

**Audit Results From
CAFR and Single Audit Procedures**

Department of Finance and Administration

**For the Year Ended
June 30, 2004**

STATE OF TENNESSEE

COMPTROLLER OF THE TREASURY

Department of Audit

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**Department of Finance and Administration
For the Year Ended June 30, 2004**

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**Department of Finance and Administration
For the Year Ended June 30, 2004**

EXECUTIVE SUMMARY

Findings

- FINDING 1 As noted in the prior two audits, the Department of Finance and Administration's Division of Capital Projects and Real Property Management has failed to implement an effective review system of land transactions entered on the Land Inventory System (LIS). As a result, land was not always properly valued. The LIS is also used by the Division of Accounts to record values for buildings. It was noted during the current audit that seven buildings that no longer exist were still reported on the state's financial statements (page 7).
- FINDING 2 As noted in the prior audit, the Office for Information Resources has not implemented adequate controls over two areas. Two additional areas that need improvement were noted in the current audit. Failure to provide such controls increases the risk that unauthorized individuals could access sensitive state systems and information (page 9).
- FINDING 3 For the second year, TennCare chose to improperly record administrative payments to Premier Behavioral Systems of Tennessee as medical assistance payments, resulting in \$4,894,492 of federal questioned costs. In addition, the current audit also revealed that the total amount of administrative payments to both Premier and Tennessee Behavioral Health exceeded the amount of funding allowed to the TennCare Partners Program by \$47,013 (page 10).
- FINDING 4 As noted in two prior audits, TennCare's monitoring of payments to the Managed Care Contractors needs improvement (page 12).
- FINDING 5 TennCare failed to follow established financial policy and procedure, and as a result, incorrectly issued an \$8,000,000 check to an institutional Medicare cross-over provider (page 18).
- FINDING 6 As noted since 1999, TennCare is still violating the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled in the way claims are paid for services provided to the mentally retarded and developmentally disabled. Testwork revealed that TennCare has continued to inappropriately pay the Division of Mental Retardation Services (DMRS) as a Medicaid provider. DMRS in turn has continued to treat the actual Medicaid service providers as DMRS vendors. TennCare has not paid DMRS the same amounts DMRS has paid the providers (page 19).

- FINDING 7 As noted in the previous five audits, some of TennCare’s providers did not have documentation to substantiate services associated with fee-for-service claims under the Medicaid Home and Community Based Services Waivers (page 29).
- FINDING 8 Since 1995, there have been weaknesses in internal control over TennCare eligibility. The current audit noted that TennCare paid for individuals with invalid social security numbers and did not reverify the eligibility of all enrollees (page 32).
- FINDING 9 As noted in the six previous audits, we continue to find deficiencies in controls over computer system security. Terminated employees still have access to the TennCare Management Information System, and TennCare needs to improve documentation of system changes (page 41).
- FINDING 10 As noted in the previous audit, TennCare’s administrative appeals process needs improvement. Based on testwork performed, it appeared that for 18 of 25 administrative appeals (72%), the delays were attributed to factors beyond the Bureau of TennCare’s control. However, for 7 of 25 administrative appeals (28%) that exceeded the 90-day federal requirement, TennCare could not provide documentation to explain and/or justify the delays (page 45).
- FINDING 11 As noted in prior audit findings in the previous four audits, TennCare does not redetermine or terminate the TennCare eligibility of Supplemental Security Income (SSI) enrollees who become ineligible for SSI. This is because TennCare still does not have a court-approved plan which would allow TennCare to make a new determination of the eligibility of these enrollees (page 47).
- FINDING 12 TennCare did not recover all costs related to deceased enrollees. The results of testwork indicated that payments of \$408,955 were made and not recovered for services on dates that were after the recorded dates of death of the recipients. We believe that because of the nature, complexity, and magnitude of the TennCare program, there will always be some payments of this type in the program. Nevertheless, we are required by federal Office of Management and Budget Circular A-133 to report this issue as a finding because questioned costs exceed \$10,000 (page 51).
- FINDING 13 TennCare charged the federal Medicaid program for payments to the Department of Children’s Services, managed care organizations, behavioral health organizations, and pharmacy and dental benefits managers, for some unallowable costs, resulting in questioned costs of \$212,720. Although we believe that a small number of errors of this nature are inherent in the program, we are nevertheless required by Office of Management and Budget Circular A-133 to report all known questioned costs when likely questioned costs exceed \$10,000 for a federal compliance requirement (page 52).

- FINDING 14 As noted in the prior three audits, TennCare did not approve contracts before the beginning of the contract period. Our testwork revealed that 25 contracts and/or amendments that had beginning effective dates between July 1, 2003, and June 30, 2004, were not fully executed before the beginning of the contract period (page 55).
- FINDING 15 TennCare staff paid a claim submitted by the provider beyond the allowable time frame and could not provide adequate documentation to justify overriding untimely filing edits. Office of Management and Budget Circular A-133 requires us to report all known questioned costs when likely questioned costs exceed \$10,000 for a federal compliance requirement. We believe that likely questioned costs for this condition exceed \$10,000 (page 58).
- FINDING 16 As noted in the prior four audits, the Bureau of TennCare has not adjusted estimates used to equal actual expenditures for services provided to TennCare enrollees residing in an Institution for Mental Diseases (page 59).
- FINDING 17 TennCare failed to ensure that provider requirements were met in accordance with the *Code of Federal Regulations*, the Centers for Medicare and Medicaid Services *State Operations Manual*, and state law. TennCare did not ensure that all managed care organizations required providers to make necessary disclosures, TennCare's applications with cross-over providers did not include required disclosures, and TennCare did not maintain adequate documentation that hospitals had met the prescribed federal health and safety standards (page 61).

This report addresses reportable conditions in internal control and noncompliance issues found at the Department of Finance and Administration during our annual audit of the state's financial statements and major federal programs. For the complete results of our audit of the State of Tennessee, please see the State of Tennessee *Comprehensive Annual Financial Report* for the year ended June 30, 2004, and the State of Tennessee *Single Audit Report* for the year ended June 30, 2004. The scope of our audit procedures at the Department of Finance and Administration was limited. During the audit for the year ended June 30, 2004, our work at the Department of Finance and Administration focused on one major federal program: the Medical Assistance Program. We audited this federally funded program to determine whether the department complied with certain federal requirements and whether the department had an adequate system of internal control over the program to ensure compliance. Management's response is included following each finding.



STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
State Capitol
Nashville, Tennessee 37243-0260
(615) 741-2501

John G. Morgan
Comptroller

May 26, 2005

The Honorable Phil Bredesen, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

and
The Honorable Dave Goetz, Commissioner
Department of Finance and Administration
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith are the results of certain limited procedures performed at the Department of Finance and Administration as a part of our audit of the *Comprehensive Annual Financial Report* of the State of Tennessee for the year ended June 30, 2004, and our audit of compliance with the requirements described in the U.S. Office of Management and Budget Circular A-133 Compliance Supplement.

Our review of management's controls and compliance with laws, regulations, and the provisions of contracts and grants resulted in certain findings which are detailed in the Findings and Recommendations section.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/dgv
04/091



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COMPTROLLER OF THE TREASURY
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December 3, 2004

The Honorable John G. Morgan
Comptroller of the Treasury
State Capitol
Nashville, Tennessee 37243

Dear Mr. Morgan:

We have performed certain audit procedures at the Department of Finance and Administration as part of our audit of the financial statements of the State of Tennessee as of and for the year ended June 30, 2004. Our objective was to obtain reasonable assurance about whether the State of Tennessee's financial statements were free of material misstatement. We emphasize that this has not been a comprehensive audit of the Department of Finance and Administration.

We also have audited certain federal financial assistance programs as part of our audit of the state's compliance with the requirements described in the U.S. Office of Management and Budget (OMB) Circular A-133 Compliance Supplement. The following table identifies the State of Tennessee's major federal program administered by the Department of Finance and Administration. We performed certain audit procedures on this program as part of our objective to obtain reasonable assurance about whether the State of Tennessee complied with the types of requirements that are applicable to each of its major federal programs.

**Major Federal Program Administered by the
Department of Finance and Administration
For the Year Ended June 30, 2004
(in thousands)**

<u>CFDA Number</u>	<u>Program Name</u>	<u>Federal Disbursements</u>
93.778	Medical Assistance Program	\$4,949,632

Source: State of Tennessee's Schedule of Expenditures of Federal Awards for the year ended June 30, 2004.

The Honorable John G. Morgan
December 3, 2004
Page Two

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

We have issued an unqualified opinion, dated December 3, 2004, on the State of Tennessee's financial statements for the year ended June 30, 2004. We will issue, at a later date, the State of Tennessee *Single Audit Report* for the same period. In accordance with *Government Auditing Standards*, we will report on our consideration of the State of Tennessee's internal control over financial reporting and our tests of its compliance with certain laws, regulations, and provisions of contracts and grants in the *Single Audit Report*. That report will also contain our report on the State of Tennessee's compliance with requirements applicable to each major federal program and internal control over compliance in accordance with OMB Circular A-133.

As a result of our procedures, we identified certain internal control and compliance issues related to the major federal program at the Department of Finance and Administration. Those issues, along with management's response, are described immediately following this letter. We have reported other less significant matters involving the department's internal control and instances of noncompliance to the Department of Finance and Administration's management in a separate letter.

This report is intended solely for the information and use of the General Assembly of the State of Tennessee and management, and is not intended to be and should not be used by anyone other than these specified parties. However, this report is a matter of public record.

Sincerely,

A handwritten signature in black ink that reads "Arthur A. Hayes, Jr." The signature is written in a cursive style with a large initial "A" and a distinct "H".

Arthur A. Hayes, Jr., CPA,
Director

FINDINGS AND RECOMMENDATIONS

1. Controls over the recording of land and buildings in the Land Inventory System need improvement

Finding

As noted in the prior two audits, the Department of Finance and Administration's Division of Capital Projects and Real Property Management has failed to implement an effective review system of land transactions entered on the Land Inventory System (LIS). As a result, land was not always properly valued. The Division of Capital Projects and Real Property Management uses the LIS to maintain records of state-owned land for each site in the state's 95 counties. For each site listed in LIS, there are one or more activity records that include the information regarding acquisition or disposal transactions of property and the associated value for each activity related to that site. The values for each activity in LIS are used to generate reports—such as the Land Value Report, the Land Inventory Report, and an Adjustments Report at the end of each fiscal year—which are used in determining the amount of land to be included in the financial statements. The current audit revealed that land acquisitions, land disposals, and land transfers were not valued correctly in LIS. The LIS is also used by the Division of Accounts to record values for buildings. It was noted during the current audit that seven buildings that no longer exist were still reported on the state's financial statements.

In response to the prior audit finding, management concurred and stated that the division would implement a new review system that establishes a system of multiple checks and reviews for all closed files, and the Division of Accounts would reconcile its building inventory to Treasury's Division of Risk Management Inventory and monitor the actions of the State Building Commission through a review of the commission's minutes. Reviews are being performed on closed land files, but certain recording problems still occurred because the reviews were not thorough enough to catch certain errors. Also, the Division of Accounts did start the reconciliation process for the buildings, but the process was not completed. Differences between the building inventory and the risk management inventory were identified and larger dollar items were researched and corrected, but not all differences were resolved.

All 20 land acquisitions and eight land disposals that occurred during the audit period were tested. Four acquisitions recorded incorrectly in LIS resulted in a total land understatement of \$134,393. Five disposals recorded incorrectly in LIS resulted in a land overstatement of \$19,402. Five of the nine incorrect transactions were due to the contract officer not indicating in LIS that the transaction involved a donated item. Testwork on land transfers indicated that three of five transfers (60%) were recorded incorrectly in LIS. These errors resulted in an understatement of \$11,102.

To record building values for financial statement purposes, the Department of Finance and Administration maintains a list of buildings and structures on LIS. The Department of

Treasury also maintains a list of state buildings and structures for insurance purposes. However, the listings have not been reconciled to one another. We selected a random sample of 48 buildings and structures from the LIS listing to observe. Testwork revealed 7 of 48 buildings and structures were not owned by the state or no longer existed and were still being reported on the financial statements. The buildings were purchased for a total of \$487,600 and had a book value of \$66,576. Five of the buildings had been identified as differences on the reconciliation to Treasury's Division of Risk Management Inventory but had not been researched and removed. The other two buildings were not identified in the reconciliation process since the buildings were erroneously included on both of the listings.

Recommendation

Management of the Division of Capital Projects and Real Property Management should reassess their review system to ensure all aspects of the major transaction types are addressed. Furthermore, they should ensure that the value entered into LIS equals the cost or the appraisal amount, changes to land are valued correctly, and the cost or value of land transferred between departments is correct. Each transaction should be reviewed to determine when the donation code should be marked in LIS. Once information is on LIS, system information should be compared to the source documents and files to ensure accuracy. The Division of Accounts should complete the reconciliation process with the Department of Treasury records. The reconciliation should be performed annually to ensure accurate records are being maintained.

Management's Comment

We concur. Corrective action is being taken to keep these types of errors from occurring and an annual reconciliation will be performed.

Five (5) of the nine (9) errors occurred when the state acquired a tract of land by gift or donation. Real Estate Management was unaware of a gift code feature in the Land Inventory System (LIS). In the absence of activating the gift code in the LIS, the land cost entered into the system also serves as a default figure for land value. When a gift is received there is no land cost, but there is still land value. Thus donated land costs entered into the system as zero caused the land value field to also show up as zero. The LIS Administrator is now aware of the gift code feature of the system and checking this aspect of the transaction has been incorporated into the review system.

The four remaining errors were due to human error. A review process, involving multiple reviews, has been instituted. This process includes comparing all data in the LIS to the original documents. The Director of Real Estate performs a final review.

The Division of Accounts will complete a reconciliation annually of Finance and Administration's records and the Department of Treasury's records.

2. The Department of Finance and Administration’s Office for Information Resources has not implemented adequate controls over four areas

Finding

As noted in the prior audit, the department’s Office for Information Resources has not implemented adequate controls over two areas. Two additional areas that need improvement were noted in the current audit. The state’s Information Technology Policies require that “... all Information Technology resources must be appropriately and adequately protected against unauthorized access, modification, destruction, or disclosure.” However, improvements are needed. Failure to provide such controls increases the risk that unauthorized individuals could access sensitive state systems and information.

In response to the prior-year audit finding, management concurred in part with the first area and concurred entirely with the second. In the first area, management stated that other compensating preventive and detective controls mitigate the risk, and management believes this condition has an acceptable level of risk when measured against other exposures taking resource precedence. Auditors determined that the compensating preventive and detective controls utilized did not appear effective. In the second area, management stated they had implemented enhanced controls in this area and were implementing a process to ensure weaknesses are reported to and addressed by management. Although the auditors observed significant progress in this area, corrective actions did not appear entirely effective.

The wording of this finding does not identify specific vulnerabilities that could allow someone to exploit the state’s systems. Disclosing those vulnerabilities could present a potential security risk by providing readers with information that might be confidential pursuant to Section 10-7-504 (i), *Tennessee Code Annotated*. We provided the department with detailed information regarding the specific vulnerabilities we identified as well as our recommendations for improvement.

This finding is a reportable condition for purposes of the State of Tennessee Single Audit of federal financial assistance. This wording will also appear in that report, which will be provided to the federal government pursuant to the procedures developed for reporting of Single Audit findings.

Recommendation

The Chief Information Officer over the Office for Information Resources should ensure that adequate controls are established. The Commissioner of Finance and Administration should adequately inform the Information Systems Council (ISC) of this finding and its consequences. Also, the Commissioner should seek guidance from the ISC regarding the priority to be attached to remedying these issues. The Chief Information Officer should also take all other steps available to establish or improve any compensating controls until these conditions are remedied.

Management's Comment

We concur in part with the first finding. While the specifics cannot be addressed in this document pursuant to Section 10-7-504 (i), *Tennessee Code Annotated*, it is management's position that best practices dictate that expenditures for mitigating security vulnerabilities should be commensurate with the costs associated with the risks. We concur that the mitigation strategies, both preventive and detective controls, need to be strengthened.

We concur with the second finding. We appreciate State Audit's acknowledgement of the significant improvements made over the past year. Management will continue to improve the process implemented to ensure that weaknesses are reported to and addressed by management.

We concur with the third finding. Immediate steps have been taken to mitigate the risk.

We concur with the fourth finding. Immediate steps have been taken to mitigate the risk.

- 3. For the second year, TennCare chose to improperly record administrative payments to Premier Behavioral Systems of Tennessee, and TennCare overpaid the administrative payments to behavioral health organizations; these conditions have resulted in federal questioned costs of \$4,926,245 and state questioned costs of \$15,260**

Finding

For the second year, TennCare chose to improperly record administrative payments to Premier Behavioral Systems of Tennessee as medical assistance payments. In addition, the current audit also revealed that the total amount of administrative payments to both Premier and Tennessee Behavioral Health (TBH) exceeded the amount of funding allowed to the TennCare Partners Program.

