DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

SEP 13 2007

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Tennessee Home and Community-Based Mental Retardation Services for July 1, 2002, Through June 30, 2003 (A-04-03-03026)

Attached is an advance copy of our final report entitled "Tennessee Home and Community-Based Mental Retardation Services for July 1, 2002, Through June 30, 2003." We will issue this report to the State Medicaid agency within 5 business days.

Tennessee's State Medicaid agency oversees section 1915(c) waivers to provide home and community-based services (HCBS) to Medicaid beneficiaries with mental retardation and developmental disabilities. Under a contract with the State Medicaid agency, the Division of Mental Retardation Services (DMRS) manages the HCBS waivers and contracts with local entities to provide HCBS to approximately 4,300 mentally retarded and developmentally disabled individuals in the community. From July 1, 2002, through June 30, 2003, the State Medicaid agency claimed Federal reimbursement of nearly $150.6 million in HCBS costs.

Our objectives were to determine whether the State Medicaid agency claimed Federal reimbursement for HCBS that were adequately supported in the providers' records and provided in accordance with the beneficiaries' approved plans of care.

Based on our sample results, we estimate that during State fiscal year 2003 the State Medicaid agency claimed approximately $11 million ($7 million Federal share) for HCBS that were not supported by provider records.

Our sample of 200 claims found 38 claims for unallowable services totaling $42,945:

- Thirty-four claims were for services that were billed at a higher level of care than was provided.

- Five claims were for services that were not adequately supported to determine that the services were provided.

- One claim was for services that exceeded the allowed level of care specified in the beneficiary's plan of care.

The 34 claims for services billed at a higher level of care than was provided include 2 claims with multiple errors, thus the claims are also included in the other two error categories. The unduplicated claim count is 38. The remaining 162 claims were allowable.

The Federal reimbursement for the unallowable claims occurred because the State Medicaid agency did not ensure that HCBS costs were allowable. Our review found that DMRS: (1) did not have a billing system to allow for unplanned changes in services provided, (2) had no controls to ensure that services billed were actually provided, and (3) had no controls to limit the number of services billed to the specifications in the beneficiary's plan of care.

We recommend that the State Medicaid agency:

- refund to the Centers for Medicare & Medicaid Services (CMS) the $6,982,530 estimated excess Federal reimbursement for State fiscal year 2003;

- direct DMRS to establish controls and procedures to:

  - account for changes in the actual level of services provided,

  - ensure that claims are adequately supported, and

  - ensure that HCBS are rendered in accordance with the beneficiary's plan of care; and

- review its claims filed after our audit period and refund any overpayments identified.

In its comments to the draft report, the State Medicaid agency did not specifically address our first recommendation to refund $6,982,530. With respect to the second and third recommendations, the State Medicaid agency agreed that additional oversight and controls were needed and said that it had increased its monitoring efforts to help ensure that proper controls and procedures were in place. The State Medicaid agency described implementing several new processes and procedures. It offered assurance that it had recouped overpayments identified for the period after our audit and had adjusted its claims for Federal financial participation accordingly.

The State Medicaid agency's comments did not warrant any revisions to the results of our review or to our recommendations. We credit the State for taking corrective actions, but we continue to recommend that the State Medicaid agency refund to CMS the $6,982,530 estimated excess Federal reimbursement for State fiscal year 2003.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for

Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov, or Peter J. Barbera, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750 or through e-mail at Peter.Barbera@oig.hhs.gov. Please refer to report number A-04-03-03026.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

SEP 18 200?

Report Number: A-04-03-03026

Mr. Darin J. Gordon
Deputy Commissioner, Bureau of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, Tennessee 37243

Dear Mr. Gordon:

Enclosed is the Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Tennessee Home and Community-Based Mental Retardation Services for July 1, 2002, Through June 30, 2003." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Eric Bowen, Audit Manager, at (404) 562-7789 or through e-mail at Eric.Bowen@oig.hhs.gov. Please refer to report number A-04-03-03026 in all correspondence.

