEGY

Audit Objective: Has TennCare addressed the state’s opioid epidemic for its members?

To gain an understanding of TennCare’s opioid strategies, we interviewed TennCare’s Chief Medical Officer, BlueCare’s Chief Medical Officer, and the Director of Children’s Health for the Tennessee Justice Center to determine TennCare’s strategies for the opioid epidemic.

We obtained opioid research studies conducted by state and federal agencies. We obtained and reviewed TennCare’s policies, presentations, and provider correspondence to determine if TennCare developed and implemented strategies to address the opioid epidemic involving its members and if TennCare developed a process to measure the effectiveness of the strategies.

TENNCARE DRUG UTILIZATION REVIEW BOARD AND TENNCARE PHARMACY ADVISORY COMMITTEE

- 1. Audit Objective:** Did the DUR Board and TPAC fulfill the required duties specified in the respective regulation or statute?
- 2. Audit Objective:** Did the DUR Board and TPAC meet the membership composition requirements?
- 3. Audit Objective:** Did the DUR Board and TPAC satisfy the meeting frequency requirement?

We reviewed the DUR Board’s minutes for the quarterly meetings held from March 8, 2016, to March 6, 2018, and the TPAC committee minutes for meetings held from February 18, 2016, to November 14, 2017. We also interviewed 6 of 11 board members and 5 of 16 committee members by haphazardly selecting a sample of members as of May 3, 2018.

We compared the requirements in the federal regulations to the composition of the board from 2015 through 2017. For the committee, we compared the requirements in state statute to the composition of the committee from 2015 through 2017.

Using the board and committee minutes, we calculated average annual attendance rates for each active board and committee member.

TENNCARE OPERATIONS

INFORMATION SYSTEMS

1. **Audit Objective:** Did TennCare follow state information systems security policies regarding information systems controls?
2. **Audit Objective:** Did TennCare make adequate progress in implementing its Tennessee Eligibility Determination System (TEDS)?

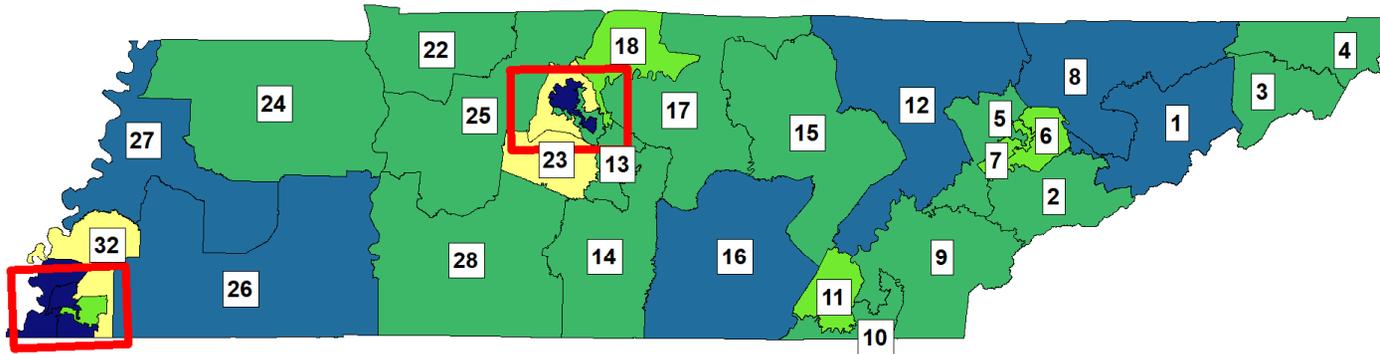
To determine whether TennCare made adequate progress in implementing TEDS, we interviewed TennCare's Chief Information Officer, the Director of Program Management, the Director of Member Services, and the Information Systems Director. We also interviewed Strategic Technology Solutions' Senior Enterprise Project Director and TennCare's independent verification and validation contractor's Project Manager. We reviewed vendor contracts, planning documents, system implementation schedules, projected and actual budgets, invoices, staffing patterns, status reports, and correspondence relating to the TEDS project.

PUBLIC RECORDS MANAGEMENT

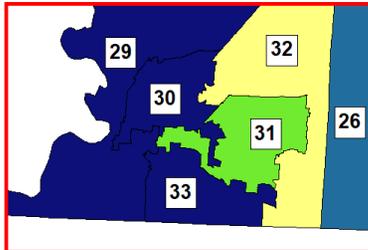
1. **Audit Objective:** Did TennCare management comply with the Public Records Commission's 2013 request to review all records disposition authorizations (RDAs)?
2. **Audit Objective:** Did TennCare management implement the Records Management Division's assessment recommendations?