Prior to February 2003, TennCare paid Premier a monthly capitation payment to provide services to TennCare enrollees. Beginning in February 2003, TennCare started reimbursing Premier for all behavioral health services provided to enrollees and paid an administrative fee for these enrollees. According to the approval letter from the Centers for Medicare and Medicaid Services (CMS) for Premier's contract amendment, the state will be allowed to claim federal financial participation (FFP) for earned administrative fees at the 50% federal matching rate, not at the higher 67.54% medical assistance rate. Management did not concur with the prior audit finding and stated:

. . . The amendment with Premier was designed to be a partial risk arrangement. All partial risk arrangements are reimbursed federal financial participation at the medical assistance rate and not at the lower administrative rate. If CMS should pursue this matter and ultimately prevail through the appeal process, TennCare will adjust the match. However, until such time, TennCare will continue to claim the match that is favorable to the State.

In our rebuttal, we noted that the approval letter to the Director of TennCare from the Centers for Medicare and Medicaid Services for Premier's contract amendment states:

During discussion regarding the available risk banding options for the contractors, you advised us that Premier had selected option 4 of the profit/loss risk-banding program. Because the TennCare Bureau is responsible for 100% of all profits or losses under option 4, the Premier BHO is deemed to be operating as a non-risk contractor . . .

We also noted that the approval letter further states that because Premier BHO is operating as a non-risk contractor, the state will be allowed to claim federal participation for earned administrative fees at the 50% federal matching rate. Although management contends that the amendment with Premier was designed to be a partial risk agreement, it appears to be a non-risk agreement. In addition, we also reported that TennCare coded administrative fee payments to Premier as "administrative" for the months of May and June 2003.

During current fieldwork, we discussed this matter with a federal CMS official. That official indicated to us that the position of the CMS in the letter had not changed and that TennCare should not claim the higher medical assistance rate for these administrative payments.

Testwork revealed that TennCare claimed the medical assistance rate of 67.54% for administrative payments totaling \$27,904,762 to Premier. It should be noted that from July 2003 through January 2004, all BHO administrative payments were initially charged to the 50% Federal Financial Participation (FFP) rate. However, according to TennCare fiscal staff, the former TennCare Director instructed staff to retroactively apply the 67.54% FFP rate to all administrative payments. This resulted in \$4,894,492 in federal questioned costs. Because no additional funds were paid for this condition, there were no state questioned costs.

Additionally, testwork revealed that TennCare overpaid \$47,013 to Premier and TBH in administrative fees for the year ended June 30, 2004. The error occurred because of a calculation error. The total overpayment resulted in \$31,753 of federal questioned costs with the remaining \$15,260 in state questioned costs.

These conditions resulted in total federal questioned costs of \$4,926,245 and state questioned costs of \$15,260.

Recommendation

The Chief Financial Officer (CFO) should ensure administrative payments to Premier are recorded appropriately so that the appropriate federal financial participation is claimed. Otherwise, the CFO should obtain, and provide to us, documentation of concurrence by CMS that TennCare's claiming of administrative payments at that higher matching rate is allowable. The CFO should also ensure that the Bureau of TennCare pays the correct amount for administrative payments and recovers the overpayments.

Management's Comment

We concur in part. Regarding the federal percentage claimed for Premier administrative costs, we will continue to discuss our position with CMS and pursue a resolution.

Fiscal Services personnel determined that calculation errors occurred in three months of the audit period (July, August, and September 2003) that resulted in the overpayment of administrative fees to the behavioral health organization, Tennessee Behavioral Health. However, the total of these overpayments as calculated by Fiscal Services is \$43,621.82, rather than \$47,013 as calculated by the auditors. The difference of \$3,391 appears to be rounding errors and the difference in the calculating methodology utilized by TennCare's Fiscal Services Division and the auditors.

A Financial Change Request was initiated on March 24, 2005, to recover the overpayment of \$43,621.82 from Tennessee Behavioral Health.

4. TennCare's monitoring of payments to the Managed Care Contractors needs improvement

Finding

As noted in two prior audits, TennCare's monitoring of payments to the Managed Care Contractors (MCCs) needs improvement. During the audit period, TennCare's MCCs included the Behavioral Health Organizations (BHOs), the Managed Care Organizations (MCOs), Doral Dental of Tennessee, Consultec LLC (Consultec), and First Health Services Corporation (First Health).

For the year ended June 30, 2004, TennCare reimbursed the MCCs as follows:

- TennCare paid approximately \$403 million to the BHOs for behavioral health claims and administration payments.
- TennCare paid over \$2.4 billion to the MCOs for actual medical claims of enrollees.
- TennCare paid over \$126 million to Doral Dental, the dental benefits manager, for dental claims.
- TennCare paid over \$2.1 billion to Consultec and First Health, the pharmacy benefits managers, for pharmacy claims.

We reviewed procedures to determine if TennCare had monitored the MCCs for the same five critical control areas mentioned in the prior audit findings. Our objectives were

- to determine if third-party liabilities (TPL) were appropriately deducted from the amount paid,

- to determine if TennCare adequately monitored to ensure that individual provider claims were not reimbursed more than once,
- to determine if TennCare adequately monitored reimbursements to ensure that the MCCs paid for valid and eligible TennCare enrollees,
- to determine if TennCare adequately monitored transactions to ensure that the MCCs paid the providers the same amounts billed to TennCare, and
- to determine if TennCare reconciled the amounts TennCare reimbursed to the MCCs to the claim encounter data received by the Division of Information Systems.

Third-Party Liability

Testwork revealed that TennCare had not taken the necessary steps to ensure that third-party liability was collected before payments to the providers were made. According to the *Code of Federal Regulations*, Title 42, Part 433, Section 138, “The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan. . . .” However, audit inquiry revealed that TennCare had not made reasonable efforts to ensure that the BHOs, Doral Dental, and First Health appropriately deducted third-party liabilities from the amount paid to the providers. According to the Deputy Chief Financial Officer, given the nature of behavioral health services provided to the enrollees, the BHOs would not have much TPL to recover. However, management could not provide us with the total TPL related to the BHO services, or with evidence that the cost of recovering TPL would exceed the amount recoverable.

To address pharmacy claims, TennCare contracted with the Public Consulting Group (PCG) to perform retroactive third-party liability and duplicate payment recovery for pharmacy claims until December 31, 2003. However, the contract with PCG was not extended. In addition, TennCare has not assumed the responsibilities of PCG since its contract termination. According to the Chief Financial Officer, an additional unit dedicated to TPL is still being considered by TennCare management to assist in the monitoring of TPL.

Duplicate Reimbursements

Testwork was performed to determine whether TennCare had adequate monitoring procedures in place to ensure that provider claims were not reimbursed more than once. Based on discussions with TennCare Information Systems (IS) staff, TennCare generated duplicate reimbursement edit reports each month since January 2004 for the BHOs and the MCOs. However, IS staff have no procedures to address the exceptions that are identified by the edit reports. In addition, according to the TennCare IS staff, reports for the months prior to January 2004 were not created because there were problems with the reports prior to refinement.

Additionally, based on discussions with the Deputy Chief Financial Officer, TennCare had no procedures in place to prevent duplicate claims payments to dental and pharmacy providers. As noted above, Public Consulting Group (PCG) was contracted to perform retroactive third-party liability and duplicate payment recovery for pharmacy claims only until December 31, 2003, and TennCare has not assumed the responsibilities.

Eligibility

TennCare did not adequately monitor payments to the BHOs to ensure that payments to providers were for services performed for eligible TennCare enrollees. Although TennCare has taken steps to establish an effective monitoring process, TennCare has not yet ensured that payments to providers were for services performed for eligible enrollees. TennCare's Fiscal Budget Unit receives reports from the TennCare IS Division that list claims paid for ineligible and dead recipients. During fieldwork, management indicated that their plan was to send the reports to the respective BHOs for response and explanation of the discrepancies. In addition, TennCare fiscal staff plans to maintain and document all of the error reports, the responses from the BHOs, and status of all the responses sent out. However, as of September 24, 2004, reports for only the months of May 2004 and June 2004 had been sent out to the BHOs. Fiscal staff noted the reports for the other 10 months have been generated but were provided along with data from prior fiscal years and therefore are not easily reviewed. Fiscal staff also stated that they have asked TennCare IS staff to break down the reports by month so that the information is more manageable. However, the reports have not been provided to the BHOs as of December 15, 2004.

Reimbursement to MCCs and Providers

Based on discussions with fiscal staff, TennCare did not have adequate procedures in place to ensure that the MCOs were actually paying the providers the same amount that the MCOs bill TennCare. Each week, TennCare receives invoices from each MCO for reimbursement of actual medical expenditures. Some of the check registers of the MCOs are sent electronically; some are faxed, or in the case of John Deere Health Plan, not sent at all. The check registers for Victory Health Plan and Preferred Health Plan are not sent at the same time as their respective invoices. As a result, TennCare could not compare the MCOs' check register totals to the billing invoices for these MCOs. Also, we noted examples of invoices that did not reconcile to the claims data, and that TennCare had no procedures in place to handle discrepancies between claims data and invoices.

In addition, TennCare's procedures for determining if Doral paid the dental providers the same amount that was billed to TennCare were ineffective. Based on discussions with TennCare staff, TennCare made comparisons between the claims data, the check registers, and the invoices monthly, but corrective action for any exceptions found was not documented. Furthermore, TennCare could not provide evidence that the appropriate party (i.e., the Fiscal Director, Dental Director, etc.) was aware of any differences between these three items. In addition, although TennCare staff indicated that the check-register-to-invoice reconciliation was done for July 2003 through September 2003, we were unable to confirm that the reconciliation was performed because it was not documented.

Encounter Reconciliation

Current testwork revealed that as of October 21, 2004, TennCare had not successfully reconciled the amount reimbursed to the MCOs to the claims encounter data for the year ended June 30, 2004. According to the Director of Managed Care Analytics, the report has not been

generated for the year ended June 30, 2004, due to lack of system space. When the system space becomes available, it will take approximately one month to run the report so that the reconciliation process can begin. Based on discussions with the Director of Managed Care Analytics, TennCare has generated reports and attempted to reconcile the encounter data sent by the MCOs with their invoices for the year ended June 30, 2003. We found that the Director of Managed Care Analytics sent a memo dated July 1, 2004, to each MCO with a report showing differences for encounter data and invoices for the year ended June 30, 2003, and requested the MCOs provide explanations and a reconciliation. As of October 28, 2004, the responses have been received from the MCOs, and TennCare is reviewing the responses to determine the appropriate action.

In addition, TennCare's procedures for reconciling the amounts TennCare reimbursed to Doral for dental claims to the claims encounter data received by the TennCare Division of IS were also ineffective. Testwork revealed that TennCare reconciled the amount TennCare reimbursed to Doral to the claims data sent with the respective invoice. However, the claims data were not, in turn, reconciled with the encounter data. TennCare staff compared the total amount of claims from the encounter data to the claims data total for the 17 payments made between October 23, 2003, and June 18, 2004. However, at no time during the audit period did the two amounts match, and TennCare staff were unable to explain the differences. For 14 of these payments, the encounter data totals were higher than the claims data totals by a total of \$1,191,218. For 3 payments, the claims data totals were higher than the encounter data totals by a total of \$3,799. Management stated that no comparisons were made before October 23, 2003.

Additional discussions with fiscal staff revealed there were no procedures in place to reconcile the amounts TennCare reimbursed to Consultec/First Health to the claim encounter data received by the TennCare Division of IS. The amount reimbursed to Consultec/First Health was reconciled with the claims data sent with the respective invoice, but the claims data were not, in turn, reconciled with the encounter data.

Inadequate monitoring of the MCCs could result in TennCare paying duplicate claims, paying claims on behalf of ineligible recipients, and paying the MCCs more than the MCCs paid out to the providers.

Recommendation

The Director of TennCare should ensure that adequate monitoring of the MCCs is performed and that it specifically addresses the five critical control areas.

The Director should ensure that

- procedures are developed to monitor TPL collection for BHO, MCO, dental, and pharmacy claims in accordance with the *Code of Federal Regulations*;
- procedures are implemented to prevent BHO, MCO, Doral Dental, and First Health providers from being reimbursed more than once;

- reports of all months of potentially ineligible enrollees are sent to the BHOs for follow-up and review and that reports are returned from the BHOs timely;
- check registers are received and compared to the invoices for all MCOs;
- the MCO invoices are reconciled to the claims data;
- reconciliations of MCO and Doral invoices to claims data are documented for all months and necessary corrective action is taken and documented for any discrepancies discovered;
- the current-year amounts reimbursed to the MCOs and the encounter data received by the TennCare Division of IS are reconciled; and
- procedures are developed to reconcile dental and pharmacy claims data to encounter data obtained by the TennCare Division of IS.

In the future, when TennCare management decides that other areas will be paid on a fee-for-service basis, it should ensure that all critical areas are identified and subsequently monitored, and that action is taken on the monitoring results.

Management's Comment

We concur. TennCare has made and will continue to make improvements in the monitoring of payments to Managed Care Contractors (MCC). The most notable improvement in this area will be the identification and handlings of questioned costs associated with MCC encounter data. During this audit, a request was submitted by the Fiscal Services Division to Information Systems for a report identifying potential questioned costs made by the MCCs such as duplicate payments and dead or ineligible enrollees. Although a preliminary report was produced and sent to some MCCs, we have found that the information in the report should be refined. Once the refined report is received by Fiscal Services, it will once again be forwarded to the appropriate MCC for evaluation. MCCs will be provided 30 days to respond with comments and what appropriate corrective actions were taken. Once returned by the MCC, the returned file will be reviewed by Fiscal Services staff to ensure that adequate justification is provided for those payments that are found to be appropriate, and necessary action is taken for other payments.

As noted in the finding, TennCare initiated the process of establishing a Third Party Liability (TPL) Unit within the Fiscal Services Division. This unit's primary responsibility will be to maximize TennCare's TPL recoveries. Once established, this unit will be able to look retrospectively against TennCare claims for additional TPL recoveries. We will continue to improve monitoring of TPL activities used by the BHO and maximize TPL in this area. The MCCs have various TPL activities today, and additional efforts around TPL collections will be pursued retroactively to the earliest legally allowable date. More specifically, contract language between TennCare and each MCO not only requires that each MCO perform TPL activities, but TennCare also encourages MCO's to have a robust TPL program by allowing the MCOs to recover some administrative costs of an approved MCO's TPL program. See contract excerpts below:

Third Party Resources

“The CONTRACTOR shall exercise, full assigned benefit rights and/or subrogation rights as applicable and shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to enrollees under this Agreement and recover any such liability from the third party”.

“Failure to seek, make reasonable effort to collect and report third party recoveries shall result in liquidated damages”.

Medical Expenses (Amendment 6)

“If approved by TennCare, the TPL or subrogation recoveries may be the net of administrative expenses incurred that are related to recovery activities”.

The Fiscal Services Division has also made noticeable improvements in documenting the results from internal control procedures. Specifically, more detailed explanations are maintained for the variances between claims data, the check registers, and the invoices for both the PBM and DBM. When unexplained differences do occur, payment will be made on the lesser of the amounts reported and notice will be forwarded to management. These same procedures will be integrated into the MCO payment process as well. The CFO has directed Fiscal Services to assign responsibilities to all necessary reviews and document completion of the reviews and results.

We have also entered into an agreement with the Comptroller’s TennCare Division to perform procedures to review the claims processing accuracy and reporting accuracy of data to TennCare by the MCOs, DBM, and BHO. This work will supplement the audit schedule of the Department of Commerce and Insurance, TennCare Oversight Division, the goal being to increase the number of reviews performed each year.

The Office of HealthCare Informatics has assigned dedicated resources working on (1) the fiscal year 2004 high-level MCO invoice/encounter reconciliation, and (2) the fiscal year 2005 monthly on-going MCO and pharmacy invoice and encounter reconciliations concurrently.

The final MCO reconciliation summary for fiscal year 2004 will be provided to the CFO for review by June 2005. In February 2005, the Bureau began conducting monthly (on-going) invoice/encounter reconciliations for July 2004 MCO and PBM invoice submissions. During this process, systems related issues occurred, requiring further modification to the reconciliation methodology. Staff are continuing to develop alternative plans of action to resume monthly reconciliation.

The progress made to date was done despite losing three analysts in the last 18 months. The Bureau will continue to implement and revise its reconciliation process of all MCOs, PBM, and Dental invoices to encounter files.

5. TennCare incorrectly issued an \$8,000,000 check to a provider

Finding

TennCare failed to follow established financial policy and procedure, and as a result, incorrectly issued an \$8,000,000 check to an institutional Medicare cross-over provider on August 15, 2003.

Medicare cross-over recipients are eligible for both Medicare and Medicaid, and are required by Medicare to pay coinsurance and a deductible to the provider for services received. Because the recipient is eligible for Medicaid, Medicare cross-over providers bill TennCare instead of the patient for the coinsurance or deductible amounts. In July 2003, a county hospital contacted TennCare and requested an increase from \$50.75 to \$97.50 in the Medicare coinsurance amount for a claim previously submitted for a cross-over recipient. Staff of Electronic Data Systems (EDS), the contractor hired to maintain and operate the system, manually enter adjustments of this type. However, because EDS made a data entry error, the claims data relating to the amount billed and the deductible for the claim in question were incorrectly increased to \$8,000,097.50 and \$8,000,000, respectively. This error resulted in TennCare generating an \$8,000,000 check to the hospital. The provider received and endorsed the check; however, the provider immediately returned the check to TennCare when it realized the error. We examined the voided check.