Sincerely,

Peter J Barbera

Peter J. Barbera
Regional Inspector General
for Audit Services, Region IV

Enclosure

Direct Reply to HHS Action Official:

Mr. Roger Perez
Regional Administrator
Centers for Medicare and Medicaid Services, Region IV
Department of Health and Human Services
61 Forsyth Street, SW., Room 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

TENNESSEE HOME AND COMMUNITY-BASED MENTAL RETARDATION SERVICES FOR JULY 1, 2002, THROUGH JUNE 30, 2003

Daniel R. Levinson
Inspector General

September 2007
A-04-03-03026

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Home and Community-Based Services Waiver Authority

Tennessee's State Medicaid agency oversees section 1915(c) waivers to provide home and community-based services (HCBS) to Medicaid beneficiaries with mental retardation and developmental disabilities. Under 1915(c) waiver authority, States can provide services not usually covered by the Medicaid program, as long as these services are required to keep a person from being institutionalized.

Division of Mental Retardation Services

Under a contract with the State Medicaid agency, the Division of Mental Retardation Services (DMRS) manages the HCBS waivers and contracts with local entities to provide HCBS to approximately 4,300 mentally retarded and developmentally disabled individuals in the community.

From July 1, 2002, through June 30, 2003, the State Medicaid agency claimed Federal reimbursement of nearly $150.6 million in HCBS costs.

OBJECTIVES

Our objectives were to determine whether the State Medicaid agency claimed Federal reimbursement for HCBS that were adequately supported in the providers' records and provided in accordance with the beneficiaries' approved plans of care.

SUMMARY OF FINDINGS

Based on our sample results, we estimate that during State fiscal year 2003 the State Medicaid agency claimed approximately $11 million ($7 million Federal share) for HCBS that were not supported by provider records.

Our sample of 200 claims found 38 claims for unallowable services totaling $42,945:

- Thirty-four claims were for services that were billed at a higher level of care than was provided.

- Five claims were for services that were not adequately supported to determine that the services were provided.

- One claim was for services that exceeded the allowed level of care specified in the beneficiary's plan of care.

The 34 claims for services billed at a higher level of care than was provided include 2 claims with multiple errors, thus the claims are also included in the other two error categories. The unduplicated claim count is 38. The remaining 162 claims were allowable.

The Federal reimbursement for the unallowable claims occurred because the State Medicaid agency did not ensure that HCBS costs were allowable. Our review found that DMRS: (1) did not have a billing system to allow for unplanned changes in services provided, (2) had no controls to ensure that services billed were actually provided, and (3) had no controls to limit the number of services billed to the specifications in the beneficiary's plan of care.

RECOMMENDATIONS

We recommend that the State Medicaid agency:

- refund to the Centers for Medicare & Medicaid Services (CMS) the $6,982,530 estimated excess Federal reimbursement for State fiscal year 2003;
- direct DMRS to establish controls and procedures to:
  - account for changes in the actual level of services provided,
  - ensure that claims are adequately supported, and
  - ensure that HCBS are rendered in accordance with the beneficiary's plan of care; and
- review its claims filed after our audit period and refund any overpayments identified.

STATE'S COMMENTS

In its comments to the draft report, the State Medicaid agency did not specifically address our first recommendation to refund $6,982,530. With respect to the second and third recommendations, the State Medicaid agency agreed that additional oversight and controls were needed and said that it had increased its monitoring efforts to help ensure that proper controls and procedures were in place. The State Medicaid agency described implementing several new processes and procedures. It offered assurance that it had recouped overpayments identified for the period after our audit and had adjusted its claims for Federal financial participation accordingly. The State's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We credit the State for taking corrective actions. However, we continue to recommend that the State Medicaid agency refund to CMS the $6,982,530 estimated excess Federal reimbursement for State fiscal year 2003.

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INTRODUCTION

BACKGROUND

Medicaid Program

In 1981, Congress authorized the waiver of certain Federal requirements to enable a State to provide home and community-based services (HCBS) to individuals who would otherwise require care in a skilled nursing or intermediate care facility or need intermediate care facility/mental retardation services reimbursable by Medicaid. The waivers, referred to as 1915(c) waivers, are named after the section of the Social Security Act that authorizes them.