To gain an understanding of TennCare's records management process, we interviewed the division's Records Officer and reviewed the Secretary of State's *Records Management Best Practices and Procedures* dated August 1, 2015. We reviewed a list of the division's RDAs, as well as the division's active and retired RDAs, to determine if the division complied with the Public Records Commission's 2013 request to review all division RDAs. To determine if TennCare management implemented the Records Management Division's recommendations, we reviewed the division's assessment dated November 17, 2017, and discussed the recommendations with TennCare's Records Officer.

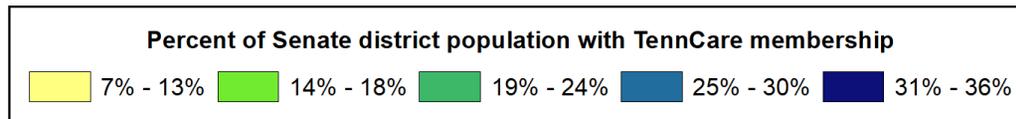
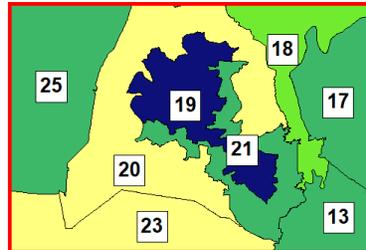
APPENDIX 2
TennCare Members by Senate Legislative District
As of March 31, 2018



Memphis

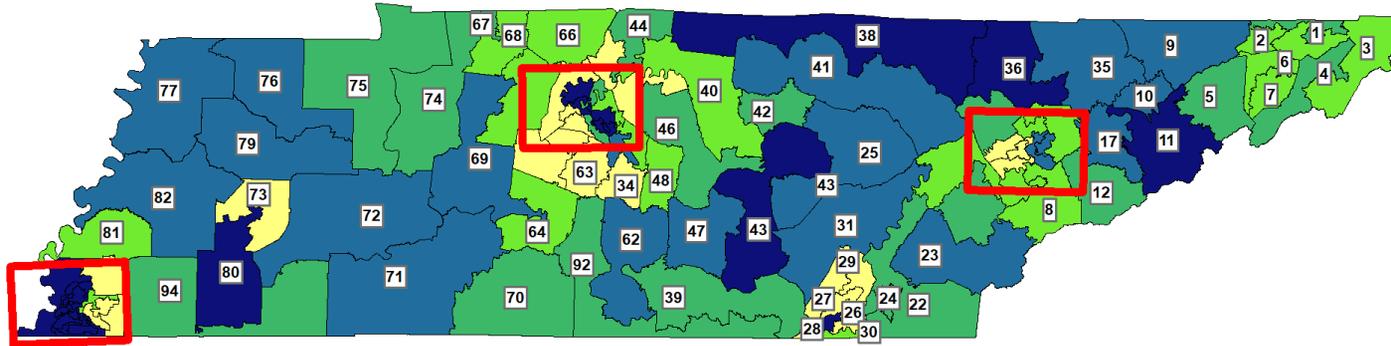


Nashville

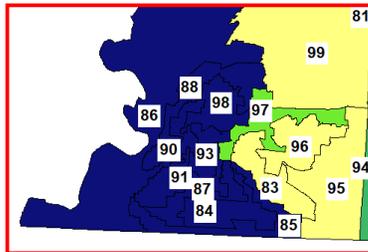


Source: Auditor-prepared based on TennCare’s membership repository as of March 31, 2018.

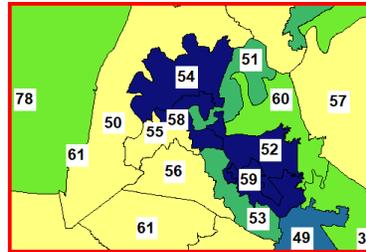
APPENDIX 3
TennCare Members by House of Representatives Legislative District
As of March 31, 2018



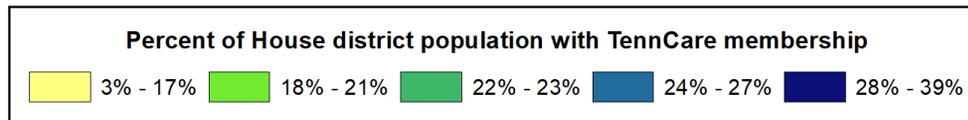
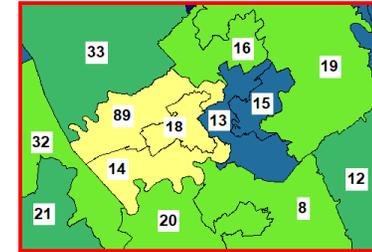
Memphis



Nashville



Knoxville



Source: Auditor-prepared based on TennCare’s membership repository as of March 31, 2018.