According to TennCare management, there were procedures in place to review and verify the accuracy of all manual adjustments. These procedures, dated January 2003, are included in EDS's *Financial Procedures Manual*. The procedures require all manual adjustments to be verified accurate by a person other than the individual performing the initial update. Had these procedures been followed, the keying error would have been detected and corrected in a timely manner prior to the check being issued. In addition, TennCare indicated that system edits were established to suspend any institutional cross-over claim over \$10,000. However, according to EDS staff, the edit was never operational.

According to TennCare and EDS management, system modifications to the new TennCare Management Information System (interChange) are being put in place that will identify payment anomalies and suspend the payment for manual review. According to EDS management, until these edits are in place, EDS will run a weekly series of queries and reports to identify claims that exceed defined monetary thresholds. All claims identified will be manually reviewed and compared to supporting documentation by EDS staff.

Following prescribed procedures and having working system edits in place are essential in preventing erroneous payments to providers, which could remain undetected.

Recommendation

The Director of TennCare should ensure that policies and procedures regarding the review of manually adjusted claims are adequate and that EDS staff responsible for this review follow the policy. We also recommend that the Director ensures that the new TennCare Management Information System (interChange) has appropriate system edits in place to identify checks over a certain amount in order to facilitate a review by management prior to issuance.

Management's Comment

We concur. TennCare's investigation determined that although the contractor does have the previously described process to verify manual adjustments, it failed to identify this keying error. Again as stated, the contractor's documentation for the legacy TCMIS identified an edit to suspend any institutional crossover adjustment in excess of \$10,000 for additional review and approval. This edit, however, was never implemented and thus failed to suspend the claim. Additionally, TennCare staff review a sample of the remittance advices for each payment cycle generated by EDS to determine the accuracy of the payments prior to authorizing their release. Unfortunately, this claim was not part of the sample selection and thus not reviewed.

TennCare's Informatics' staff also analyzed all payments made by EDS in the fiscal year ended June 30, 2004 to determine if any other aberrant payments were issued. That search identified no payments other than the one discussed in this finding. This analysis is now routinely performed on a quarterly basis. In response to this finding, TennCare also verified that a maximum payment edit to preclude errors of this type was installed and operational in the new interChange system.

It should be noted, that this error **did not** result in the loss of state or federal funding as the check was returned by the provider. Additionally, the TCMIS contract language provided that "The Contractor shall be liable for overpayments and duplicate payments if adequate documentation to determine accuracy of processing is not maintained by the Contractor or if the Contractor fails to utilize available information or fails to process correctly." Therefore, had the check not been returned, EDS would have been liable for the overpayment. Additionally, TennCare assessed EDS the maximum allowable liquidated damage for making this error.

- 6. As noted since 1999, TennCare is still violating the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled in the way claims are paid for services provided to the mentally retarded and developmentally disabled**

Finding

As noted in the prior five audits, TennCare has contracted with and paid Medicaid providers in violation of the terms of the Medicaid Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (HCBS MR/DD waiver). The

Code of Federal Regulations (CFR), Title 42, Part 431, Section 10(e) (3), allows other state and local agencies or offices to perform services for the Medicaid agency. As a result, the Bureau of TennCare has contracted with the Division of Mental Retardation Services (DMRS) (both the Bureau and DMRS are within the Department of Finance and Administration) to oversee the HCBS MR/DD waiver program. However, after five years of repeated findings, TennCare continues not to comply with HCBS MR/DD waiver requirements regarding claims for services.

The prior audit finding noted the following:

- TennCare did not make direct payments to providers of services covered by the waiver and allowed claims to be processed on a system not approved as a Medicaid Management Information System.
- TennCare is not paying DMRS the same amount DMRS pays providers.
- TennCare allowed DMRS to combine services without waiver approval.

These issues continue to be problems. Even though management concurred or concurred in part with these prior audit findings the first four years, management decided not to concur last year.

Testwork revealed that TennCare has continued to inappropriately pay DMRS as a Medicaid provider. DMRS in turn has continued to treat the actual Medicaid service providers as DMRS vendors. According to Medicaid principles, as described in the *Provider Reimbursement Manual*, Part I, Section 2402.1, DMRS is not a Medicaid provider because it does not perform actual Medicaid services.

Failure to Process and Pay Claims on Approved MMIS

Furthermore, the waiver agreement also requires provider claims to be processed on an approved Medicaid Management Information System (MMIS) and provider payments to be issued by TennCare. Under Appendix F of the HCBS MR/DD waiver, TennCare has selected the payment option which states, “All claims are processed through an approved MMIS.” However, under the current arrangement, TennCare has allowed DMRS to process claims on its own system and make payments to providers through the State of Tennessee Accounting and Reporting System (STARS).

In response to the previous audit finding for year ended June 30, 2003, management stated:

We do not concur. We do not agree with the Centers for Medicare and Medicaid Services on this issue and will work with them on a resolution. Payments made by the Division of Mental Retardation Services (DMRS) for services provided through the Home and Community Based Services (HCBS) waivers were not made directly to individual providers or via an approved Medicaid Management Information System during the audit period; however, payments made by TennCare to DMRS for services provided through the HCBS waivers were made

through the approved TennCare Medicaid Management Information System. We believe this arrangement is in compliance with federal regulations. . . .

In our rebuttal, we noted that management explicitly stated that it disagrees with the Centers for Medicare and Medicaid Services (CMS), the federal grantor, on the issue of processing and paying claims on an approved Medicaid Management Information System. We stated that the current waiver agreement between CMS and TennCare requires provider claims to be processed on an approved Medicaid Management Information System and provider payments to be issued directly by TennCare.

In response to this issue in the audit finding for year ended June 30, 2002, management stated:

We concur that the payments made by the Division of Mental Retardation Services (DMRS) were not made via an approved Medicaid Management Information System during the audit period. Direct provider payment has been discussed at meetings with the system contractor for inclusion in the design of the new system. Staff from DMRS and the TennCare Division of Long Term Care (TDLTC) have participated in TennCare Management Information System planning sessions and have made it clear that the new system must be able to accommodate direct provider payment for mental retardation (MR) waiver providers. Implementation is scheduled for October 2003. In addition, direct payment of providers and a simplified rate structure have been included in the Infrastructure Development and Corrective Action plan for the MR waiver programs. . . .

In response to this issue in the audit finding for year ended June 30, 2001, management stated:

Federal regulations allow providers to reassign payment to DMRS. Signed provider agreements include reassignment of payment of DMRS. However, we concur that the payments made by DMRS were not made via an approved MMIS system. TDLTC has had meetings with TennCare Information Systems staff, Fiscal staff and Provider Services staff to begin developing mechanisms for direct provider payment. . . .

In response to this issue in the audit finding for year ended June 30, 2000, management stated:

. . . During the request for proposal and contract process with interested new fiscal agents, the possibility for direct provider payment and voluntary reassignment of provider payment to DMRS will be explored. . . .

In response to this issue in the audit finding for year ended June 30, 1999, management stated:

. . . Provisions will be implemented that allow the provider voluntary reassignment of their service payment to a government agency, i.e., DMRS, with the ability to cancel the arrangement should he choose to receive direct payment from the Medicaid agency. As a long-term goal, we will work toward the federal requirement that the Medicaid agency make payments directly to the provider of services. This effort will not be completed for several years due to computer system limitations.

While the HCBS MR/DD waiver document has an option which could allow payments to be made through a different system, this option was not selected by TennCare. TennCare in the HCBS MR/DD waiver also indicated that providers may voluntarily reassign their payment to DMRS. However, the provider agreements in effect during the audit period required the provider to accept payment from DMRS since direct payments through the TennCare Management Information System (TCMIS) were not possible during the audit period. The Centers for Medicare and Medicaid Services (CMS) agreed with our position and have instructed TennCare to comply. A report dated July 27, 2001, on a compliance review conducted by CMS for the HCBS MR/DD waiver stated:

Section 1902(a)(32) requires that providers have the option of receiving payments directly from the State Medicaid Agency. The state should modify its payment system to comply with this requirement.

In an approval letter of the cost allocation plan, CMS stated,

. . . We are particularly concerned about the findings that TennCare has been making Medical Assistance Payments (MAP) for the MRDD HCBS under their waiver directly to DMR [DMRS], instead of making the payments directly to the actual service providers. . . .

TennCare Is Not Paying DMRS the Same Amount DMRS Pays Providers

Testwork revealed as it has been reported in the previous five audits that TennCare is not paying DMRS the same amount DMRS pays providers because DMRS has paid waiver claims outside the prescribed waiver arrangements. The waiver is designed to afford individuals who are eligible access to home and community-based services as authorized by Section 1915(c) of the Social Security Act. Regulations require any claims submitted by providers for services performed for waiver recipients to be processed in accordance with all applicable federal regulations and waiver requirements, and the state to receive the federal match funded at the appropriate federal financial rate.

The billing and payment process used by TennCare and DMRS is as follows:

1. Medicaid service providers perform services for waiver recipients.
2. Providers bill DMRS for services at rates agreed upon by DMRS and its providers.

3. DMRS pays providers based on rates established by DMRS, not the rates in the waiver. The DMRS rates are sometimes higher and sometimes lower than the waiver rates.
4. DMRS bills TennCare based on the waiver rates.
5. TennCare pays DMRS the waiver rates using the TCMIS.

In an approval letter of the cost allocation plan, CMS stated:

. . . [DMRS] Using their own payment system separate from the TennCare Management Information System, the DMR paid the actual HCBS providers for their services in accordance with entirely different fee schedules that they negotiated and agreed upon in their contracts (or provider agreements) which were never approved by TennCare. For the most part, DMR was in fact administering the State's HCBS waiver and was simply billing the TennCare Bureau as the funding source for the waiver services rendered to the Medicaid eligible recipients. In accordance with the provisions of the Social Security Act and with the terms of the federally approved waiver, the State should only be claiming MAP [Medical Assistance Payments] at the Federal Medical Assistance Percentage (FMAP) for waiver services costs that it pays directly to the actual providers of the HCBS. . . .

In management's six-month follow-up report to the Division of State Audit regarding the 2003 finding, management stated:

TennCare submitted HCBS-MR waiver renewal applications for the statewide and Arlington waivers with revised rate structures to CMS on February 23, 2004. The waiver renewal would revise the HCBS rate structure so that TennCare will pay the Division of Mental Retardation Services (DMRS) the lesser of the TennCare waiver service rate (not the average rate payment specified in the waiver) or the amount paid by DMRS to the waiver service provider. The waiver services definitions were also revised to eliminate combined services. However, on May 10, 2004, TennCare requested CMS to stop the 90-day review clock to allow for submission of additional information and to request a 90-day extension of the current approved waivers. CMS approved the requests to extend the waivers for 90 days and to stop the 90-day review clock. New waiver applications and 90-day extensions of the current waivers were submitted to the Centers for Medicaid Services on September 15, 2004.

Proposed changes to the TennCare Management Information System, in order to correct the way that claims are being processed and paid, would ensure that the rate DMRS is paying to HCBS providers is the exact amount TennCare is reimbursing DMRS. The Comptroller's Office, Medicaid Division, has reviewed cost settlement data prepared by the Department of Mental Health and

Developmental Disabilities (DMHDD). However, denied claims data has not yet been verified so the settlement has not been completed. The anticipated completion date is not yet known.

Management concurred in part with this portion of the prior-year audit finding and stated:

. . . TennCare is paying DMRS the rates established in the waiver and approved by CMS. These payments are paid on an interim basis and are being cost settled to ensure that no amounts greater than the waiver rates are paid. . . .

In our rebuttal, we noted:

Although management concurred in part, it is not clear from management's comments with which part it does not concur. Management acknowledges that DMRS is not paying providers rates established in the waiver and approved by CMS, and that a cost settlement will be necessary to ensure approved waiver rates have not been exceeded. TennCare in effect has allowed payments to providers outside the prescribed approved waiver rates. It is unclear when a cost settlement will occur.

In the audit for year ended June 30, 2002, management also concurred with this issue in the prior-year audit finding and stated:

We concur that until approval of the cost allocation plan, DMRS administrative expenses are partially reimbursed by TennCare. . . .

Also, regarding DMRS' paying waiver claims outside the prescribed waiver agreement, management stated in response to the finding for the year ended June 30, 2001:

We concur that DMRS has been paid in accordance with the rates in the waiver and that, in most cases, the rates paid to providers by DMRS have been different. The rates in the approved waiver document are estimated average rates. It is common for states to contract with providers for rates that are different than the average rates in the waiver to accommodate for differences in regional cost of living and staffing costs. The goal is for the rates paid to average what has been approved in the waiver application for FFP. The amount paid to DMRS in excess of what was paid providers was intended to provide reimbursement to DMRS for administrative cost of daily operations for the waiver program. The amounts realized via this mechanism do not, in fact, cover all the administrative costs incurred by DMRS; therefore, DMRS is not "profiting" from this arrangement. However, we intend to include in TennCare's contract with DMRS a description of payment for administrative services in accordance with the cost allocation plan approved by CMS (verbal notification has been received approving the cost allocation plan and official notification is expected soon). The cost allocation plan includes a process to perform a year-end cost settlement.

This response was similar to the response for the year ended June 30, 2000. TennCare included in its contract a section entitled “payment methodology” and described the payment of administrative costs through the cost allocation plan.

While DMRS may not be recovering enough money through the claims reimbursement process to pay its providers and fund all administrative costs, it should be noted that administrative costs should be claimed using a cost allocation plan. Under the current arrangement with the Bureau, any profit (the excess of TennCare’s reimbursements to DMRS over DMRS’ payments to providers) from the reimbursement of treatment costs would be inappropriately used to pay administrative costs.

The federal government has also noted this inappropriate practice of using claims reimbursement to partially fund administrative costs in the CMS compliance review report dated July 27, 2001, in which CMS stated:

The State Medicaid Agency reimburses the DMRS for the services and DMRS reimburses the providers. It appears that, in some cases, the DMRS reimburses providers less than the payment received from the Bureau of TennCare. Governmental agencies may not profit by reassignment in any way, which is related to the amount of compensation furnished to the provider (e.g., the agencies may not deduct 10 percent of the payment to cover their administrative costs). To do so places the agency in the position of “factor” as defined in 42 CFR 447.10(b). Payment to “factors” is prohibited under 42 CFR 447.10(h).

Testwork specifically revealed that because TennCare has not ensured that DMRS complied with the waiver and federal regulations, TennCare paid DMRS more than DMRS had paid the providers in 4 of 5 claims (80%). TennCare paid DMRS less than DMRS paid the providers on the other claim. In total for the 5 claims examined, TennCare paid \$14,719 to DMRS, and DMRS paid the providers only \$12,095.

As noted in finding 7, testwork on the sample of five also revealed that some of these claims were not adequately approved and/or documented. As a result, the questioned costs relating to the inadequate approval and/or documentation have been reported in finding 7. Hence, no additional questioned costs relating to the differences in payments will be reported in this finding.

Combined Services Without Approval

In the prior three audits, it was noted that DMRS contracted with providers who were providing a service described as community participation (CP) combo. Combo services are provided by DMRS to individuals in the HCBS MR/DD waiver. DMRS provides many different combo services. However, the HCBS MR/DD waiver does not allow any combination of services.

In response to the prior-year audit finding, management stated:

We concur that approval of “bundled services” in the Home and Community Based Services (HCBS) waivers for the mentally retarded was not previously obtained from the Centers for Medicare and Medicaid Services (CMS). To resolve this finding, on February 23, 2004, TennCare submitted waiver renewal applications for HCBS waiver #0357 and HCBS waiver #0128.90.R1 with revised waiver service definitions. CMS is currently reviewing the waiver renewal applications.

Management had also concurred with this portion of the 2002 audit finding and stated:

We concur that approval of “bundled services” has not been sought from CMS. . . . TDLTC and DMRS intend to remedy the issue regarding flexibility in the provision of day services through revision of waiver definitions for the waiver renewal application that will be completed within the next 6 months.

Management had also concurred in part with the 2001 finding and stated in response to that finding:

CMS has indicated that it is permissible to allow a combination of day services, as long as the provider is not paid for two day services that are billed during the same period of time. TDLTC will have further discussions with CMS and DMRS pertaining to the way DMRS has elected to pay for combination services. The system will be revised as necessary to comply with federal regulations and ensure appropriate payment for services rendered. TDLTC will monitor for overpayment via survey and post payment review.

In addition, a transmittal letter from HCFA (the Health Care Financing Administration, now known as CMS) dated January 23, 1995, stated:

For a state that has HCFA approval to bundle waiver services, the state must continue to compute separately the costs and utilization of the component services to support final cost and utilization of the bundled service that will be used in the cost-neutrality formula.

During fieldwork, we asked long-term care staff for documentation that CMS has approved this type of combo service. Management stated that on February 23, 2004, TennCare submitted a waiver renewal application to CMS to include changes in the waiver service definitions. However, TennCare has stopped this process to make additional changes, and the new application was submitted on September 15, 2004.

Recommendation

Note: This is the same basic recommendation made in prior audits.

Failure to Process and Pay Claims on Approved MMIS

The Director of TennCare should take immediate action to comply with all federal requirements, including those in the waiver. The Director should also ensure that TennCare pays providers in accordance with the waiver.