1915(c) Waivers

The State Medicaid agency contracted with the Division of Mental Retardation Services (DMRS) to manage and operate HCBS under section 1915(c) waivers, as is described in a Department of Health and Human Services document:

> Under 1915(c) waiver authority, states can provide services not usually covered by the Medicaid program, as long as these services are required to keep a person from being institutionalized. Services covered under waiver programs include: case management, homemaker, home health aide, personal care, adult day health, habilitation, respite care, "such other services requested by the state as the Secretary may approve," and "day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness."[1]

DMRS manages the HCBS waivers and contracts with local entities to provide HCBS to approximately 4,300 mentally retarded and developmentally disabled individuals in the State. Under these waivers, the State Medicaid agency claims Federal reimbursement (approximately 64 percent) using negotiated service rates for the cost of medical assistance provided to mentally retarded and developmentally disabled persons. These rates are negotiated between the State Medicaid agency and the Centers for Medicare & Medicaid Services (CMS). From July 1, 2002, through June 30, 2003, the State Medicaid agency claimed Federal reimbursement of nearly $150.6 million in HCBS costs.

[1]U.S. Department of Health and Human Services. "Understanding Medicaid Home and Community Services: A Primer." Available online at http://aspe.hhs.gov/daltcp/reports/primer.htm. Accessed April 16, 2003.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether the State Medicaid agency claimed Federal reimbursement for HCBS that were adequately supported in the providers' records and provided in accordance with the beneficiaries' approved plans of care.

Scope

CMS requested that we perform audits of two separate issues relating to the HCBS program in Tennessee: the awarding and monitoring of contracts and the delivery of services. This report discusses the delivery of services. We issued a final report on the awarding and monitoring of contracts (A-04-03-03025) on October 6, 2006.[2]

We reviewed DMRS's HCBS claims for payment for the period July 1, 2002, through June 30, 2003 (State fiscal year (FY) 2003). Those paid claims were the basis for the State Medicaid agency's claim for Federal reimbursement of $150.6 million.

We did not assess the State Medicaid agency's overall internal controls. We limited our review to gaining an understanding of selected State Medicaid agency and DMRS controls related to Medicaid funding and to the operation of the HCBS waiver program. We did not review the negotiated rates between CMS and the State Medicaid agency.

We performed our audit at the State Medicaid agency and DMRS in Nashville, Tennessee.

Methodology

To accomplish our objectives, we:

- reviewed Federal regulations and waiver provisions;
- interviewed CMS, State Medicaid agency, and DMRS officials;
- reconciled the State Medicaid agency's paid claims tape consisting of 83,339 claims paid to providers to the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64) for our audit period; and

[2]In that report, we recommended that the State Medicaid agency increase its monitoring oversight, and the State Medicaid agency concurred.

selected a statistical sample of 200 of these claims totaling $374,945 (Appendix A) and then:

- visited provider offices to obtain claim records;
- made follow-up calls, sent e-mail messages, and sent faxes to obtain additional or missing records from the service providers; and
- identified any claims that were not paid in accordance with the beneficiaries' plans of care.

We used an unrestricted variable appraisal program to estimate excess Federal reimbursement. (See Appendix B.)

We conducted our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Based on our sample results, we estimate that during State FY 2003 the State Medicaid agency claimed approximately $11 million ($7 million Federal share) for HCBS that were not supported by provider records. Our sample of 200 claims found 38 claims for unallowable services totaling $42,945:

- Thirty-four claims[3] were for services that were billed at a higher level of care than was provided.
- Five claims were for services that were not adequately supported to determine that the services were provided.
- One claim was for services that exceeded the allowed level of care specified in the beneficiary's plan of care.

The remaining 162 claims were allowable.

The Federal reimbursement for the unallowable claims occurred because the State Medicaid agency did not ensure that HCBS costs were allowable. Our review found that DMRS: (1) did not have a billing system to allow for unplanned changes in services provided, (2) had no controls to ensure that services billed were actually provided, and (3) had no controls to limit the number of services billed to the specifications in the beneficiary's plan of care.

[3]This total includes two claims with multiple errors, thus the claims are also included in the two error categories that follow. The unduplicated claim count is 38.

FEDERAL REQUIREMENTS AND WAIVER PROVISIONS

Federal regulations (42 CFR § 441.301) require that HCBS are furnished under a written plan of care subject to approval by the State agency.
Tennessee's HCBS waiver states:

> An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP [Federal financial participation] will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

Federal regulations (2 CFR part 225, Appendix A (C)(1)(j)) state that costs must be adequately documented to be allowed under Federal awards.

