

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

**Department of Finance and Administration**

**For the Year Ended  
June 30, 2005**

**STATE OF TENNESSEE**

**COMPTROLLER OF THE TREASURY**

**Department of Audit**

**Division of State Audit**

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**Department of Finance and Administration  
For the Year Ended June 30, 2005**

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**Department of Finance and Administration  
For the Year Ended June 30, 2005**

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**EXECUTIVE SUMMARY**

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**Findings**

- FINDING 1 As noted in the prior three audits, TennCare does not have sufficient controls to prevent or detect duplicate payments to the Managed Care Contractors (page 6).
- FINDING 2 As noted in the prior audit, TennCare failed to ensure that provider requirements were met in accordance with the *Code of Federal Regulations*. TennCare did not ensure that all managed care organizations required providers to make necessary disclosures required by the *Code of Federal Regulations* regarding ownership and control information and criminal offense histories of the providers (page 9).
- FINDING 3 Management had not implemented adequate security controls over the network on which TennCare's management information system resides. Failure to provide such controls increases the risk that unauthorized individuals could access sensitive state systems and information (page 12).
- FINDING 4 For the third year, TennCare chose to ignore federal guidance and to improperly record administrative payments to Premier Behavioral Systems of Tennessee as medical assistance payments, resulting in \$3,254,103 of federal questioned costs (page 13).
- FINDING 5 As noted in the prior eight audits, 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 15).
- FINDING 6 As noted in the prior three audits, TennCare has failed to fully comply with the Home and Community Based Services Waiver for the mentally retarded and developmentally disabled by not allowing waiver providers the option of direct payments from TennCare (page 20).
- FINDING 7 For the third year, TennCare's administrative appeals process needs improvement. Delays in the processing of appeals results in the state and the federal government incurring additional costs of providing services to enrollees until the results of the appeals are determined (page 22).
- FINDING 8 As noted in prior audit findings in the previous five 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 does not have a court-approved plan which would allow TennCare to make a new determination of the eligibility of these enrollees (page 25).

FINDING 9 Similar to findings noted in the previous six audits, one TennCare provider did not have documentation to substantiate services associated with a fee-for-service claim under the Medicaid Home and Community Based Services Waivers. While only one of 107 claims examined was missing documentation, and questioned costs were only \$54, we are nevertheless required by Office of Management and Budget Circular A-133 to report this matter because likely questioned costs exceed \$10,000 (page 28).

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, 2005, and the State of Tennessee *Single Audit Report* for the year ended June 30, 2005. The scope of our audit procedures at the Department of Finance and Administration was limited. During the audit for the year ended June 30, 2005, our work at the Department of Finance and Administration focused on two major federal programs: the Medical Assistance Program and Temporary State Fiscal Relief. We audited these federally funded programs to determine whether the department complied with certain federal requirements and whether the department had an adequate system of internal control over these programs 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

April 17, 2006

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, 2005, 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  
05/093



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March 9, 2006

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, 2005. 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 programs administered by the Department of Finance and Administration. We performed certain audit procedures on these programs 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.

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**Major Federal Programs Administered by the  
Department of Finance and Administration  
For the Year Ended June 30, 2005  
(in thousands)**

<u>CFDA Number</u>	<u>Program Name</u>	<u>Federal Disbursements</u>
93.778	Medical Assistance Program	\$5,136,057
N/A	Temporary State Fiscal Relief	104,304

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Source: State of Tennessee's Schedule of Expenditures of Federal Awards for the year ended June 30, 2005.

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The Honorable John G. Morgan  
March 9, 2006  
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 20, 2005, on the State of Tennessee's financial statements for the year ended June 30, 2005. 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 Medical Assistance 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." with a stylized flourish at the end.

Arthur A. Hayes, Jr., CPA  
Director

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## FINDINGS AND RECOMMENDATIONS

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**1. TennCare management has still not adequately assessed and mitigated all of the risks of inappropriate payments to TennCare's Managed Care Contractors (MCCs), resulting in unallowable costs paid to the MCCs**

### Finding

It is the responsibility of management to assess the risks to their operations and to design and implement effective mitigating controls. As noted in the prior three audits, TennCare's monitoring of payments to Managed Care Contractors (MCCs) needs improvements. TennCare has not assessed the risks associated with processing payments to the MCCs and has not designed adequate controls to mitigate the risks of unallowable payments to the MCCs on behalf of TennCare recipients. During the audit period, TennCare's MCCs included the Managed Care Organizations (MCOs), Doral Dental of Tennessee (Doral), and First Health Services Corporation (First Health).