TennCare Is Not Paying DMRS the Same Amount DMRS Pays Providers

TennCare management should discontinue its practice of paying lip service to the finding by continuing to refer to pending requests for exceptions as excuses for noncompliance with clear requirements. By annually repeating this strategy, management has circumvented the clear rules for reimbursements while responding in a way to try to make it appear that they are meeting the spirit of the rules while only seeking continuing clarification of the letter of the rules. After six years, it is time for management to stop posturing and to comply with the rules. Circumvention of rules as a management policy reflects a control environment that prioritizes form over substance and rewards attempts to justify noncompliance through stalling maneuvers rather than a good-faith commitment to compliance with the spirit and the letter of rules even when that compliance requires departure from the status quo and effort to make needed changes in policy and procedure.

For providers paid through the DMRS system, the Director should ensure that TennCare pays DMRS the lesser of the approved TennCare waiver rate or the amount paid by DMRS to the providers.

Combined Services Without Approval

The Director should ensure that TennCare has CMS approval for all bundled services.

Management's Comment

Management concurs that this finding has been repeated in the last five audits and that it has taken an excessive time to resolve. Management, however, does not concur that it has attempted to circumvent the rules, nor is that our management policy. Management takes this audit finding, as well as all of our findings, very seriously and has devoted extensive resources to resolving the findings. It should be noted that of the 48 findings in the 2002 audit, 35 have been resolved with only 13 of those findings repeated in this audit, as well as an additional two new findings for a total of 15. Additionally, the narrative of seven of the 13 repeat findings states that although the issue is not fully resolved, that the finding in 2003 documents that substantial progress has been made. We believe that these statistics speak for themselves to support the level of commitment by TennCare management to resolving these findings.

Although this finding was not resolved by the end of the audit period on June 30, 2004, TennCare was working closely with the Centers for Medicare and Medicaid Services (CMS) to resolve the disagreement involving the requirement that TennCare make direct payments to providers of services through an approved MMIS, as well as, to get approval for reimbursing DMRS providers for bundled services. Both of these issues have now been resolved in the new TennCare waivers. TennCare, with the assistance of the Comptroller's Office and the Department of Finance and Administration, is also well on the way to finally completing a reconciliation of payments to DMRS for services and administrative costs for the period July 1, 1996 to June 30, 2003 in accordance with the CMS approved Cost Allocation Plan. After completion of that time period, we will complete fiscal years 2004 and 2005 reconciliations. TennCare also worked with DMRS and the Comptroller's staff to develop a new reimbursement methodology that would assure that all DMRS providers would be paid consistent rates and that the amounts paid by TennCare to DMRS would be the same amount that DMRS paid to its providers.

Failure to Process and Pay Claims on Approved MMIS

The renewals of the waivers effective on January 1, 2005, admittedly after the end audit period, include approvals of TennCare to reimburse DMRS for payments made by them to providers. This documentation has been provided to management of the Division of State Audit.

TennCare Is Not Paying DMRS the Same Amount DMRS Pays Providers

We concur. As stated earlier, we are in the process of cost settling the prior periods to address payment differences in accordance with the CMS approved cost allocation plan. DMRS is putting procedures in place to bill TennCare the amount DMRS paid the provider beginning with dates of service January 1, 2005, as well as to place frequency limitations on a number of the services. DMRS' computer system is not currently capable of billing TennCare using specific dates of service for procedures with frequency limitations, but they are working to correct this situation. Their current computer software is antiquated and no longer supported by the software vendor, making it impractical to upgrade the current software to this new requirement. DMRS will be manually applying the frequency limitations prior to billing TennCare concurrent with implementing new computer software that complies with the date of service requirements. It is anticipated that DMRS will have their new computer software in place in early 2006, after which the manual intervention will no longer be required.

Combined Services Without Approval

We concur. Effective January 1, 2005, CMS approved the waiver application renewals for the HCBS waivers #0357.90 and #0128.90.R2A. The waiver renewals contained revised definitions which were approved by CMS, including those which had bundled services.

7. Since 1999, some of TennCare's providers could not provide documentation to substantiate services associated with fee-for-service claims under the Medicaid Home and Community Based Services Waivers

Finding

As noted in the previous five audits, some of TennCare's providers did not have documentation to substantiate services associated with fee-for-service claims under the Medicaid Home and Community Based Services (HCBS) Waivers. Although the state is operating under a waiver from the federal Centers for Medicare and Medicaid Services (CMS) to implement a managed care demonstration project, more and more services are being paid on a fee-for-service basis.

We tested a sample of 100 claims (which included all areas of TennCare that operated on a fee-for-service basis during the audit period) to determine the adequacy of documentation supporting the medical costs associated with these claims for services. This review consisted of obtaining support for the sample of claims such as medical records, pre-admission evaluations, and service plans for HCBS Waiver recipients. Testwork revealed problems with 4 of 100 claims (4%) paid by TennCare. Specifically, the following issues were noted:

- For three HCBS Mentally Retarded/Developmentally Disabled (MR/DD) Waiver claims, service plans associated with these claims either could not be located or were not signed prior to services being provided. According to the *Operations Manual for Community Providers*, Chapter 2, billing cannot be claimed for services prior to the development and authorization of the service plan.
- For one HCBS MR/DD Waiver claim, the documentation provided did not support the service billed and was not adequately documented. Therefore, we could not determine that the service was medically necessary. Also, the service plan associated with the claim could not be located.

The total amount of questioned costs for the four claims noted above was \$14,477 out of a total of \$159,654 tested. Federal questioned costs totaled \$9,778. The remaining \$4,699 was state matching funds. The total amount of the population sampled was \$5,891,280,941. We believe likely questioned costs exceed \$10,000 for this condition. In addition the amount TennCare paid the Division of Mental Retardation Services (DMRS) for these four claims was not the same amount DMRS paid to the actual provider. (See finding 6 for more information on this issue.)

Management concurred with the prior audit finding regarding missing or unsigned service plans and supporting documentation and stated:

DMRS [the Division of Mental Retardation Services] will be required to submit a corrective action plan within 30 days of receipt of the audit findings. The TennCare Division of Developmental Disability Services will review and approve the plan and monitor to ensure the implementation of corrective actions.

We noted that TennCare submitted on May 12, 2004, a request to DMRS to notify TennCare within 30 days of the corrective action taken by DMRS to resolve the finding. However, according to TennCare management, DMRS did not submit the corrective action until September 2004.

Based upon discussion with various management personnel during the audit, it was determined that TennCare uses a variety of techniques to review medical documentation. These techniques included reviewing providers that prescribed excessive amounts of drugs, as well as focused reviews on certain services. Although management is reviewing selected areas, based upon our examination of medical documentation, it still appears that additional effort is needed to ensure that providers maintain the required documentation.

Without having adequate documentation that medical services are provided and are consistent with the medical diagnosis, TennCare is paying for and billing the federal government for undocumented and thus unallowable medical costs.

Additional Questioned Costs

In compliance with Office of Management and Budget Circular A-133, we are required to report all known questioned costs if likely questioned costs exceed \$10,000 for a compliance requirement. The compliance requirement "Allowable Costs/Cost Principles" has total questioned costs exceeding \$10,000. Therefore, we are required to report known questioned costs as follows:

- TennCare did not recover \$782 of patient liabilities for enrollees in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled, causing TennCare to pay more for services than necessary. Of this amount, \$528 was federal questioned costs. The remaining \$254 was state matching funds.
- For one pharmacy claim, the claim was not net of all applicable credits. According to the TennCare Management Information System, the individual had third-party liability; however, no third-party liability was deducted. Federal questioned costs totaled \$56. The remaining \$27 was state matching funds. The Office of Management and Budget A-133 Compliance Supplement, which references the *Code of Federal Regulations*, Title 42, parts 135 through 154, requires that:

States must have a system to identify medical services that are the legal obligation of third parties, such as private health or accident insurers. Such third party resources should be exhausted prior to paying claims with program funds. Where a third party liability is established after the claim is paid, reimbursement from the third party should be sought.

Recommendation

The Director of TennCare should ensure that providers maintain the required documentation to support costs charged to the program. The Director of TennCare should consider expending additional resources to conduct reviews of medical records. The Director of TennCare should assign specific responsibility to a member of management to ensure that the scope of work is expanded in regard to verifying medical necessity and that adequate documentation exists to support services billed. The Director of TennCare should ensure that all service plans are maintained and signed before services are provided.

The Director and all staff should recognize the possibility that undocumented charges could represent fraudulent charges and should take appropriate actions.

Management's Comment

We concur. After review by TennCare, a revised DMRS Provider Manual was promulgated by DMRS in March of 2005. The Provider Manual clearly outlines provider responsibilities, including the need for providers to adequately document all services provided and to have appropriately completed and signed service plans.

However, we do not concur that the improper documentation noted in the second bullet in the finding should be considered questionable simply because it could not be located. TennCare and DMRS made significant efforts to recover a copy of the documentation supporting the claim, including utilizing the resources of the Office of the Inspector General. However, the provider has filed bankruptcy and would not produce the documentation. In addition, the *Code of Federal Regulations*, Title 42, Section 433.318, "Overpayments involving providers, who are bankrupt or out of business," provides that the agency is not required to refund the federal share of the overpayment due from a bankrupt provider. Therefore, despite TennCare's concern that the claim documentation could not be recovered, there is no federal overpayment amount.

Effective February 1, 2005, TennCare established a separate Utilization Review Unit in the Division of Developmental Disability Services to perform postpayment claims review and medical necessity reviews of fee-for-service claims. The Utilization Review Unit manager and one nurse reviewer were hired for this unit in February of 2005, and efforts are underway to hire a third nurse. Instances of inappropriate billing that are identified during utilization review activities will be referred for recoupment or fraud investigation, as appropriate. As part of the Annual State Assessment, TennCare continues to review service plans to ensure that plans are completed appropriately and signed before services are reimbursed.

Finally, we have implemented edits in the TCMIS to detect claims from DMRS that have patient liability and possible third party resources.

8. Since 1995, there have been weaknesses in internal control over TennCare eligibility

Finding

The prior nine audits of the Bureau of TennCare have noted internal control weaknesses over TennCare eligibility. Management concurred in part with the prior audit findings, as discussed throughout this finding. The issues noted regarding invalid social security numbers, and enrollees' eligibility reverification remain uncorrected. Additionally, although improvements have been made, we noted one ineligible enrollee in a sample of 60 enrollees.

The Department of Human Services (DHS) has the responsibility for eligibility determinations for TennCare Standard and TennCare Medicaid. The Department of Children's Services (Children's Services) is responsible for eligibility determinations of children in state custody. Children's Services enrolls children in state custody in both TennCare Standard and TennCare Medicaid. TennCare receives daily eligibility data files from the DHS eligibility system, the Automated Client Certification and Eligibility Network (ACCENT), which update information in the TennCare Management Information System (TCMIS).

Invalid and Pseudo Social Security Numbers Again Discovered

This issue was first reported in the audit for the year ended June 30, 1997. In that audit, we discovered that some TennCare participants had fictitious or "pseudo" social security numbers. For purposes of this finding, pseudo social security numbers are those numbers beginning with 888 that are assigned by TennCare to individuals who enroll without social security numbers. Invalid social security numbers include all other numbers where the first five digits indicate a range of numbers that have not been assigned by the Social Security Administration. In response to the 1997 finding, management stated that the reverification project would help to ensure that valid numbers are obtained from enrollees. The audit report for the year ended June 30, 1998, reported that there were still some enrollees on TennCare's system with uncorrected "pseudo" social security numbers. In response to that finding, management stated that "Health Departments included information in their training that addressed validation of Social Security Numbers and obtaining a valid number for enrollees with pseudo numbers." In the audit report for year ended June 30, 1999, we reported that there were still some enrollees on TennCare's system with uncorrected "pseudo" social security numbers. The response to that finding ignored the "pseudo" social security numbers issue. In the audit report for the year ended June 30, 2000, we again reported that TennCare had some enrollees with uncorrected "pseudo" social security numbers. In response to that finding, management stated "it is our intent to address this issue as a part of our planning for the new TCMIS." In the audit report for year ended June 30, 2001, we again reported that some individuals had uncorrected "pseudo" social security numbers in TennCare's system. In response to that finding, management stated, "There are pseudo social security numbers in the TCMIS and the Bureau is working on a means of validating and correcting them through the Social Security Administration (SSA)." In the audit report for year ended June 30, 2002, we reported that there were enrollees on TennCare's system with uncorrected invalid and "pseudo" social security numbers. In response to that finding, management stated, "the TCMIS assignment of pseudo social security numbers occurs for newborns to the system. Benefits for illegal/undocumented aliens are issued with pseudo

numbers, since they cannot get a SSN legally. These are the only cases that will never have a ‘real’ SSN.” In the audit report for the year ended June 30, 2003, we once again reported that there were enrollees other than newborns and illegal aliens on TennCare’s system with uncorrected invalid and “pseudo” social security numbers.

TennCare Management concurred in part with that portion of the 2003 audit finding and stated,

. . . To further assure that invalid and pseudo SSNs are corrected and/or updated appropriately and timely, TennCare Information Systems and Member Services have developed additional procedures. Monthly reports are generated of recipients in the TCMIS with current eligibility who have invalid and/or pseudo social security numbers. Reports on invalid social security numbers are based on Social Security Administration (SSA) web-site criteria. Reports on pseudo social security numbers provide information based on whether an enrollee is an alien or a non-alien and also based on whether the enrollee is under 1 year old or 1 year and older. The TennCare Information Systems staff quality check the reports and send the invalid social security numbers to the TennCare Member Services Troubleshooting Unit.

Member Services validates and performs outreach to assure that the incorrect social security number is corrected through the social security number on SOLQ (the Social Security Administration’s database) or the DHS ACCENT system. If the social security number is verified, then no additional action is taken. If ACCENT indicates another social security number, the staff person again goes to SOLQ for verification. If verification is still not possible, outreach is made to the individual to verify the social security number.

Once a number is verified through SOLQ, TCMIS may then be updated with the correct number. Social security numbers that are active DHS or SSI (Supplemental Security Income) cases must be corrected by the appropriate agency. For any records that Member Services cannot validate, the record is referred back to the source agency for validation. This follow-up process was implemented after our previous audit findings and we will continually work to improve the process to gain and maintain acceptable results in an appropriate and timely manner.

We determined that procedures have been implemented to identify individuals with invalid social security numbers. Based on discussion with TennCare staff, we determined that the reports for the pseudo social security numbers mentioned in management’s comments were not generated until March 2004. Management’s plan was to submit these reports to the various intake agencies (DHS, Children’s Services, and the Department of Mental Health and Developmental Disabilities) for follow-up and correction. Based on discussion with TennCare staff, problems with the DHS reports caused delays. In addition, TennCare management stated that reports were sent to Children’s Services beginning March 2004. However, no action had been taken by Children’s Services with regard to working the reports.

We used computer-assisted audit techniques (CAATs) to search TCMIS. Our search revealed that 7,437 TennCare participants had invalid or pseudo social security numbers as of July 2004. We had eliminated participants that appeared to be newborns (less than one year old) or illegal/undocumented aliens eligible for emergency services (using criteria provided by TennCare). We analyzed this file and determined that 3,041 of the participants had been identified in the prior year as having invalid or pseudo social security numbers and were still on TennCare as of June 2004. From this population, a sample of 30 participants was selected for testwork. Results indicated that of the 30 participants, TennCare or its contractors had correctly updated TCMIS or ACCENT subsequent to July 2004 to reflect valid social security numbers for eight participants. Two additional participants had been terminated in July 2004. However, for 20 of the 30 participants (67%), we noted that neither TennCare nor its contractors had updated TCMIS or ACCENT to reflect valid social security numbers as of September 30, 2004. All of these 20 enrollees had been on TennCare continuously since March 2003 or earlier.

The total amount paid during the audit period for the 20 individuals with uncorrected pseudo social security numbers was \$20,563. Federal questioned costs totaled \$13,416. The remaining \$7,147 was state matching funds. The amount of questioned costs could not be determined for the remaining 3,011 enrollees not examined.

According to the *Code of Federal Regulations*, Title 42, Part 435, Section 910(a), “The agency must require, as a condition of eligibility, that each individual (including children) requesting Medicaid services furnish each of his or her social security numbers (SSNs).” In addition, according to the *Code of Federal Regulations*, Title 42, Part 435, Section 910(g), “The agency must verify each SSN of each applicant and recipient with SSA [Social Security Administration], as prescribed by the Commissioner, to insure that each SSN furnished was issued to that individual, and to determine whether any others were issued.” TennCare is also required to follow *Rules of the Department of Finance and Administration, Bureau of TennCare*, Chapter 1200-13-14-.02(2)(a), which states, “To be eligible for TennCare Standard, each individual must: . . . 5. Present a Social Security number or proof of having applied for one, or assist the TDHS [Tennessee Department of Human Services] caseworker in applying for a Social Security number, for each person applying for TennCare Standard.” Also, according to *Rules of the Tennessee Department of Human Services, Division of Medical Services*, Chapter 1240-3-3-.02(10), “As a condition of receiving medical assistance through the Medicaid program, each applicant or recipient must furnish his or her Social Security Number (or numbers, if he/she has more than one) during the application process. If the applicant/recipient has not been issued a number, he/she must assist the eligibility worker in making application for a number or provide verification that he/she has applied for a number and is awaiting its issuance.”

Enrollees Not Reverified

This issue was first reported in the audit for the prior fiscal year ended June 30, 2003. In that audit, we reported that one enrollee was not reverified the required number of times during the period. Management concurred with that finding and stated, “Supervisory reports are now generated indicating overdue reviews. This should ensure that Medicaid cases are reviewed on a timely basis. . . .”