Section 4442.6 of the CMS "State Medicaid Manual" states that an assessment of the individual to determine the services needed to prevent institutionalization must be included in the plan of care. It further explains that the plan of care must specify the medical and other services to be provided, their frequency, and the type of provider.

UNALLOWABLE HOME AND COMMUNITY-BASED SERVICES

Unallowable Costs Claimed

Of the 200 claims in our sample, 38 included unallowable services:

- Thirty-four claims were for services totaling $41,651 that were paid at a higher level of care than was actually provided. For example, a physician determined that the beneficiary needed skilled intermittent care for the administration of prescribed medication. The plan of care for this beneficiary specified residential habilitation services at a staffing level of 4:2:1. This means that for a facility with four beneficiaries, two staff members must be present during peak hours (day and evening) and one staff member must be present at night when the beneficiaries are sleeping.

  In 1 month, the provider billed 28 days of residential habilitation at the 4:2:1 level. However, the provider's records did not support this level of care as having been provided. Provider records show that on more than one occasion, one or more of the staff members who were supposed to be present were absent for all or part of the shift. The level of service was lower than was specified by the beneficiary's plan of care.

- Five claims were for services totaling $1,264 that were not adequately documented to support that the service was provided. For example, a physician determined that the beneficiary had limited capabilities. The plan of care for this beneficiary specified 10 units (10 hours) of nursing services each month. One month, the provider billed for the entire 10 units, but the nursing progress reports and the billing calendar only supported 4 units (4 hours) of services. No records were provided to support the remaining 6 units billed.

- One claim was for services totaling $30 that exceeded the level of service specified in the beneficiary's plan of care. The beneficiary's plan of care specified 90 units of day habilitation each month, but the provider billed for 94 units of service. Therefore, the provider billed and was paid for four more units of service than the plan of care specified, for a total of $30 in unallowable services.

Inadequate State Medicaid Agency Oversight of the Division of Mental Retardation Services's Procedures and Controls

Ultimately, the State Medicaid agency was responsible for ensuring that DMRS claimed only allowable HCBS costs. Our review found that DMRS paid provider claims based on the services billed, without either taking into account the requirements of the plan of care or determining whether the services were actually provided.

DMRS's billing system did not allow for unplanned changes in services. Although its billing system allowed for changes with advance notice, the system did not allow for last-minute changes. For example, if the plan of care for a beneficiary required two staff members to be present for an 8-hour shift but only one staff member was present, the provider could not bill for the lower level of service provided. The billing system did not allow for these types of inevitable daily fluctuations in the level of care.

DMRS is contractually required to maintain comprehensive medical records and documentation of services provided to HCBS beneficiaries. The State Medicaid agency is required to monitor the plans of care for beneficiaries receiving HCBS and perform periodic audits of HCBS beneficiaries' records. We issued a final report on this issue (A-04-03-03025) that recommended that the State Medicaid agency increase its monitoring oversight, and the State Medicaid agency concurred with our recommendation.

Excess Reimbursements Related to Unallowable Costs Claimed

The 200 claims in our sample were for $374,945 in Medicaid payments that the State Medicaid agency claimed for Federal reimbursement. Of this amount, the State Medicaid agency overpaid to DMRS $42,945 for 38 claims that contained unallowable services. In cases where some level of services was provided, we considered an overpayment to be the difference between the level of services actually provided and the level of service billed.

By projecting these results to the entire population of claims paid in State FY 2003, we estimate that the State Medicaid agency overpaid $10,910,203 ($6,982,530 Federal share) to DMRS for HCBS and claimed this amount for Federal reimbursement.

RECOMMENDATIONS

We recommend that the State Medicaid agency:

- refund the $6,982,530 estimated excess Federal reimbursement for State FY 2003;
- direct DMRS to establish controls and procedures to:
    - account for changes in the actual level of services provided,
    - ensure that claims are adequately supported, and
    - ensure that HCBS are provided in accordance with the beneficiary's plan of care; and
- review its claims filed after our audit period and refund any overpayments identified.