APPENDIX 4
48 Episodes of Care as of April 2018

Design Year⁵¹	Performance Period⁵²	Wave	Episode
2013	2015	1	Perinatal
			Asthma acute exacerbation
			Total joint replacement
2014	2016	2	Chronic obstructive pulmonary disease – acute exacerbation
			Colonoscopy
			Cholecystectomy
			Acute percutaneous coronary intervention
			Non-acute percutaneous coronary intervention
2015	2016	3	Gastrointestinal hemorrhage
			Esophagogastroduodenoscopy
			Respiratory infection
			Pneumonia
			Urinary tract infection – outpatient
			Urinary tract infection – inpatient
2015	2016	4	Attention-deficit/hyperactivity disorder
			Congestive heart failure – acute exacerbation
			Oppositional defiant disorder
			Coronary artery bypass grafting
			Valve repair and replacement
			Bariatric surgery
2016	2017	5	Breast biopsy
			Otitis media
			Tonsillectomy
2016	2017	6	Skin and soft tissue infections
			Human immunodeficiency virus
			Pancreatitis
			Diabetes acute exacerbation
2017	2019	7	Spinal fusion
			Spinal decompression (without spinal fusion)
			Femur/pelvic fracture
			Knee arthroscopy
			Ankle non-operative injuries
			Wrist non-operative injuries
			Shoulder non-operative injuries
			Knee non-operative injuries
Back/neck pain			
			Acute seizure

⁵¹ The design year is when the episode was designed, but not put into operation yet.

⁵² The performance period is when the first year of claims data is analyzed and is based on the prior year's claims.

Design Year⁵¹	Performance Period⁵²	Wave	Episode
2017	2019	8	Syncope
			Acute gastroenteritis
			Bronchiolitis
			Pediatric pneumonia
2017	2019	8	Colposcopy
			Hysterectomy
			Gastrointestinal obstruction
			Appendectomy
2018	2020	9	Hernia repair
			Kidney and urinary tract stones
			Cystourethroscopy

Source: TennCare management.

APPENDIX 5
2018 Episodes of Care Revisions as of September 2018

Overview
We included an overview of some of the 2018 episodes of care revisions. These revisions occurred in September 2018, which occurred outside the scope of our fieldwork. Therefore, our results are based on the 2016 thresholds.
Quarterback received 50% of the difference between the commendable threshold and its average risk-adjusted episode, multiplied by the quarterback's number of valid episodes.
Quarterback who owes a risk sharing payment (withholding) pays 50% of the difference between the acceptable threshold and its average risk-adjusted episode spend, multiplied by the quarterback's number of valid episodes.
The gain sharing limit is now designed to cap the amount of rewards a quarterback can receive to prevent incentivizing underutilization and inappropriate care. The MCOs and TennCare work together to define and set the gain sharing limit.

Source: TennCare management.

APPENDIX 6
Perinatal Episode as of January 12, 2017

Overview
The perinatal episode revolves around women with low- to medium-risk pregnancies.
The trigger event is the birth of a live infant.
All pregnancy-related care, including prenatal visits, lab tests, ED visits, medications, ultrasound imaging, delivery of the baby, and post-partum care, is included.
A complete perinatal episode begins 40 weeks (280 days) prior to the delivery and ends 60 days after the mother is discharged from the hospital following the birth of her infant.
Assigning Accountability
The quarterback is the provider or provider group that is responsible for the delivery.
Exclusion Examples
Members in active cancer management.
Members with human immunodeficiency virus (HIV).
If the rendering provider of the trigger claim is a maternal fetal medicine specialist (a high-risk pregnancy expert).
Measuring Quality (Linked to Bonus Sharing Payments)
Screening for HIV
Screening for Group B streptococcus.
C-section
Measuring Quality (Not Linked to Bonus Sharing Payments)
Screening for gestational diabetes
Screening for asymptomatic bacteriuria
Screening rate for hepatitis B specific antigens
Tetanus, diphtheria, and pertussis vaccination rate

Source: TennCare management.