Although we determined that there are procedures in place to ensure that Medicaid cases are reviewed on a timely basis, problems exist with reverification of TennCare Standard enrollees. During the year ended June 30, 2004, reverifications for TennCare Standard enrollees did not start until January 22, 2004.

A sample of all TennCare enrollees who required at least one reverification during the audit period was tested to determine if TennCare met the reverification requirements during the audit period. Of the 60 enrollees tested, testwork revealed that 13 TennCare Standard enrollees (22%) did not meet the reverification requirements during the audit period. There were no outstanding appeals for these enrollees which would allow them to retain eligibility until final determination.

Specific details from the sample testwork were as follows:

- TennCare did not begin the reverification process for ten enrollees during or after the audit period.
- TennCare did not begin the reverification process for three enrollees until after the audit period. However, the reverification process still had not been completed as of September 30, 2004.

According to the *Code of Federal Regulations*, Title 42, Part 435, Section 916, “The agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months. . . .” All enrollees sampled had been on TennCare continuously for at least the 12 months of the audit period. Without reverifying enrollees every 12 months, TennCare cannot ensure that the enrollees continue to be eligible for TennCare as individual circumstances change over time.

The total amount paid during the audit period for the enrollees after the date the enrollees should have been reverified was \$119,033. Federal questioned costs in the sample totaled \$80,246. The remaining \$38,787 was state matching funds.

Ineligible Enrollee Discovered

During the audit period, TennCare reimbursed all of the managed care organizations (MCOs), the behavioral health organizations (BHOs), the pharmacy benefits manager (PBM), and the dental benefits manager (DBM) for services provided to enrollees. TennCare continued to pay for other services on a fee-for-service basis. These services included Medicare cross-over claims, claims for enrollees in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled, nursing home claims, and claims paid to the Department of Children’s Services for services provided for children in state custody or at risk of state custody.

A sample of 60 claims was selected from the above population in order to test the eligibility of the related enrollees. Testwork revealed one of 60 enrollees (2%) was not eligible to be on TennCare during the dates of service. Our review of ACCENT and discussion with DHS personnel revealed that the enrollee was first selected by TennCare for reverification on

August 30, 2002, and came in for an appointment on October 28, 2002. The person was denied for being over the income limits on October 30, 2002, and was appropriately sent a medical eligibility (ME) packet to complete and return to TennCare. TennCare received the ME packet on December 2, 2002. According to management at DHS, the packet was incomplete and it was returned to the enrollee with a deadline for the enrollee to complete and return the packet by February 3, 2003. The enrollee continued to remain on TennCare despite the fact that the enrollee failed to return the ME packet on time. Furthermore, there were no open appeals pertaining to the case which would allow the enrollee to remain on the program. This enrollee's eligibility should have ended on February 3, 2003; however, it did not. As a result, the enrollee was not eligible during the July 7, 2003, date of service indicated on the claim.

We believe that because of the nature, complexity, and magnitude of the TennCare program, there will always be some payments of this type in the program. Nevertheless, we are required by federal Office of Management and Budget Circular A-133 to report this issue as a finding because likely questioned costs exceed \$10,000. The cost paid by TennCare for the claim in question was \$9. The total sample amount of claims paid for the 60 enrollees tested was \$72,085. Federal questioned costs totaled \$6. The remaining \$3 was state matching funds. The total paid for enrollees in the population sampled was approximately \$5.9 billion. In addition, we identified costs totaling \$517 that were paid for the ineligible enrollee from July 1, 2003, through June 30, 2004. Federal questioned costs totaled \$324. The remaining \$193 was state matching funds.

Recommendation

Note: For the issues that have been repeated in this finding over the years, this is the same basic recommendation that has been made in many past audits.

The Director should ensure that valid social security numbers are obtained for all individuals in a timely manner. The Director should ensure that all TennCare recipients are reverified at least once every 12 months. The Director should continue to ensure that only eligible enrollees are receiving TennCare, and all ineligible enrollees are removed from the program in a timely manner.

Management's Comment

We concur in part. While the Bureau of TennCare cannot deny that errors are found in the day to day process of determining and verifying TennCare eligibility for nearly 1.4 million Tennesseans, we do believe management has taken the previous audit findings seriously and has implemented multiple processes along the way to address these issues and assure information be as accurate as possible. Further, there are several federal regulations that have not been noted in the finding that acknowledge eligibility errors and alleviate financial responsibility within specific guidelines. Additionally, Federal requirements recognize errors and/or delays that may occur in eligibility determinations that are designed to protect an enrollee and prohibit the state from terminating an individual until such matters can be determined.

TennCare continues to follow existing procedures, in accordance with federal regulations, to monitor eligibility errors. The *Code of Federal Regulations*, Title 42, Part 431, Section 810, addresses basic elements of a traditional Medicaid Eligibility Quality Control (MEQC) plan that relieves financial liability for states that operate within a 3% eligibility error rate. TennCare operates under an alternative plan as approved by HCFA (now CMS) in August 2000; (“As with MEQC pilot projects approved in non-1115 states, alternative MEQC programs approved in 1115 states are relieved of any liability for disallowances for errors that exceed the 3-percent tolerance (as provided in CFR 42-431.865) for traditional Medicaid eligibles and for individuals added under the waiver.”) While TennCare continues to refine and improve our processes to ensure only eligible individuals are enrolled, the terms of our MEQC plan relieve TennCare of liability for errors resulting from eligibility determinations.

TennCare has consistently provided results of MEQC reviews to the Centers for Medicare and Medicaid Services. The Department of Human Services was found to be correct in 96.98% of the sample Medicaid cases for the federal fiscal year (FFY) 2003 as required for reporting to CMS in August 2004. TennCare was found to be correct in 99.63% of sampled waiver cases for eligibility determinations.

Invalid and Pseudo Social Security Numbers

We concur in part. There are legitimate reasons for assigning pseudo social security numbers to certain enrollees (newborns, aliens, persons applying for social security numbers, etc.). The Bureau of TennCare developed and implemented an extensive policy as well as a corrective action plan for correcting and/or updating pseudo social security numbers (SSNs) for enrollees who do not meet the acceptable criteria. We continue to identify and correct invalid and pseudo social security numbers through research and outreach activities or through the annual redetermination process.

While we disputed the actual number of pseudo numbers that were identified in last year’s audit report, the comparison of the 3,041 participants that this year’s finding indicates as repeats is a significant decrease from the 14,687 noted in the previous year’s finding. The significant decrease is a direct result of TennCare’s increased efforts to follow current and develop new policies as needed. TennCare delayed implementing portions of the policies and procedures awaiting the implementation of the new TCMIS interChange system. However, since implementation, TennCare has mailed initial notices to enrollees with pseudo SSNs who meet the specified criteria (no appeal cases or DCS children, etc.) and is preparing to mail final termination notices to enrollees who have not responded.

The finding indicated there were 20 enrollees with invalid or pseudo SSNs that were still on TennCare. Depending on the selected criteria for notices, as described in the Pseudo Policy, there will not always be a termination date; therefore, this is not always a valid expectation.

- Eighteen (18) of the cases were Adoption Assistance children. DCS children are a vulnerable population and it has been TennCare’s decision to work with DCS to identify solutions to update our files with valid SSNs and not disenroll a child in this vulnerable setting for this reason until all possible solutions have been exhausted.

DCS has had policies in place for Adoption Assistance children to remove a child's valid social security number from their files and replace it with a pseudo in order to protect the child from abusive situations, in accordance with state law. SSA, in a recent policy publication, has determined that they will no longer issue new numbers for these children unless a stringent set of criteria is met. (See SSA policy at: <http://www.ssa.gov/pubs/10093.html>). This setback has delayed the cleanup efforts to replace the pseudo SSNs with re-issued numbers. DCS is in the process of designing a new system within their infrastructure. This new system will have different features in place to protect case files for children, as required by state law, which will permit DCS to continue to use original valid SSNs in most cases. The implementation of this system should prevent additional cases from adding to the pseudo list and will necessitate a follow-up process to go back and reassign children their valid SSN. The completion of the entire systems upgrade will be achieved over a period of time. The general goals are as follows:

- In January 2005, a new security measure was installed that allows only authorized individuals access to a child's pre-adoptive history. Additionally, this will allow DCS to link cases by adding an additional field that will match a child's new and current social security numbers.
- In September 2005, there will be an additional upgrade to the system. This upgrade will allow for there to be a separate field to record the pseudo SSNs generated by TennCare. This will make it possible to prepare a file of clients reporting both the client's SSN and the client's pseudo SSN.
- The long-term resolution will be accomplished in the new FACETS system that DHS is implementing, which will determine eligibility for all departments and money streams. Both departments are collaborating on this build. DHS will replace ACCENT with FACETS in 2007.

The Bureau is continuing to work with DCS to develop a plan to reassign valid SSNs for these children.

- One individual was identified as being an illegal alien. In accordance with federal regulations and TennCare's Pseudo Policy, illegal aliens will never have a valid SSN and therefore, this enrollee should not be represented in this finding. They must however, be provided emergency services in accordance with the federal Emergency Medical Treatment & Labor Act (EMTALA) provisions, and therefore require the assignment of pseudo SSNs.
- We concur that one individual had a SS5 date and no termination date.

Enrollee Not Reverified

We do not concur. The *Code of Federal Regulations*, Title 42, Part 435, Section 916 specifically refers to Medicaid enrollees and TennCare's 1115 Waiver outlines eligibility determinations for TennCare Standard eligibles. Further, compliance with timelines for

eligibility reverification must be reviewed with consideration to the circumstances as they relate to other existing federal requirements as well as state law and court orders. For example:

- 42 CFR 435.911(c) allows for unusual circumstances for timely determination of eligibility requirements;
- 42 CFR 435.911(e)(2) prohibits a state from denying eligibility because it has not determined eligibility within time standards; and
- 42 CFR 435.930(b) requires the state to continue to furnish eligibility until an individual is determined to be ineligible.

In accordance with TennCare's 2002 1115 Waiver, the Bureau implemented an initial reverification project to bring all TennCare Standard enrollees current and allow the Bureau of TennCare to be proactive with selection for reverification of this population as is with the Medicaid eligible population. However, the Court Order that TennCare received in December 2002 required the Bureau of TennCare to cease **ALL** reverification efforts and reinstate previously termed enrollees. Due to the events and timeframes outlined within the Court Order or as a result of the Agreement to the Court Order, it was impossible to meet a 12 month reverification timeline. Once the Bureau was able to resume reverification on January 22, 2004, the decision was made to begin with the individuals who remained unverified from the initial round and then move toward individuals who were entering the program and coming up for an initial review. Furthermore, there were additional policies implemented as a result of the Agreement to the Court Order which cause individuals' reverification date to move forward or be bypassed. Due to the sheer volume created by these circumstances, it became impossible to assure that enrollees were reverified within a 12 month period.

Enrollees that were not selected for reverification within a 12 month period all came into the program immediately prior to or following the Court Order and therefore fall into the criteria for moving their reverification date forward. TennCare consistently mailed monthly mailings of reverification notices during Round 2 that began January 22, 2004 to all individuals who have been eligible for more than 12 months with the exception of the enrollees who met the bypass criteria (SPMI population, individuals with appeals, individuals with a pending status in the ME process).

Based on the judicial events and revisions to policy and procedures that have been required, and in light of the federal regulations that recognize errors and/or delays in eligibility determinations (specifically for terminating eligibility) that are designed to protect an enrollee and prohibit the state from terminating an individual until such matters can be determined (as described above), it is TennCare's position that renewal procedures for all TennCare Standard enrollees have been conducted in accordance with the intent of federal and state requirements.

Ineligible Enrollee Discovered

We do not concur. TennCare does not disagree that there was an ineligible enrollee discovered in TCMIS. However, as supported by our explanation of the processes we described in last year's response to this finding, it is not TennCare's intent to allow an ineligible enrollee to

remain on the program indefinitely, but it is our intent for the processes to identify potential ineligible enrollees for resolution. As described in our general comments, there are several federal requirements that recognize errors and/or delays that may occur in eligibility determinations, as well as requirements for MEQC procedures to be approved by CMS and utilized by the state agency, for which TennCare is in compliance.

Auditor's Rebuttal

Invalid and Pseudo Social Security Numbers Again Discovered

Concerning the illegal alien, our review revealed that the individual applied for TennCare Standard and was determined eligible in June 2002. Eligibility was terminated in July 2004; however, the individual filed an appeal in August 2004, and eligibility was reinstated pending resolution of the appeal, which is still unresolved as of April 19, 2005. While the *Code of Federal Regulations*, Title 42, Part 440, Section 255(c), allows the Medicaid state agency to provide emergency services to illegal aliens, the two-year period of eligibility in this case does not appear to meet the definition of emergency services cited in the federal regulations.

Enrollees Not Reverified

Management's comments do not address 42 CFR 435.916, which addresses periodic redeterminations of Medicaid eligibility. The portion of the code that management does cite, 42 CFR 435.911, appears to address initial eligibility determinations of new enrollees, an issue we do not address in the finding.

Ineligible Enrollee Discovered

Management does not concur but states, "TennCare does not disagree that there was an ineligible enrollee discovered in TCMIS."

The MEQC plan and the other regulations referred to by management do not relieve management of the responsibility to terminate ineligible individuals from the program.

According to the *Code of Federal Regulations*, Title 42, Part 431, Section 800, the MEQC is a required program which is designed to "reduce erroneous expenditures by monitoring eligibility determinations. . . ." Furthermore, the *Code of Federal Regulations*, Title 42, Part 431, Section 865, establishes rules and procedures for disallowing federal financial participation in erroneous medical assistance payments due to eligibility errors "as detected through the Medicaid eligibility quality control (MEQC) program." The errors noted in the finding were not errors identified by TennCare's MEQC program but were, in fact, errors resulting from a lack of adherence to procedures to remove enrollees who were clearly ineligible for TennCare services from the program.

We will continue to report, as required by Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, costs questioned for

ineligible enrollees. The ultimate resolution of these questioned costs is the responsibility of the U.S. Department of Health and Human Services.

9. Terminated employees still have access to the TennCare Management Information System, and TennCare needs to improve documentation of system changes

Finding

As noted in the six previous audits, one of the most important responsibilities, if not the most important, for the official in charge of an information system is security. The TennCare Management Information System (TCMIS) contains extensive recipient, provider, and payment data files, processes a high volume of transactions, and generates numerous types of reports. One factor that is critical to the integrity of the TennCare program is deciding who needs access and what type of access to permit. Good security controls restrict access to data and transaction screens on a “need-to-know, need-to-do” basis.

Subsequent to the previous audit, management corrected a problem related to justification forms not being obtained for all users. In other areas, the error rates have not been as high as in the past. However, for the audit period ending June 30, 2004, we continue to note deficiencies in controls over TCMIS security.

Not All Users Needed the Access Granted (This portion of the finding has been reported in one previous audit.)

The prior audit finding noted that TennCare has allowed TCMIS users more access than was needed or failed to terminate users when necessary. Management did not concur with this portion of the prior-year finding but stated:

. . . We have incorporated procedures each year based on audit recommendations as well as evaluating our own internal security processes. TennCare is committed to having procedures in place that provide a high confidence level that only the users that need access to the system have access to the system and that users have appropriate access levels. . . .

Current testwork revealed that for the year ended June 30, 2004, 6 of 60 TCMIS users (10%) had access that was not needed. The details follow:

- One user who works at the Department of Finance and Administration did not request access to TCMIS and does not require it for her job.
- Five users were no longer state employees or state contractors. Four of the users received their access through the Department of Health, and one user received her access through TennCare.

System Changes to TCMIS Were Not Adequately Documented, and Procedures Over System Changes Need Improvement (This portion of the finding has been reported in one previous audit.)

TennCare partially concurred with this portion of the prior-year finding and stated,

. . . TennCare has implemented additional procedures to document, track and report all SCRs [system change requests] and WRs [work requests] to the TennCare Information Systems Director. . . .

Although we determined that TennCare improved the tracking of SCRs and WRs by requiring more details to be maintained on the system logs, weaknesses remained. For the year ended June 30, 2004, we found problems with 16 of 60 program changes (27%) that were tested. The objectives of our work were to determine if TennCare had a program change authorization form, if approval of the change was documented, and if there was a description of the change. The problems were as follows:

- For eight program changes, TennCare IS personnel could not provide documentation of approval by TennCare IS and/or the requestor prior to when the changes were moved into the production environment. TennCare IS personnel did have program change authorization forms and did have a description of the program change documented.
- For seven program changes, TennCare IS personnel did not have a program change authorization form and there was no documentation that the changes were approved by IS and/or the requestor when the changes were moved into the production environment, but there was a description of the change documented.
- For one program change, TennCare IS personnel did not have a program change authorization form or program documentation that contained a description of the change, and there was no documentation of approval by TennCare IS and/or the requestor prior to the changes being moved into the production environment.

In addition, the Production Move Log, which serves as a log of all TennCare program changes, is updated manually by EDS Production Control personnel. Manual updates of the log increase the risk that some production moves will not be recorded in the log. In the prior-year finding, TennCare stated that “there have been no instances that TennCare can identify where any production move has been omitted.” However, without adequate documentation of the changes and because of the manual log process to document these changes, the risk that unauthorized production moves could occur and not be detected by TennCare increases.