STATE'S COMMENTS

In its comments on the draft report, the State Medicaid agency did not specifically address our first recommendation to refund $6,982,530. With respect to the second and third recommendations, the State Medicaid agency agreed that additional oversight and controls were needed and said that it had increased its monitoring efforts to help ensure that proper controls and procedures were in place. The State Medicaid agency described implementing several new processes and procedures. It offered assurance that it had recouped overpayments identified for the time period after our audit and had adjusted its claims for FFP accordingly. The State's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We credit the State for taking corrective actions. However, we continue to recommend that the State Medicaid agency refund to CMS the $6,982,530 estimated excess Federal reimbursement for State FY 2003.

APPENDIXES

SAMPLING METHODOLOGY

OBJECTIVES

Our objectives were to determine whether the State Medicaid agency claimed Federal reimbursement for home and community-based services that were adequately supported in the providers' records and provided in accordance with the beneficiaries' approved plans of care.

POPULATION

The universe consisted of 83,339 paid claims representing $150,556,300 paid to providers by the Division of Mental Retardation Services for the audit period July 1, 2002, through June 30, 2003.

SAMPLE UNIT

The sampling unit was a paid claim.

SAMPLE DESIGN

We used an unrestricted random sample of paid claims.

SAMPLE SIZE

We selected 200 claims from the universe.

ESTIMATION METHODOLOGY

Using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services, RAT-STATS Variable Appraisal Program for unrestricted samples, we projected the amount the State Medicaid agency paid for services that were not provided in accordance with Federal regulations and waiver provisions.

APPENDIX B

SAMPLE RESULTS AND PROJECTION

Sample Results

Sample Size	Value of Sample	Number of Claims With Excess Reimbursements	Value of Excess Reimbursements
200	$374,945	38	$42,945

Estimated Excess Reimbursements

Point Estimate	$17,894,829
90-percent Confidence Interval	
Lower Limit	$10,910,203
Upper Limit	$24,879,455

STATE OF TENNESSEE
BUREAU OF TENNCARE
310 Great Circle Road
Nashville, TN 37243

May 25, 2007

Mr. Peter J. Barbera
Regional Inspector General
For Audit Services, Region IV
Department of Health and Human Services
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Dear Mr. Barbera:

This letter comes in response to the draft report entitled "Tennessee Home and Community Based Mental Retardation Services" (# A-04-03-03026) for the period July 1, 2002 through June 30, 2003. We appreciate the opportunity to review the report and provide written comments.

Regarding the Summary of Findings, TennCare does not dispute statements made regarding the 200 claims reviewed in the sample and the specific findings noted for the 38 unallowable services identified. Further, we acknowledge that additional oversight and controls were needed during the period covered by the audit and have, since the time period for which the audit was conducted, increased our monitoring efforts to help ensure that proper controls and procedures are in place. Below, please find specific actions that have been taken since June 2003, which correspond with each of your recommendations:

Direct DMRS to establish controls and procedures to:

Account for changes in the actual level of services provided.
In accordance with federal regulations and the State's approved 1915(c) waiver, services are to be based on an individualized assessment of need. However, a person's needs may fluctuate throughout the day, i.e., s/he may require more intensive staffing for particular types of activities or for particular times of day. In 2003, waiver service definitions and rates specified particular staffing ratios that did not afford such flexibility in the provision of individualized supports. In order to better address this and other issues, TennCare submitted and subsequently received approval for a 3-tiered waiver structure (i.e., 3 new waivers) which became effective January 1, 2005 using a different methodology to develop staffing patterns based on the individual needs of the enrollee instead of requiring a prescribed staffing pattern. Present practice is that individual levels of functioning are determined through the ICAP tool and the staffing ratio for each individual is determined by the "Circle of Support." Staffing patterns are no longer prescribed and reflected in service descriptions. Rather, minimum expectations are defined for each service.

Beyond that, each person must have a staffing plan to support the plan of care. That staffing plan must address all environments where services are provided.

In 2004, DMRS established a Quality Management System to evaluate provider performance in ensuring that waiver services are in accordance with the plan of care. Staff from the Quality Assurance Unit conduct annual provider surveys to determine if services are implemented as identified in the Plan of Care and are meeting the enrollee's needs. Monitoring is also accomplished through required monthly face-to-face visits by Independent Support Coordinators/Case Managers and the completion of monthly status review reports.