APPENDIX 7

Glossary

applicant

A person who has applied for TennCare but whose application has not been approved or denied.

assisted care living facility

Community-based residential alternative to nursing facility care that provides and/or arranges for daily meals, personal care, homemaker, and other supportive services, or healthcare including medication oversight (to the extent permitted under state law) in a home-like environment to persons who need assistance with activities of daily living.

at risk – managed care organization (MCO)

When an MCO is “at risk,” it is responsible for paying all covered services needed by its members. The state pays the MCO a monthly fee for each enrollee assigned to its plan.

attendant care

Hands-on assistance, safety monitoring, and supervision for a CHOICES member who, due to age and/or physical disability, needs more extensive assistance than can be provided through intermittent personal care visits.

backup plan

A written plan specifying how a CHOICES member’s needs will be met in situations when regularly scheduled home- and community-based services (HCBS) providers are unavailable or do not arrive as scheduled. A backup plan is a required component of the plan of care for all CHOICES members receiving companion care or non-residential HCBS in their own homes.

buprenorphine

A partial agonist that suppresses opioid withdrawal symptoms for individuals in treatment for opioid use disorder.

capitation payment

The fee paid by the state to a managed care contractor operating under a risk-based contract for each enrollee covered by the plan for the provision of medical services. Capitation payments are made whether or not the enrollee uses services and without regard to the amount of services used during the payment period.

care coordination tool

Tool that identifies and tracks the closure of gaps in care linked to quality measures; allows providers to view their member panel and members’ risk scores; and allows users to see when one of their attributed members has had an admission, discharge, or transfer from a hospital and track follow-up actions.

case

A household unit that includes one or more persons who are TennCare-eligible.

Children’s Health Insurance Program (CHIP)

A state-federal program to provide health benefits to uninsured, low-income children. Also known as CoverKids in Tennessee.

CHOICES (TennCare CHOICES in Long-term Services and Supports)

A program that provides long-term services and supports benefits to enrollees meeting the CHOICES program criteria through the use of the provider network of TennCare managed care contractors.

consumer-directed worker (worker)

An individual who has been hired by a CHOICES member participating in consumer direction of home- and community-based services (HCBS) or his representative to provide one or more eligible HCBS to the member.

consumer direction of eligible home- and community-based services (HCBS)

Under the CHOICES program, the opportunity for a member assessed to need specified types of HCBS to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers in delivering the needed service(s). The services eligible for consumer direction are attendant care, personal care visits, in-home respite care, and companion.

Controlled Substance Monitoring Database (CSMD)

The Tennessee Department of Health operates the Controlled System Monitoring Database (CSMD), which tracks controlled substances, including opioids, prescribed and dispensed in Tennessee. Physicians and pharmacists use the CSMD to review patient opioid-use histories to ensure that dosage limits have not been exceeded and to guard against patients misusing or attempting to fraudulently obtain opioids.

dual eligible

An individual who is eligible for both Medicare and TennCare, or who qualifies for TennCare assistance with Medicare cost sharing.

electronic visit verification system

An electronic system in which CHOICES caregivers can check in at the beginning and check out at the end of each period of service delivery. The system monitors the member’s receipt of home- and community-based services and is also used to generate claims for submission by providers.

eligible

A person who has been determined eligible for the TennCare program. As it relates to CHOICES, a person is eligible to receive CHOICES benefits only if the person has been enrolled in CHOICES by TennCare.

episode-based payment

The state’s proposed payment innovation model that achieves a specific patient objective including all associated upstream and downstream care and cost.

episodes of care

One of Tennessee's Health Care Innovation Initiative strategies that focuses on the healthcare delivered in association with acute healthcare events, such as a surgical procedure or an inpatient hospitalization. Episodes encompass care delivered by multiple providers in relation to a specific healthcare event.

episode window

The entire duration of an episode.

faith-based recovery network/drugfree coalitions/lifeline peer groups

Collaborations between the Department of Mental Health and Substance Abuse Services and faith-based organizations and community organizations to increase outreach, reduce the stigma of addiction, and provide access to recovery programs.