Recommendation

The Director of Information Systems should ensure that personnel responsible for security maintain periodic communication with contractors and other state agencies to which they grant access to ensure that all access granted is needed and that terminated individuals have

their access removed. The Director of Information Systems should ensure that adequate processes are in place to ensure that program changes are adequately documented and approved for the new system.

Management's Comment

Not All Users Needed the Access Granted

We concur. As referenced in the audit finding, the error rate with the current audit is *significantly lower than in past years*. The decrease in the error rate resulted from the implementation of additional procedures relating to security, recommendations from previous audits, and revision of existing procedures. Historically, TennCare has relied on business unit managers/supervisors to notify the TennCare security team when an employee leaves/terminates. In addition, users having access to the TCMIS from external entities are required to provide TennCare with notice when an employee no longer needs access as a result of termination or change in job duties. As noted in this finding, there were six (6) users having access deemed as not required. Five (5) of these individuals were from external state agencies. The sixth individual was an internal contractor no longer employed. Once the security team was made aware of these individuals, access was immediately terminated.

Additionally, subsequent to the end of the audit period, we implemented additional procedures for terminating and granting access to the system including the receipt of a weekly list of active terminations. This report is reviewed by the security team and terminated individuals are deleted. TennCare also sends monthly reports of active users to the business units for review, and now actively tracks the responses to assure timely receipt. As a result, there has been significant improvement in the notification process.

Equally important, we receive periodic reports on users not logging into the system for a significant period of time (30 days). Additionally, an enhancement of the new TennCare TCMIS is to automatically lock out individuals who have not accessed the system in 30 days. These users must contact the security team to renew their access privileges. The process for granting and terminating access to the system has been greatly enhanced and we will continue to review security processes for quality control to ensure we are performing due diligence with regard to this finding.

TennCare has also hired a system Security Officer who has conducted a review of all internal security procedures, and the resulting changes have significantly enhanced this area. We are currently in the process of issuing security policies and procedures for TennCare IS. The procedures listed above have been incorporated in the Information Systems Security Procedures manual. TennCare further plans to enhance the level of security by expanding this function, which should greatly improve the control of access to the TennCare system by employees of TennCare, as well as other state agencies.

System Changes to TCMIS Were Not Adequately Documented, and Procedures Over System Changes Need Improvement

TennCare partially concurs with this portion of the finding as stated.

Effective September 2, 2004, TennCare implemented the following additional procedures to document, track, and report all system change requests (SCRs) and work requests (WRs).

- All new system change requests (SCRs and WRs) are reviewed, numbered, and logged by TennCare IS each day.
- Analysis and monitoring of SCRs and WRs is performed in weekly meetings with EDS. This review includes requests being carried forward from the old TCMIS as well as the new ones associated with the new TCMIS interChange (iC) system.
- Status updates on outstanding requests (SCRs and WRs) are received weekly from EDS. Completed requests are sent for state verification. TennCare IS logs are updated as status is received.
- The Data Center Move Log indicates each daily change made affecting the system, including the associated SCR or WR number. This log is monitored to ensure changes to the production programs are documented and approved by the state. Program changes are kept in a temporary library until the next scheduled release of the production iC TCMIS.
- EDS schedules a new release of the production iC TCMIS approximately every two weeks. Any modules that have been updated and shown on the Data Center Move Log that are being propagated into the base system code are reviewed and approved by the TennCare Change Control Board, which is made up of participants from TennCare IS, TennCare Policy, OIR, and EDS. The first Change Control Board meeting was held November 12, 2004.
- We are in the process of implementing a software program to track changes to the system. This will replace some of the manual tracking that is currently occurring. All SCRs and WRs initiated since July 1, 2004 have already been entered into this system, and are being tracked through this system in parallel with our manual tracking logs. Some management reports are also being produced out of this system.

Although we partially concur that TennCare needed improvement in the tracking of SCRs and WRs for the year ended June 30, 2004, the previously referenced changes outlined have significantly enhanced our internal control. TennCare has recently created and is currently staffing a Contract Management Unit that is designed to track and monitor all change requests (WRs, SCRs and PCRs). The tracking program that is being installed will be mandated for EDS and, as such, there will be a consolidated list of the status and priority of all outstanding requested changes. The Contract Management Unit is tasked to ensure all change requests are monitored to final resolution and meet all contract performance and responsibility requirements.

10. For the second year, TennCare’s administrative appeals process needs improvement

Finding

As noted in the previous audit, TennCare’s administrative appeals process needs improvement.

TennCare Standard applicants and enrollees have the opportunity to appeal and have an administrative hearing regarding the denial of their application, the effective coverage date, cost-sharing disputes, and disenrollment from TennCare. TennCare Standard applicants and enrollees have 40 days from the date of the adverse action to submit an appeal to the TennCare Bureau. By policy and practice in effect during the audit period,

- TennCare reinstates coverage for enrollees who have filed an appeal within 20 days of the adverse action and processes the appeal;
- TennCare does not reinstate coverage for enrollees who have filed an appeal between the 21st and 40th days but processes the appeal; and
- TennCare does not process appeals received after the 40th day and notifies the enrollee that the appeal was not filed within the appeal time frame.

The *Code of Federal Regulations* (CFR), Title 42, Part 431, Section 244, requires that TennCare process and resolve administrative appeals within 90 days of receipt of an appeal. According to TennCare management, if TennCare is unable to resolve the appeal within 90 days, the appellant is provided interim TennCare coverage until final resolution of the appeal. As a result, TennCare may provide coverage to appellants who are not eligible for TennCare Standard.

Management concurred in part with the prior-year finding and stated:

... While the TennCare Deputy Commissioner has taken action to reorganize the administrative appeals system within the Member Services Division to ensure a more efficient process with sufficient controls and prompt administration and proper tracking of appeals, he does not have complete control over administrative decisions being rendered within 90 days. While we attempt to have administrative hearings and the resulting decision within 90 days, it is not always possible for resolution to occur within that time period. There are multiple reasons for hearings and decisions on the appeal to be rendered beyond the 90 days. One example occurs when an enrollee requests a continuance of his/her hearing, and the hearing official grants the continuance over an objection by the state. Another example occurs when the hearing is conducted within 90 days, but the hearing official is delinquent in issuing the order.

Notwithstanding the changes referenced above, the TennCare Bureau is currently working with the Department of Human Services (DHS) to streamline the appeals

process for eligibility and other administrative appeals and to set up within DHS an appropriate structure of administrative personnel to process these hearings in a timely manner. DHS will process the appeals and the hearings will be conducted by hearing officials within the Office of the Secretary of State. We believe that this restructuring will result in a more efficient process for enrollees and applicants and will reduce the timeframes that go beyond the 90-day requirement.

According to management, the administrative appeals process will to be moved to DHS in January 2005. During fieldwork, we selected a sample of 25 of 17,097 enrollees whose administrative appeal exceeded the 90-day federal requirement. Based on testwork performed, it appeared that for 18 of 25 administrative appeals (72%), the delays were attributed to factors beyond the Bureau of TennCare's control. However, for 7 of 25 administrative appeals (28%) that exceeded the 90-day federal requirement, TennCare could not provide documentation to explain and/or justify the delays.

The Rosen lawsuit requires TennCare to continue to provide services to enrollees when TennCare does not meet the 90-day requirement. The costs related to these enrollees will not be questioned in this audit because the *Code of Federal Regulations*, Title 42, Part 431, Section 250, states that the agency may receive federal financial participation for services provided under a court order. However, when unnecessary delays occur, the state and the federal government are subject to additional costs of providing services to enrollees until the result of the appeal is determined.

Recommendation

The Director of TennCare should take immediate action to ensure that appeals are processed and resolved within the 90-day federal time requirement or document when delays are beyond TennCare's control. Once this process is moved to DHS, the Director of TennCare should continue to work with DHS as necessary to ensure that appeals are processed timely by identifying impediments to timely resolution and making changes to the process accordingly.

Management's Comment

We concur. TennCare contracted with the Department of Human Services to process administrative appeals. Effective January 4, 2005, DHS began processing administrative appeals received November 15, 2004 forward. TennCare's Member Services Division has been and will continue to work with and train DHS staff to process these appeals.

TennCare gave DHS the additional resources (staffing and equipment) needed to process appeals more efficiently and timely. The resources are as follows:

Intake Unit—20 positions
Conciliation Unit—101 positions
Hearing Prep—46 positions

Total new positions—167 positions

Note: TennCare previously had a total of 70 positions.

The Conciliation Unit was given the most positions to attempt an early resolution of the cases. Further, DHS has a new tracking system, Appeals Resolution Tracking System (ARTS), that will facilitate reports required by TennCare daily, weekly and monthly.

TennCare is also providing consulting support consisting of eligibility appeals experts to facilitate monitoring while DHS is providing reports to TennCare regarding timeliness.

11. Although TennCare management continues to acknowledge its responsibility to take action in this matter, for the fifth consecutive year TennCare does not have a court-approved plan to redetermine or terminate the TennCare eligibility of SSI enrollees who become ineligible for SSI

Finding

As noted in prior audit findings in the previous four audits, TennCare does not redetermine or terminate the TennCare eligibility of Supplemental Security Income (SSI) enrollees who become ineligible for SSI. This is because TennCare still does not have a court-approved plan which would allow TennCare to make a new determination of the eligibility of these enrollees. According to 1200-13-13-.02(1)(c) of the *Rules of the Tennessee Department of Finance and Administration, Bureau of TennCare*, “The Social Security Administration determines eligibility for the Supplemental Security Income (SSI) Program. Tennessee residents determined eligible for SSI benefits are automatically eligible for and enrolled in TennCare Medicaid benefits.” However, when an individual enrolled in TennCare as an SSI enrollee is terminated from SSI, TennCare does not redetermine or terminate the enrollee’s eligibility. Currently, TennCare does not terminate SSI recipients unless the recipient dies, moves out of state and is receiving Medicaid in another state, or requests in writing to be disenrolled. This issue was first reported in the audit for year ended June 30, 2000. Management concurred in part with that audit finding and stated:

. . . The State is prohibited by court order from disenrolling persons who have been enrolled in TennCare as SSI recipients at any time since November 1987, unless these persons die or move out of state and indicate a wish to be transferred to the Medicaid program in their new state. These individuals are carried on the TennCare rolls as Medicaid eligibles, which means that they have no copayment obligations. Until such time as the State can terminate the TennCare eligibility of former SSI enrollees, we believe it makes more sense to focus our reverification efforts on those enrollees who could actually be disenrolled from the program. . . .

However, in the audit for the year ended June 30, 2001, we reported that TennCare still did not have a court-approved plan which would allow TennCare to make a new determination of the eligibility of these enrollees. Management concurred with this finding and stated:

The Director will ask the Attorney General to take action to bring this issue back before the court for final disposition. . . . The AG will be asked to present this decision, coupled with assurances that eligibility review will be performed by the Department of Human Services to determine whether the individual qualifies for any other category of TennCare benefits (including the right to appeal if DHS determines that the individual is no longer eligible for any category of benefits) to the Court with a request to set aside or modify its November 13, 1987, Order. A positive finding by the Court could lift the injunction and permit the disenrollment, if appropriate, of those individuals who have been provided continuous Medicaid and TennCare benefits following termination of SSI.

In the audit finding for year ended June 30, 2002, we reported that TennCare had drafted a plan dated July 12, 2002, that would allow the Bureau to make a new determination of the eligibility of enrollees who become ineligible for SSI, once the court approves the plan. In that finding, it was noted that management stated that the plan would be submitted to the Attorney General, who will in turn present the plan to the court for court approval. In response to that finding, management stated:

We concur. In an effort to obtain Court approval, the proposal referenced in the finding was submitted to the Attorney General with a request that it be submitted to the Court for approval. The Attorney General has requested additional information regarding systems and programmatic implementation of the proposal. This information is to include such things as a detailed methodology for systems matching to determine current addresses for persons terminated from SSI who have not utilized TennCare benefits. In addition, the Department of Human Services is developing a process to provide the reviews required by the Daniels Order to determine if persons who have been terminated from SSI qualify for other distinct categories of benefit eligibility. The Attorney General will submit the proposal to the Court when the implementation plans are complete. When the Court has reviewed the proposal and approved or modified it, it will be implemented.

In the previous audit finding for year ended June 30, 2003, we reported that TennCare added the additional information to the proposal as requested by the Attorney General. We noted that in June 2003 TennCare presented the proposal to counsel for the Daniels' class action lawsuit, but agreement could not be reached. Management did not concur with that finding and stated:

TennCare management has approached Plaintiff's attorneys numerous times and thus far, Plaintiff's attorneys have been unwilling to accept any plan dealing with de novo eligibility determinations for the SSI class. TennCare management has been involved in ongoing discussions with the Plaintiff's attorneys regarding all TennCare related lawsuits. While settlement agreements have been reached in several of these cases, the parties have not come to an agreement related to the Daniels' Order. Although it is not possible to determine whether Plaintiff's

attorneys will ever accept a plan submitted by TennCare, TennCare management will continue to work with the Plaintiff's attorneys and when the parties reach an agreement, it will be submitted to the court for approval. TennCare is continuing to terminate these individuals due to death and when the individual is receiving Medicaid in another state or requests termination in writing.

As stated in our rebuttal to that finding, management has not taken issue with any statements made in the finding or the recommendation.

Based on discussions with TennCare legal staff during fieldwork, TennCare and the Plaintiff's attorneys still have not reached an agreement for the Daniels' class action lawsuit. Management stated that TennCare is currently in discussions with the Department of Human Services to draft a new proposal detailing how the de novo (new) determination of Medicaid eligibility can be made. Once the new proposal is complete, TennCare will present the proposal to Counsel for the Daniels' class. Once an agreement is reached, the Attorney General will submit the proposal to the court. After the court approves the proposal for the court-approved plan, TennCare will implement the court-approved plan.

The *Cluster Daniels et al. vs. the Tennessee Department of Health and Environment et al.* court order states,

. . . defendants are hereby ENJOINED from terminating Medicaid benefits without making a de novo [a new] determination of Medicaid eligibility independent of a determination of SSI eligibility by the Social Security Administration. The Court further ENJOINS defendants to submit to the Court and to plaintiffs, within thirty (30) days of entry of this Order, the plan by which defendants have implemented de novo determination of Medicaid eligibility. . . .

Furthermore, the court has required that the Medicaid program must determine whether or not the recipient's termination from SSI was made in error.

Management has stated that TennCare follows the direction of the Attorney General's office concerning how to comply with the court order. We requested information from the Attorney General's office on this matter and received a response dated October 17, 2001, which stated:

There is no reason that the affected state agencies (Bureau of Medicaid/TennCare, Department of Human Services) cannot or should not proceed to attempt to comply with the district court's orders and injunction by devising a plan which would satisfy the requirements of those orders. (Under the terms of the Court's orders, the Court will have to approve any State plan to make de novo determinations of Medicaid eligibility independent of determinations of SSI eligibility by the Social Security Administration.) Furthermore, we understand that a number of efforts have been made over the years following entry of those orders to devise a plan which would satisfy the orders' requirements. The efforts have included extensive negotiations between counsel for plaintiffs, counsel for

the federal defendants, the Attorney General's office and the Tennessee Department of Human Services (which makes, under law, the Medicaid eligibility determinations). Unfortunately, these efforts have been unsuccessful to date.

By not having a court-approved plan that would allow TennCare to determine if terminated SSI recipients are still eligible for TennCare and to terminate ineligible enrollees, TennCare is allowing potentially ineligible enrollees to remain on TennCare until they die, move out of state and receive Medicaid in another state, or request in writing to be disenrolled.

According to TennCare management, there were approximately 153,000 non-dual SSI enrollees and approximately 139,000 dual SSI enrollees at June 30, 2004. Dual enrollees are enrollees receiving Medicaid (TennCare) and Medicare benefits. Of these, approximately 55,000 non-dual and 70,000 dual enrollees have lost SSI eligibility but remain on TennCare without a new determination of eligibility because TennCare does not have a court-approved plan. As a result, TennCare does not know how many of the approximately 125,000 would be currently eligible under existing eligibility guidelines.

According to a recent study concerning per capita costs for the TennCare Program, the average estimated MCO cost per SSI enrollee for fiscal year 2004 is \$524.07 per month for non-dual enrollees and \$278.67 per month for dual enrollees. Based upon these average costs per enrollee, the approximate cost for the 55,000 non-dual and 70,000 dual enrollees who have lost SSI eligibility but remain on TennCare without a new determination of eligibility was \$346 million and \$234 million, respectively. As a result, the total amount paid for these enrollees is approximately \$580 million for year ended June 30, 2004.

Recommendation

The Director of TennCare should continue efforts to work with the counsel for the Daniels' class action lawsuit to develop and implement a court-approved plan that would allow TennCare to determine if terminated SSI recipients are still eligible for TennCare and terminate ineligible enrollees.

The Director should continue to ensure that TennCare complies with all court orders and injunctions that relate to the eligibility of SSI enrollees.

Management's Comment

We concur. TennCare's position has not changed since the last audit. The Deputy Commissioner will continue to work towards a court-approved proposal with Plaintiff's counsel. TennCare also will continue to disenroll those persons who Plaintiff's counsel has agreed that we may disenroll.