In the fall 2007, DMRS will begin implementing its new Integrated Service Information System (ISIS). In phase one, Cost Plans will be entered electronically and approved by the Regional Offices before Providers can request payment using the Providers Claim Processing (PCP) application. ISP amendments sent in on paper by the providers are entered by the RO's in order to change and initiate new cost plans. (This is the same process using the current CS Tracking system or ISIS: SAM Phase I - just a different tool.) By the end of the year, the Providers themselves will be able to enter Cost Plan changes (for example, when a service level changes) with the Regional Offices performing review and approval. By the beginning of calendar year 2009, the entire ISP will be electronic with the release of the full version of ISIS. As each section of the ISP is completed, the system will develop and generate an appropriate cost plan. Cost plans will only include services and rates that match the approved ISP. The system will also be able to check the number of enrollees in a home and the number of approved staff to verify that inappropriate billing does not occur.

Ensure that claims are adequately supported.
The TennCare Utilization Review (UR) process was implemented by staff in the TennCare Division of Long Term Care-Developmental Disability Services in February 2005 to conduct post-payment reviews to ensure that services are medically justified, appropriately documented, and accurately billed. The UR process includes a review of the DMRS approved service plan, billing documents, and supporting documentation as compared to TennCare Interchange adjudicated claims. Any discrepancies identified are noted in a report that is submitted to DMRS with opportunity for review and comment. Final decision that claims that have been paid without supporting documentation results in recoupment of amounts paid for that period. To date, six (6) utilization reviews have been conducted. Total recoupment to date is $798,131.28.

In 2007, the DMRS Internal Audit and Fiscal Accountability Review (FAR) functions were merged under the leadership of a Director of Internal Audit. This Division follows the Department of Finance and Administration's (F&A) Policy #22 which defines the process and guidelines for monitoring sub-recipients. The FAR monitors at least 33% of all contracts and ensures that this percentage encompasses at least 66% of the total contacted amount for each year. Each year a plan is submitted to F&A identifying the list of contracts to be monitored. FAR reviewers conduct an onsite review covering a minimum of 3 months of services. The sample size for each contract provider is 10% of the total enrollees served with test sample limits set at a minimum of 4 and maximum of 15. A review of the claims billed is compared to supporting documentation and all discrepancies are noted in a report that is submitted to the contract provider for comment. Recoupment for unsupported charges is made after review of the agency's comments. The initial report and final resolution is then submitted to TennCare for additional follow up where appropriate.

Ensure that HCBS are rendered in accordance with the beneficiary's plan of care.
In 2003, TennCare created a Quality Review Unit within the Division of Long Term Care-Developmental Disability Services to provide oversight of the community based system of services and supports. This Unit is responsible for conducting an Annual State Assessment of all HCBS services to include reviewing a random sample of the plan of care for selected enrollees each year. The process includes pulling the plans for selected enrollees and comparing the approved activities to supporting documentation. Reviewers also interview the enrollee, enrollee's family members, and support staff to determine if enrollees have access to services and supports as outlined and whether the goals and objectives appropriately reflect the enrollee's unique needs, preferences, a decisions. All discrepancies are written up as findings and are submitted to DMRS for comment and corrective action. The findings and corrective action plan are discussed each month during a TennCare/DMRS Quality Review meeting. Follow-up and focused reviews are conducted as needed to insure that corrective actions have been taken.

As noted above, DMRS established a Quality Management System to evaluate provider performance in ensuring that waiver services are in accordance with the plan of care in 2004. Staff from the Quality Assurance Unit conduct annual provider surveys to determine if services are implemented as identified in the Plan of Care and are meeting the enrollee's needs. Monitoring is also accomplished through required monthly face-to-face visits by Independent Support Coordinators/Case Managers and the completion of monthly status review reports. Providers receive an annual performance assessment and as a follow up measure, Regional Office Agency Teams conduct a follow up review called a Targeted Elements Assessment. DMRS provides TennCare a list of enrollees reviewed as provider surveys are conducted. TennCare includes a select number of these individuals as part of the Annual State Assessment process each year.

Review claims filed after OIG audit period and refund any overpayments identified.
As a result of these processes and procedures, TennCare has in fact extensively reviewed claims filed after the OIG audit period, has taken initiative to recoup overpayments identified, and has adjusted its claims for FFP accordingly.

If you have any questions regarding the information provided, please feel free to contact me at (615) 507-6443.

Sincerely,

Darin J. Gordon /sp

Darin J. Gordon
Deputy Commissioner

DJG/PK/SP:cm