Federally Facilitated Marketplace (FFM)

An organized marketplace for health insurance plans operated by the U.S. Department of Health and Human Services. Until the Tennessee Eligibility Determination System is implemented, TennCare relies on the FFM to determine eligibility for Medicaid benefits based on low income.

fraud

An intentional deception or misrepresentation made by a person who knows, or should have known, that the deception could result in an unauthorized benefit to themselves or another person, including any act that constitutes fraud under applicable federal or state law.

home- and community-based services (HCBS)

Services that are provided in a home or community setting as an alternative to (or to delay the need for) long-term care services in a nursing facility or an intermediate care facility for individuals with intellectual disabilities.

income

Monies received, such as salaries, wages, pensions, certain rental income, interest income, dividends, and royalties, that produce a gain or benefit to the recipient.

interChange

TennCare's Medicaid management information system (MMIS). All state Medicaid programs must have a MMIS to process claims and control business functions, such as reporting.

long-term services and supports

One of Tennessee's Health Care Innovation Initiative strategies that focuses on improving quality and shifting payment to outcomes-based measures for the Quality Improvement in Long-Term Services and Supports program and for enhanced respiratory care.

managed care contractor (MCC)

A managed care organization that has signed a TennCare Contractor Risk Agreement with the state, operates a provider network, and provides covered health services to TennCare enrollees.

managed care organization (MCO)

An appropriately licensed Health Maintenance Organization under contract with TennCare.

marketing

TennCare uses the term “marketing” to refer to all contacts made by managed care entities with enrollees, including letters, enrollee satisfaction surveys, newsletters, etc.

Medicaid

A program jointly funded by states and the federal government for medical assistance provided under Title XIX of the Social Security Act for certain persons with low income and/or special circumstances.

Medicaid transportation broker

An entity that contracts with the state Medicaid agency to manage non-emergency medical transportation services in a designated area.

Medication-Assisted Treatment (MAT)

The use of medications, in combination with counseling and behavioral therapies, to provide a “whole patient” approach to the treatment of substance use disorders.

Modified Adjusted Gross Income (MAGI)

An amount found on an individual’s tax return that is used to determine eligibility for Medicaid benefits based on low income (the MAGI-based eligibility category). Most TennCare applications collected from the Federally Facilitated Marketplace are in this category.

neonatal abstinence syndrome

A postnatal drug withdrawal syndrome that occurs primarily among opioid-exposed infants shortly after birth, often manifested by central nervous system irritability, autonomic overactivity, and gastrointestinal tract dysfunction.

Non-chronic Opioid User Prior Authorization

A document that physicians must fill out if a member needs an additional 10-day supply of opioids beyond the initial 5-day supply. It requires physicians to document the member’s diagnosis, reason for prescribing opioids, and whether non-opioid treatments have been considered.

non-emergency medical transportation

An important benefit for beneficiaries with situations that do not involve an immediate threat to the life or health of the individual who need to get to and from medical services but have no means of transportation.

outcome payments

Payments made by the managed care organization to the provider that are designed to reward the high-performing patient-centered medical homes for providing high-quality care while effectively managing overall spending.

patient-centered medical homes (PCMH)

A comprehensive care delivery model designed to improve the quality of primary care services for TennCare members, the capabilities of and practice standards of primary care providers, and the overall value of healthcare delivered to the TennCare population.

payment reform

TennCare's initiative to improve healthcare quality, reduce costs, and improve how healthcare is paid for in the United States by rewarding high-quality care and outcomes and encouraging clinical effectiveness. *See also Tennessee Health Care Innovation Initiative.*

Performance Improvement Projects (PIPs)

A measurement strategy implemented by Magellan, the division's pharmaceutical managed care organization, to perform data analysis of member opioid use based on member-filled prescriptions. PIPs are designed to analyze data as it relates to specific study questions, such as if prescription and dosage limits have decreased opioid usage among members.

personal care visits

Intermittent visits of limited duration, under the CHOICES program, not to exceed four hours per visit and two visits per day, at intervals of no less than four hours between visits, to provide hands-on assistance to a member who, due to age and/or physical disability, needs help with activities of daily living.

pharmacy benefits manager (PBM)

An organization under contract with the Tennessee Department of Finance and Administration to pay for and/or coordinate pharmacy benefits for enrollees to the extent that such services are covered by the TennCare program. A PBM may have signed a TennCare Contractor Risk Agreement with the state or may be a subcontractor to a managed care organization.