12. TennCare did not recover all costs related to deceased enrollees

Finding

Using computer-assisted auditing techniques, we performed a data match between TennCare's paid claims and encounter data and the date-of-death information on TennCare's eligibility file and on the records of the Department of Health's Office of Vital Records. The results indicated that payments of \$408,955 were made and not recovered for services on dates that were after the recorded dates of death of the recipients.

Management has developed several procedures to recover payments for claims for services occurring after the dates of death. For the fee-for-service payments paid by TennCare directly, TennCare's procedures included using a manual recovery process. For the MCO, BHO, Pharmacy, and Dental payments, the procedures included sending listings of possible deceased enrollees to the managed care contractors for explanation and recovery where appropriate.

We believe that because of the nature, complexity, and magnitude of the TennCare program, there will always be some payments of this type in the program. Nevertheless, we are required by federal Office of Management and Budget Circular A-133 to report this issue as a finding because questioned costs exceed \$10,000. Total federal questioned costs were \$276,208. The remaining \$132,747 was state matching funds.

Recommendation

The Director of TennCare should continue the manual recovery process and should continue to send listings to the managed care contractors and obtain explanations and recoveries where appropriate.

Management's Comment

We concur. It should be noted that TennCare has reduced the amount of questioned costs from the prior audit period from \$782,075 to \$408,955 this audit period, a reduction of 47.7 percent. TennCare continues to monitor for potentially deceased enrollee payments by using both manual and electronic review methods.

As part of the procedures in place, comparisons are made between the PBM's [Pharmacy Benefits Manager] weekly invoices and dates of service against the date-of-death information from Vital Records to determine if pharmacy claims are appropriate for a given week's invoice. If exceptions are found, notice is sent to the PBM to either validate the charge or reverse the charge within 30 days. A similar comparison is made of the DBM [Dental Benefits Manager] claims on a semi-monthly basis. Again, if exceptions are found, notice is sent to the DBM to either validate the charge or reverse the charge within 30 days.

As with all information concerning dates of service versus dates of death, there is an unavoidable time lag between the actual date of death and the date when that information reaches Vital Records. We have created a new report which retrospectively makes a review of the payment(s) made after an enrollee's date of death, but before the notification of death was provided to TennCare, for all payments to the MCCs [Managed Care Contractor]. We continue to work to reduce the amount of questioned costs through additional research with the MCCs. We have found that many of the questioned costs identified by the Comptroller's Office were appropriately made or recovered prior to the audit. For this reason, we anticipate that other questioned costs were appropriately handled once the research is complete.

13. TennCare charged the federal Medicaid program for payments to the Department of Children's Services, managed care organizations, behavioral health organizations, and pharmacy and dental benefits managers, for some unallowable costs

Finding

TennCare has paid the Department of Children's Services (Children's Services) and other service providers for services provided to children in state custody. Some of these payments should not have been charged to the federal Medicaid program. In accordance with its agreement with TennCare, Children's Services contracts separately with various practitioners and entities to provide Medicaid services not covered by the managed care organizations (MCOs) and the behavioral health organizations (BHOs) that are also under contract with TennCare. During the year ended June 30, 2004, TennCare paid approximately \$135 million in fee-for-service reimbursement claims to Children's Services for services provided to children in the state's custody. Additionally, TennCare makes payments for services provided to children in the state's custody to the MCOs, BHOs, and the pharmacy and dental benefits managers.

Previous audits of TennCare have identified millions of dollars that TennCare had reimbursed to Children's Services and other service providers on behalf of ineligible children. TennCare is now receiving periodic lists from Children's Services identifying children in its custody, incarcerated youth in its custody, children on runaway status, and children placed in a medical hospital; and it appears that TennCare has taken steps to put in place to use this data to identify unallowable billings. This cooperation between Children's Services and TennCare has significantly reduced the number of inappropriate billings and payments; however, through the use of computer-assisted audit techniques, we identified some unallowable payments made to Children's Services and other service providers.

Although we believe that a small number of errors of this nature are inherent in the program, we are nevertheless required by Office of Management and Budget Circular A-133 to report all known questioned costs when likely questioned costs exceed \$10,000 for a federal compliance requirement. We have identified the following questioned costs exceeding \$10,000 for the compliance requirement Allowable Costs/Cost Principles:

- TennCare made payments totaling \$216,458 for the year ended June 30, 2004, for juveniles in the youth development centers and detention centers. Of this amount,

\$137,789 was paid as direct services to the MCOs or BHOs; to Doral Dental, the dental benefits manager, for dental claims; or to Consultec and First Health, pharmacy benefits managers, for MCO and BHO drug claims. Another \$73,089 was paid to the MCOs in administrative fee payments, and \$5,670 was paid to Children's Services for services provided to children in the state's custody. Federal questioned costs totaled \$146,257. The remaining \$70,201 was state matching funds.

- TennCare improperly reimbursed \$58,455 to Children's Services for children who were not in the state's custody during the dates of service billed to TennCare. Federal questioned costs totaled \$39,481. The remaining \$18,974 was state matching funds.
- TennCare improperly paid Children's Services \$4,146 for children who were on runaway status. Federal questioned costs totaled \$2,800. The remaining \$1,346 was state matching funds.
- TennCare improperly paid \$26,951 to Children's Services for children who are in the state's custody but had been placed in a medical hospital or a behavioral health facility. These costs should have been covered by the MCO or BHO. Federal questioned costs totaled \$18,203. The remaining \$8,748 was state matching funds.
- TennCare improperly reimbursed \$8,853 to Children's Services for claims involving the same children with overlapping dates of service. Federal questioned costs totaled \$5,979. The remaining \$2,874 was state matching funds.

Recommendation

The Director of TennCare should continue to coordinate with the Department of Children's Services to minimize TennCare reimbursement to managed care organizations, behavioral health organizations, pharmacy and dental benefits managers, and Children's Services for unallowable costs. The Director should continue to coordinate with Children's Services in removing the TennCare eligibility of incarcerated youth and in implementing and maintaining proper controls to prevent billings for hospitalized children, children on runaway status, and children not in the state's custody.

Management's Comment

We concur. As stated in previous audits, it appeared that the cooperation and coordination between TennCare and DCS could be improved. For fiscal year 2004, TennCare and DCS signed an interdepartmental agreement (contract) to officially establish the parameters of billing data that TennCare receives from DCS.

This contract included numerous performance standards that are designed to reduce inappropriate DCS billings. Failure to meet these billing standards, and other standards related to lawsuit judgments, may result in penalties, or liquidated damages, that can be assessed against DCS. Per the contract's Attachment D, "Performance Standards," DCS is held to several standards that include:

Standard 4: DCS will not submit any claims to TennCare for services to children who are not TennCare-eligible, which includes children who are incarcerated.

Standard 5: DCS will not submit any claims to TennCare for services to children who are not physically present to receive the service (e.g., children who are on runaway status, children who are hospitalized).

Standard 11: TennCare will be promptly notified by DCS when TennCare-eligible children enter or leave custody and when children are in situations where they cannot receive DCS TennCare-reimbursed services (e.g., on runaway status).

Standard 19: Billings will be submitted only for DCS children in custody or at risk of State custody/placement.

TennCare has enforced compliance with these standards as is evidenced by the assessment of liquidated damages for violations that were incurred in May 2004. TennCare initiated the recoupment of the \$7,000 liquidated damage by reducing payments to the agency — effectively lowering the monthly payment for the amount of the penalty.

The amount noted in the finding as questioned costs paid for services rendered for incarcerated youth for MCO/BHO encounters has been recovered from DCS via a financial change request on March 18, 2005 for \$137,789.20. Other payments totaling \$73,088.98 for administration payments (capitation fees) to MCOs were also recovered from DCS via a financial change request on March 18, 2005. The process for recouping improper payments made to the MCOs, BHOs, PBM [Pharmacy Benefits Manager], and DBM [Dental Benefits Manager] will continue to be made when issues are identified through the review process.

With the large numbers of children in the system at DCS, cycling both in and out of custody or placement locations, there is always the chance of a timing error in eligibility data between DCS's billing cycle and information updating the TennCare eligibility files. We will continue to use the custody files from DCS to do retrospective monitoring of claims paid by TennCare and the managed care entities.

It should be noted that TennCare has reduced the questioned costs associated with this finding from approximately \$1.7 million for the audit period ending June 30, 2003, to approximately \$314,863 this audit period — a reduction of over 80 percent from FY 2003. Through cooperation with and assistance from DCS, more active monitoring procedures, enforcement of contract rules, and implementation of better automated controls, TennCare will endeavor to reduce the amount of improperly paid claims from DCS even more this coming fiscal year.

14. For the fourth consecutive year, TennCare did not approve contracts before the beginning of the contract period

Finding

As noted in the prior three audits, TennCare did not approve contracts before the beginning of the contract period. We first reported that contracts relating to graduate medical education were not approved timely during the June 30, 2001, audit. Management concurred in part and stated,

We agree that the agreements should have been signed before funds were disbursed. This was an oversight and the contracts were signed within 18 days of the disbursement.

However, in the audit for the year ended June 30, 2002, we again noted that not all contracts were approved before the beginning of the contract period. Management concurred with that finding and stated, “Every attempt will be made to ensure contracts are signed before the effective date.”

Again, in the audit for the year ended June 30, 2003, we noted that not all contracts were approved before the beginning of the contract period. Management concurred in part and stated:

. . . We concur that certain contracts were not fully executed before their effective dates. However, we have been advised by the Attorney General’s office that contracts, once executed, are effective for the period stated in the contract and that transactions occurring between the effective date and the execution date are covered by the contract. In addition, it should be noted that State contracting guidelines do not require contracts between state agencies; therefore, we disagree that payments made to DMRS [Division of Mental Retardation Services] and DCS [Department of Children’s Services] were unauthorized. If any unallowable expenses are paid to state agencies, they will be recouped. Payments were not made to other contractors before the contracts were signed. We do recognize the benefits of having contracts in place timely and will continue to attempt to ensure that contracts are signed before the effective dates.

In our rebuttal to the finding, we stated:

We did not state in the finding that “payments made to DMRS and DCS were unauthorized.” We said that the failure to have a contract in place before the contract period begins could obligate the state to pay for unauthorized services, i.e., services provided in good faith that did not correspond to the services ultimately agreed upon in the final contract. This could lead to unnecessary litigation that could have been avoided if the contracts were finalized prior to the effective date of the contract. Or, in the case of state agencies, costs that would have been borne by federally funded programs may have to be covered with state funds. Four of the 23 contracts addressed in the finding were with state entities.

During fieldwork we discussed the prior year's management comments with the Attorney General's Office. According to the Deputy Attorney General, services could legally be provided under a finalized, non-executed contract. However, according to the Deputy Attorney General, no payments should be made by a state agency before the contract is fully executed. While it is technically permissible to allow services to be provided prior to a contract's approval, it is still not in the best interest of the state.

For the current audit period, we again performed testwork on contracts and contract amendments to determine timeliness of approvals. Our testwork revealed that 25 contracts and/or amendments that had beginning effective dates between July 1, 2003, and June 30, 2004, were not fully executed before the beginning of the contract period. In addition, three provider agreements were not fully executed before the beginning of the contract period. Two of these providers were paid a total of \$1,941 for services before the agreements were fully executed.

Chapter 0620-3-3-.06(3) of the *Rules of the Department of Finance and Administration* states, "Upon approval by the Commissioner of Finance and Administration a contract shall be fully approved. . . ." A contract should serve as the legal instrument governing the activities of TennCare as they relate to the contractor and should specify the scope of services, grant terms, payment terms, and other conditions.

No Contract Amendment for Extending Contract Term for DMRS Providers

Testwork revealed that the Division of Mental Retardation Services extended existing provider agreements without appropriate authorization by TennCare, an original party to the three-party agreements between TennCare, DMRS, and the provider. We obtained copies of letters written by the Deputy Commissioner of DMRS sent to five of its providers, stating that the contract with their respective agency would be extended for the period July 1, 2004, to December 31, 2004, while a new provider agreement was being prepared. However, TennCare had no knowledge of this provider agreement extension, according to TennCare management.

Provision D.2, "Modification and Amendment," of the provider agreements in effect for July 1, 2003, to June 30, 2004, states that the contract ". . . may be modified only by a written amendment executed by all parties hereto and approved by the appropriate Tennessee State officials in accordance with applicable Tennessee State laws and regulations." In addition, Section B, "Contract Term," of the provider agreement states that the contract is ". . . effective for the period commencing on September 1, 2003, and shall end June 30, 2004. The state shall have no obligation for services rendered by the Contractor, which are not performed within the specified period."

Because TennCare failed to adequately monitor DMRS, DMRS extended the terms of service in the existing provider agreements without TennCare authorization. According to staff within DMRS Contract Services, Central Office, DMRS did not contact TennCare's Director of Developmental Disabilities Services, who is responsible for the monitoring of this program regarding the extension of the individual provider agreements. In addition, according to DMRS staff, the Director of Developmental Disabilities was not notified that any letter had been sent extending the terms of the provider agreements. We contacted TennCare's Director of

Developmental Disabilities Services, who stated that he was not notified of an extension of the contract and was not aware of the letter sent by the DMRS Deputy Commissioner.

Not having an executed contract in place at the beginning of the contract term can lead to confusion between the parties regarding the scope of services, grant terms, payment terms, and other conditions. In addition, if contracts are not approved before the contract period begins and before services are rendered, the state could be obligated to pay for services not agreed to in the final contract.

Recommendation

The Director of TennCare should assign to appropriate staff the responsibility of ensuring contracts are signed within a reasonable time before the effective dates, in order to allow adequate time for review and final approval. The Director should then monitor staff's performance and take corrective action as necessary. The Director should also ensure that no payments are made prior to fully executing a contract. The Director should ensure that DMRS is properly monitored to prevent DMRS from amending agreements TennCare is a party to without its knowledge.

Management's Comment

We concur. TennCare management has made a concerted effort to improve compliance with the Department of Finance and Administration rules in the current fiscal year. Often, contracts/amendments are signed by TennCare and submitted to the Department of Finance and Administration, Office of Contract Review (OCR) and the Comptroller's office for review before the beginning date of the contract. TennCare should have allowed more time for review by these entities. Therefore, efforts are being made to ensure that all contracts/amendments are signed by TennCare and submitted to OCR with sufficient time to ensure Comptroller approval before the actual begin date of the contract. TennCare now intends to submit contracts/amendments to OCR 60 days before the beginning date of the contract.

TennCare also is urging program administrators to work closely with contractors to identify and resolve any contract issues prior to the submission of contract document for signature. This will decrease the amount of time needed for contractor review and signature. This step will ensure timely processing prior to the beginning date of the contract.

No Contract Amendment for Extending Contract Term for DMRS Providers

We concur. Provider contracts in the HCBS waivers are three-way contracts between the provider, DMRS and TennCare. During the audit period, DMRS extended some provider contracts via letter and without the knowledge or approval of the Bureau of TennCare. On March 11, 2005, the Bureau of TennCare notified DMRS in writing that payments would not be made for services provided during the period that additional provider contracts were extended by DMRS without TennCare knowledge and approval.

TennCare is currently reviewing the provider contracting process to determine the best way to monitor and enforce this requirement. At this time, the Bureau is researching the “Pros” and “Cons” of multiple approaches and discussing them with DMRS in order to find the solution that provides the best integrity with the greatest ability for operational success for both agencies. Once a decision has been made, the Bureau will develop formal written procedures and implement the process.

15. TennCare did not have documentation to support the payment of old claims

Finding

TennCare staff paid a claim submitted by the provider beyond the allowable time frame and could not provide adequate documentation to justify overriding untimely filing edits. Previous audits have indicated numerous claims that were not paid timely, and reasons for the late payments were undocumented. In response to our last audit, TennCare’s Long-Term Care management implemented a control effective February 2, 2004, requiring an “Edit Override Authorization” form to be completed and approved by the director or assistant director of Long-Term Care whenever an untimely filing edit is overridden. We believe that there have been improvements in documenting the reasons for overriding untimely filing edits through the use of these forms. Testwork in the current audit revealed one error. Office of Management and Budget Circular A-133 requires us to report all known questioned costs when likely questioned costs exceed \$10,000 for a federal compliance requirement.

The *Code of Federal Regulations*, Title 42, Part 447, Section 45(d), “Timely processing of claims,” states,

(1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service. (2) The agency must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt. (3) The agency must pay 99 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt. (4) The agency must pay all other claims within 12 months of the date of receipt, except in the following circumstances: (i) This time limitation does not apply to retroactive adjustments paid to providers who are reimbursed under a retrospective payment system. . . . (ii) If a claim for payment under Medicare has been filed in a timely manner, the agency may pay a Medicaid claim relating to the same services within 6 months after the agency or the provider receives notice of the disposition of the Medicare claim. (iii) The time limitation does not apply to claims from providers under investigation for fraud or abuse. (iv) The agency may make payments at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, correction action, or other court order to others in the same situation as those directly affected by it.

Using computer-assisted auditing techniques, we identified 3,017 claims totaling \$431,723 that were potentially paid beyond the time frames specified in the *Code of Federal Regulations* based on dates of service and paid dates. We selected 31 claims out of the 3,017 identified and asked management for documentation to support the timely payment of the claim or the appropriate override forms. We determined that for one out of 31 claims tested (3%), TennCare made an untimely payment for a claim, and TennCare staff did not provide the related “Edit Override Authorization” form. Federal questioned costs for this claim totaled \$3,246.93. The remainder of \$1,560.49 is state matching funds. We believe that likely questioned costs for this condition exceed \$10,000.