Pharmacy Lock-In Program

TennCare was granted authority, as of July 1, 2004, to implement and maintain a pharmacy lock-in program, designed to address member abuse. This program allows the division to assign one pharmacy where the member must fill all of his or her prescriptions if TennCare suspects the member is doctor shopping for opioids.

plain language

The reading level of notices, letters, explanations, or other written material sent by TennCare, its managed care contractors, or other contractors to TennCare enrollees and applicants. Language used in such materials must not exceed a sixth-grade reading level, as measured by the Flesch Index, Fog Index, or Flesch-Kincaid Index.

population-based payment

A report that shows a physicians' controlled substance prescribing rate compared with other physicians statewide and in the same geographic areas.

pre-admission evaluation

A document providing an assessment of an individual's functioning level that is used to determine medical eligibility for long-term services and supports.

prescriber report card

The state's proposed payment innovation model that maintains patients' health over time, coordinating care by specialist and avoiding episode events when appropriate.

Prescription for Success

A collaboration of state agencies that started in 2014 to coordinate anti-opioid strategies, share opioid related data, and expand opioid strategy collaborations with other states.

primary care transformation

One of Tennessee's Health Care Innovation Initiative strategies that focuses on the role of the primary care provider in promoting the delivery of preventive services and managing chronic illnesses over time. This initiative has developed an aligned model for patient-centered medical homes, Tennessee Health Link for TennCare members with the highest behavioral health needs, and a shared care coordination tool that allows providers to identify and track the closure of gaps in care linked to quality measures.

principal accountable provider (quarterback)

A facility, physician, or group of physicians who has the best chance to influence the overall quality and cost of the episode.

redetermination

The annual process that occurs for all TennCare Medicaid and standard enrollees during which they must provide documentation that they continue to meet the eligibility requirements for continued enrollment in the TennCare program.

Supplemental Security Income (SSI)

A means-tested welfare program administered by the Social Security Administration to provide cash for basic needs to low-income aged, blind, and disabled people. In Tennessee, SSI recipients are eligible for TennCare.

TennCare waiver

A program approved by the Centers for Medicare and Medicaid Services in which the federal government has waived certain rules to allow TennCare to do some things that Medicaid cannot do, such as offer more benefits than Medicaid.

Tennessee Eligibility Appeals Management System (TEAMS)

TennCare's standalone database used to manage and document eligibility appeals. The Tennessee Eligibility Determination System (TEDS) will replace TEAMS.

Tennessee Health Care Innovation Initiative

The strategy launched by Governor Haslam in February 2013 to change the way healthcare is paid for in Tennessee by moving from paying for volume to paying for value. The three strategies to this initiative are primary care transformation, episodes of care, and long-term services and supports. The initiative brings together healthcare providers and clinicians, employers, major insurance companies, patients, and family members to reform the healthcare payment and delivery system in Tennessee. *See also* [payment reform](#).

Tennessee Health Link

A program designed to coordinate healthcare services for TennCare members by incentivizing increased care coordination for TennCare members with the highest behavioral health needs. This model involves a greater emphasis on care coordination by creating an interdisciplinary care team and helping improve communications between a member's primary care and behavioral healthcare providers.

Tennessee Pre-Admission Eligibility System (TPAES)

TennCare's eligibility system for long-term services and supports program.

Tennessee Prescription Safety Acts of 2012 and 2016

Requires healthcare practitioners to check the Controlled Substance Monitoring Database (CSMD) before prescribing or dispensing opioids and to enter dispensed opioid information into the CSMD, including patient, prescribing physician, prescription, dispensing date, quantity, strength, and whether the prescription was new or a refill.

Tennessee Together

A plan Governor Bill Haslam introduced in January 2018 to end the opioid epidemic in Tennessee by focusing on three major components: prevention, treatment, and law enforcement.

The Controlled System Monitoring Database Act of 2002

Created the Controlled Substance Monitoring Database (CSMD) Committee to establish, administer, maintain, and direct the CSMD.

third-party administrator (TPA)

Non-risk-bearing administrator of, or claims processor for, health plans. In the TennCare program, the dental benefits manager (DBM) and the pharmacy benefits manager (PBM) are licensed as TPAs. The TennCare program carries the risk of loss for claims rather than the DBM or PBM.

Title XIX of the Social Security Act

See [Medicaid](#).

trigger

Within episodes of care, each episode has a "trigger" that initiates the start of an episode. For example, in a total joint replacement episode, the trigger is joint replacement surgery.