Recommendation

The Director of Long-Term Care should continue to ensure that claims are paid within the allowable time frame. When justifiable circumstances arise and management must pay claims outside the allowable time frame, the Director must continue to ensure the decision to override is fully supported by the use of the “Edit Override Authorization” form. In addition to limiting override authority to a minimum number of individuals, the form should completely document reasons for paying late claims, who overrode the edit, and approval by a supervisor.

Management’s Comment

We concur. It is unclear from available documentation as to why this claim was paid outside of the timely filing limits. The new interChange TCMIS has improved the internal audit trail functionality that will enable us to research and respond as to why and by whom a particular claim was paid outside the obvious timely filing limits. Such information was not available in the legacy computer system.

16. As noted since 2000, the Bureau of TennCare has not adjusted estimates used to claim federal financial participation for expenditures for providing services to TennCare enrollees residing in an Institution for Mental Diseases

Finding

As noted in the prior four audits, the Bureau of TennCare has not adjusted estimates used to equal actual expenditures for services provided to TennCare enrollees residing in an Institution for Mental Diseases (IMD). TennCare did correct the issue noted in the prior audit related to having an adequate Medicaid Management Information System as required by Special Terms and Conditions (STC) 17.

STC Attachment D-5e states:

CMS [Centers for Medicaid Services] will provide FFP [Federal Financial Participation] at the applicable federal matching rate for . . . Actual expenditures for providing services to a TennCare enrollee residing in an Institution for Mental Diseases (IMD) for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days.

The special terms and conditions (STCs) required by the federal Centers for Medicare and Medicaid Services (CMS) describe in detail the nature, character, and extent of anticipated federal involvement in the TennCare waiver. CMS's approval of the waiver and federal matching contributions are contingent upon the Bureau's compliance with the STCs.

In prior audits and in the current audit, we noted that TennCare staff has used an estimate for these expenditures rather than actual expenditures as required by this STC. This issue was first noted in the audit for year ended June 30, 2000. Management concurred with this portion of the finding and stated that they "have requested updated information from Mental Health and Mental Retardation."

In the audit for year ended June 30, 2001, we reported that TennCare was still using estimated expenditures rather than actual to draw funds. Management again concurred with this portion of the finding and responded that the BHO was directed to develop a quarterly report listing that would be used to calculate the correct figures for each quarter for calendar years 2000 to date.

In the audit for the year ended June 30, 2002, we reported that TennCare in fact had not requested information on actual expenditures from the BHOs and continued to use estimated expenditures rather than actual to draw funds. Management once again concurred with the audit finding for year ended June 30, 2002, and stated,

TennCare is currently reviewing reports of enrollees in Institutions for Mental Disease that were prepared by the Department of Mental Health and Developmental Disabilities (DMHDD). DMHDD worked with the Behavioral Health Organizations to develop the report format and recently submitted reports for 1997-2001 to the Bureau for analysis. . . . Once the Bureau's analysis is complete, appropriate adjustments will be made to expenditures and federal draw amounts.

In that audit, we reported that TennCare had received reports for fiscal years 1997-2003; however, adjustments were not made to expenditures or federal draw amounts because TennCare fiscal staff was still trying to validate the accuracy of the reports.

In the prior audit, management concurred in part with the audit finding and stated:

. . . TennCare has used a process of estimating costs for Institutes of Mental Disease (IMD) on a monthly basis and will reconcile those estimates to actual

expenditures. Once the ongoing reconciliation is complete, we will submit adjustments to previous estimates of federal funds claimed. The process of using estimates and reconciling to actual costs is not an inappropriate method of claiming federal funding. We do agree that we have not reconciled timely and will complete the reconciliation as soon as practicable.

For the current audit period, TennCare has received reports for the first three quarters of fiscal year 2004. However, as of August 1, 2004, TennCare still has not adjusted expenditures or federal draw amounts. TennCare staff indicated that the reason why no adjustments had been made was because they had questions about whether this regulation applied to state institutions only or to both state and private institutions. As of August 1, 2004, management has indicated that all the previous concerns about the reports have been resolved. TennCare reduced federal draws by over \$17 million in the previous year for services not billable to the federal government. A portion of this \$17 million represents costs for services provided to TennCare enrollees residing in an Institution for Mental Diseases; however, this amount was still based on estimates rather than actual expenditures.

Recommendation

The Chief Financial Officer should make the appropriate adjustments for actual expenditures for services provided to enrollees residing in an Institution for Mental Diseases.

Management's Comment

We concur. Subsequent to the audit period, we received all the data necessary to complete the reconciliation of fiscal years 1997 - 2004. We will file the amended reports with CMS by April 30, 2005. We will make every effort to comply with this special term and condition going forward using the process we have developed.

17. TennCare failed to ensure that provider disclosure requirements were met, and failed to document that hospitals had met the prescribed federal health and safety standards

Finding

TennCare failed to ensure that provider requirements were met in accordance with the *Code of Federal Regulations*, the Centers for Medicare and Medicaid Services (CMS) *State Operations Manual*, and state law. TennCare contracts with Managed Care Organizations (MCOs); the MCOs then contract with providers to provide services to TennCare enrollees.

During the audit, we noted three specific weaknesses:

- TennCare did not ensure that all MCOs required providers to make necessary disclosures.

- TennCare’s applications with cross-over providers did not include required disclosures.
- TennCare did not maintain adequate documentation that hospitals had met the prescribed federal health and safety standards.

TennCare did not ensure that all MCOs required providers to make necessary disclosures

The objective of our testwork was to determine if TennCare ensured that the MCOs required providers to make the necessary disclosures when the MCOs entered into or renewed existing provider agreements. Based on discussions with TennCare personnel and based on our review of provider agreements, provider applications, and other provider documents, we determined that the MCOs’ provider agreements or provider applications did not include specific language which required providers to disclose ownership/controlling interest and convictions of criminal offense. Our testwork revealed that for 23 of 33 providers tested (70%), there was no evidence that the MCOs required the disclosures from the providers.

The *Code of Federal Regulations*, Title 42, Part 455, Section 106(a), states:

Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who: (1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and (2) Has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

It should be noted that after the audit period, as of July 1, 2004, TennCare amended the general MCO Contract to include the following addendum:

2-18tt. Require the provider to comply and submit to the CONTRACTOR disclosure of information in accordance with the requirements specified in 42 CFR 455, Subpart B.

Because TennCare had not required through its standard provider agreement or provider application all providers to report ownership and criminal offense disclosures, TennCare may not have been able to identify potential conflicts of interest and persons who had been convicted of criminal offenses.

TennCare’s Medicare cross-over provider application form did not require all required disclosures

During fieldwork, it was noted that TennCare’s cross-over provider application entitled “Tennessee Department of Health No. 3 Provider Application” did not require providers to disclose information about criminal offenses as prescribed by the *Code of Federal Regulations*, Title 42, Part 455, Section 106(a)(2). Instead, the provider application only required providers to attest that they have not been “. . . determined guilty of Medicaid and/or Medicare fraud . . . ”

instead of requiring disclosure of being “convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.” In addition, the provider agreement required providers to certify that they had not been convicted of a criminal offense “within a three (3) year period preceding this contract . . .” instead of since the inception of Medicare, Medicaid, and the title XX services program.

As a result, under the existing application and agreements, a provider could have been convicted of a criminal offense against Medicaid and/or Medicare more than three years ago or had a conviction which was not fraud and truthfully answer “no” to the question.

Lack of documentation that hospitals met health and safety standards

TennCare did not have documentation that hospitals met federal health and safety standards. According to the Department of Health, either a Certificate and Transmittal (C&T) form or Joint Commission on Accredited Hospitals (JCAHO) accreditation satisfies the prescribed federal health and safety standards. Based on a review of TennCare’s files, we determined that for 8 of 20 hospitals tested (40%), TennCare’s provider files did not have documentation that the provider met federal health and safety standards. We considered TennCare’s documentation to be adequate evidence that hospitals met the prescribed federal health and safety standards if

- the Department of Health C&T form “survey date” was within 15 months of the date of service or within 36 months for a JCAHO accredited hospital,
- and if the hospital was initially JCAHO accredited, the hospital met one of the following criteria:
 - its JCAHO accreditation was current as of the date of service, or
 - if its accreditation had expired, the survey was conducted within 15 months after accreditation had expired.

How often the Department of Health should generate a C&T form is dictated by the CMS *State Operations Manual*, Section 2022B, which states:

The SA [state agency] recertifies the compliance of accredited hospitals on a schedule consistent with accreditation interval, which may be only every three years.

Otherwise, any hospital whose JCAHO accreditation had expired or was never JCAHO accredited falls under *Tennessee Code Annotated*, Title 68, Chapter 11, Section 210, which states in part:

- (a) (1) Every facility, for which a license has been issued, shall be inspected within (15) months following date of last inspection by a duly appointed representative of the department. . . . (5) (a) All health care facilities licensed by the department which have obtained accreditation from a federally recognized

accrediting health care organization [JCAHO] shall be deemed to meet all applicable licensing requirements . . . may be exempt from subdivision (a) (1) so long as the facility remains accredited.

Without evidence that TennCare has ensured that providers/hospitals have met federal health and safety standards, the health and welfare of enrollees may be jeopardized.

Recommendation

The Director of TennCare should ensure that MCOs comply with the new provision of the MCO General Contract. The Director of TennCare should update the cross-over provider application by amending criminal disclosure requirements pursuant to the *Code of Federal Regulations*, Title 42, Part 455, Subpart B. Also, the Director should ensure that documentation to confirm that hospitals meet federal health and safety standards is obtained.

Management's Comment

TennCare did not ensure that all MCOs required providers to make necessary disclosures

We concur in part. The federal requirements regarding disclosure do not require notice of this requirement be specifically outlined in provider agreements. All provider agreements do require that providers comply with all applicable state and federal laws and regulations.

Additionally, the Bureau received confirmation from several MCOs that disclosure requirements were being met through the credentialing process and took the opportunity to remind MCOs of this requirement. Even though all provider agreements require compliance with all federal and state laws, rules and regulations, the Bureau agreed to take additional measures to assure compliance by including specific language of the disclosure requirement in the MCO contract. This was done in the July 1, 2004, MCO Contract Amendment and included the following language:

2-18.tt. Require the provider to comply and submit to the CONTRACTOR disclosure of information in accordance with the requirements specified in 42 CFR, Part 455, Subpart B.

Additionally, the basis of this finding was taken from a claims sample from which provider agreements were reviewed and the disclosure requirements outlined in 42 CFR, Part 455, Subpart B, were not incorporated verbatim into the provider agreement during the audit period. However, our current contract requirements, as amended July 1, 2004, will be in place for future audit periods.

TennCare's Medicare cross-over provider application form did not require all required disclosures

We concur with the finding and will amend the current disclosure requirements in our current provider application to include full disclosure regarding any criminal offense against Medicaid and/or Medicare regardless of when it took place without any time limitation that now exists in that document. It should be noted, however, that these crossover providers by definition are Medicare providers subject to the same requirement. Therefore, Medicare procedures would have already assured that there were not any providers that have been convicted of fraud in Medicaid and Medicare. We have asked the Office of General Counsel to help us with the wording in our revised Provider Agreement so that it will be legally correct and are awaiting a response on that now.

Lack of documentation that hospitals met health and safety standards

We partially concur with this finding. Historically, the Department of Health has systematically notified us of current hospital licensure. However, the Provider Services Division has initiated a process whereby we will on an annual basis in June of each year verify that each hospital in the State of Tennessee has renewed their licensure. We will also maintain documentation of that verification.

STATUS OF PRIOR AUDIT FINDINGS

State of Tennessee *Single Audit Report* for the year ended June 30, 2003

Audit findings pertaining to the Department of Finance and Administration were included in the *Single Audit Report*. The updated status of these findings as determined by our audit procedures is described below.

Resolved Audit Findings

The current audit disclosed that the Department of Finance and Administration has taken action to correct the previous audit findings concerning

- TennCare's failure to explain the payment of claims to both the Department of Children's Services and the Behavioral Health Organizations;
- unallowable payments for full-time state employees;
- TennCare's failure to follow financial change request procedures;
- TennCare's failure to follow the required procurement process when it obtained telephone answering services;
- revision of TennCare's departmental rules;
- TennCare's numerous and serious administrative and programmatic deficiencies;
- TennCare's monitoring of the Medicaid Waiver for Home and Community Based Services;
- a pre-admission evaluation not being on file;
- TennCare's possible payment of legal services while vendors were at lunch;
- the TennCare Management Information System's lack of flexibility and internal control;
- provider agreement compliance with federal requirements;
- TennCare's Director of Information Systems' failure to provide information necessary to conduct the audit of TennCare timely;
- the failure to prepare reports required by state law; and
- the lack of a process to recover funds that the Division of Mental Retardation Services recovered from providers.

Repeated Audit Findings

The current audit disclosed that the Department of Finance and Administration has not corrected the previous audit findings concerning

- control over the recording of land and buildings in the Land Inventory System;
- control over certain areas in the Office for Information Resources;
- the approval of contracts;
- TennCare's lack of a plan for the redetermination of eligibility for individuals who have lost Supplemental Security Income benefits;
- internal control over TennCare eligibility;
- TennCare's administrative appeals process;
- unallowable payments to the Department of Children's Services;
- payments to the Department of Children's Services that should have been made to Behavioral Health Organizations;
- claims not paid in accordance with the Home and Community Based Services Waiver;
- the approval and review process of services for the Medicaid Home and Community Based Services Waiver;
- the inappropriate recording of payments to Behavioral Health Organizations;
- inadequate monitoring of payments made by Managed Care Contractors;
- recovery procedures for payments on behalf of deceased enrollees;
- TennCare's providers not substantiating the medical costs associated with fee-for-service claims;
- TennCare's untimely payment of claims;
- compliance with TennCare's Special Terms and Conditions; and
- controls over access to the TennCare Management Information System.

These findings will be repeated in the *Single Audit Report* for the year ended June 30, 2004.

Most Recent Financial and Compliance Audit

Audit report number 03/076 for the Department of Finance and Administration, issued in November 2003, contained certain audit findings that were not included in the State of

Tennessee *Single Audit Report*. These findings were not relevant to our current audit and, as a result, we did not pursue their status as a part of this audit.

OBSERVATIONS AND COMMENTS

FRAUD CONSIDERATIONS

Statement on Auditing Standards No. 99 promulgated by the American Institute of Certified Public Accountants requires auditors to specifically assess the risk of material misstatement of an audited entity's financial statements due to fraud. The standard also restates the obvious premise that management, and not the auditors, is primarily responsible for preventing and detecting fraud in its own entity. Management's responsibility is fulfilled in part when it takes appropriate steps to assess the risk of fraud within the entity and to implement adequate internal controls to address the results of those risk assessments.

During our audit, we discussed these responsibilities with management and how management might approach meeting them. We also increased the breadth and depth of our inquiries of management and others in the entity as we deemed appropriate. We obtained formal assurances from top management that management had reviewed the entity's policies and procedures to ensure that they are properly designed to prevent and detect fraud and that management had made changes to the policies and procedures where appropriate. Top management further assured us that all staff had been advised to promptly alert management of all allegations of fraud, suspected fraud, or detected fraud and to be totally candid in all communications with the auditors. All levels of management assured us there were no known instances or allegations of fraud that were not disclosed to us.

TENNCARE'S FAILURE TO SUBMIT REPORTS REQUIRED BY STATE LAW

The prior audit noted that the Bureau of TennCare failed to submit the annual report or monthly summary statements required by Section 71-5-105, *Tennessee Code Annotated*. These reports provide the Governor and members of the General Assembly with statistical and other information related to the Medicaid/TennCare program. It was determined during the current audit that TennCare again did not submit all the information required by this law. We discussed this matter with staff from the state's Fiscal Review Committee. The Fiscal Review Committee is a part of the state's General Assembly. The Fiscal Review staff indicated that it was not aware of any member of the General Assembly who needed this information or was waiting for this information and indicated that if they needed it, it would be requested from the Bureau of TennCare. Because the need no longer remains for this information to be provided to the General Assembly, we recommend that the Director of TennCare initiate efforts to have this law modified or repealed.

REVIEW OF CONTRACTING PROCESS FOR HOME AND COMMUNITY BASED SERVICES WAIVER FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED

The U.S. Department of Health and Human Services, Office of Inspector General, recently conducted an audit of the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled. One objective of that the audit was to examine the Division of Mental Retardation Services' procedures for contracting with waiver providers. The report has not been released at this time. To avoid a duplication of effort, our audit did not include tests of DMRS' procedures for contracting with waiver providers.

AUDIT ISSUES REFERRED TO TENNCARE MANAGEMENT AND PROGRAM INTEGRITY

During the audit we noted several situations where TennCare's providers failed to provide audit documentation to substantiate the costs paid to the provider. See finding 7 for further details regarding this matter. It appears this lack of documentation could result from several reasons, including fraud. As a result, when we discovered these issues, we referred them to TennCare management and to TennCare's Program Integrity Unit for follow-up. Discussions with management revealed that it plans to recover the costs of the claims where no documentation was provided. Management at the Bureau of TennCare should examine the claims in question and determine if any fraud has occurred.