For the year ended June 30, 2005, TennCare reimbursed the MCCs as follows:

- TennCare paid over \$1.9 billion to the MCOs for actual medical claims of enrollees.
- TennCare paid over \$136 million to Doral Dental, the dental benefits manager, for dental claims.
- TennCare paid over \$2.4 billion to First Health, the pharmacy benefits manager, for pharmacy claims.

We reviewed TennCare's procedures to determine whether controls over payments to the MCCs mitigated the risk of or prevented unallowable payments to the MCCs. Our specific objectives were:

- to determine if TennCare's controls would detect or prevent the payment of improper amounts for services provided to TennCare enrollees, including third-party liabilities (TPL) that should be appropriately deducted from the amount paid;
- to determine if TennCare's controls would ensure that the MCCs paid the providers the same amounts billed to TennCare;
- to determine if TennCare's controls would ensure that the MCCs paid the providers for services that were actually rendered;
- to determine if TennCare's controls would detect or prevent reimbursements to the MCCs for services provided to invalid or ineligible recipients; and
- to determine if TennCare's controls would detect or prevent individual provider claims from being reimbursed more than once.

Management concurred with the prior audit finding and stated that TennCare has made and will continue to make improvements in the monitoring of payments to MCCs. In reaction to the prior audit finding, management implemented manual controls to address the TPL issues and to ensure that the MCCs paid the providers the same amounts billed to TennCare. In addition, TennCare either performed, or contracted with third-parties to perform, post-payment reviews to ensure the MCCs paid the providers the proper amount for services, that the services were actually rendered, and that services were provided only to eligible recipients.

However, although TennCare is performing post-payment reviews which encompass the duplicate payments, given the complexity and high volume of transactions, these manual controls were not sufficient to prevent or detect duplicate payments to the MCCs for the same claim.

InterChange, TennCare's new Medicaid Management Information System, was designed to include critical system edits to prevent individual provider claims from being reimbursed more than once. However, TennCare has not been able to process MCCs' payments through the system because the encounter data received from the MCOs is not uniform among the MCOs or compatible with interChange. As a result, TennCare currently pays the MCCs based on the MCCs' submission of invoices, supporting claims detail, and check registers.

While no duplicate claims were discovered during our examination, our review revealed that TennCare does not have sufficient controls to prevent individual provider claims from being reimbursed more than once. According to TennCare staff, and as noted in management's response to the prior finding, TennCare's Division of Managed Care Analytics planned to generate duplicate reimbursement error reports from encounter data from the period January 2004 through June 2005 to be submitted to the MCCs for response and explanation of the discrepancies. However, the error criteria used created reports with too many false errors indicated for the MCCs to manage. The reports were retracted and the criteria were refined to match interChange's duplicate reimbursement edit.

As of November 1, 2005, these error reports have not be regenerated and sent to the MCCs. Another issue is that the duplicate reimbursement error reports were designed to detect duplicate payments after the payments are made. If TennCare was able to process payments through the interChange system, all claims would be subject to systematic controls that would prevent the payment of duplicate claims.

### **Recommendation**

The risk of making payments for the same services more than once should be considered in a documented risk assessment performed by management under the direction of the TennCare director. That same risk assessment document should detail sufficient controls to reduce the risk of duplicate payments to an acceptably low level.

Preferably, the necessary changes will be made to permit the processing of payments to the MCCs to occur through the interChange system. This would allow the system edits to check payments for duplication. If the necessary changes cannot be made immediately, then the

process for sending reports of possible duplicate claims to the MCCs for investigation should be refined as needed so that the process can be both practicable and effective.

### **Management's Comment**

We concur. We will continue to monitor the MCOs using the Department of Commerce and Insurance as well as the Comptroller's Office. This monitoring includes testing for correct payment of claims, including prevention of duplicate payment, coordination of benefits, correct rate paid, as well as accurate billing to TennCare of financial activity. We agree that monitoring of claim activity systematically will provide a better monitoring tool and internal control than what is currently in place.

The Fiscal Division within the Bureau of TennCare receives weekly invoices and check register data from each of the MCOs. The MCOs submit within seven days of submitting the invoice a reconciliation workbook and claims detail file (via CD ROM or FTP transfer). The invoice and all check register totals reported in the reconciliation by the MCO are reconciled by Fiscal with the check register submitted with the invoice. Differences in amounts are to be properly explained by the MCO and are tracked on the 'MCO Reconciliation Checklist' spreadsheet. In addition, the invoice claims detail file totals are reconciled to the claim amounts from the reconciliation workbook. Differences in amounts are followed up with the MCOs for resolution. The Bureau of TennCare Internal Audit Division reviews the reconciliations performed by the Fiscal Division for accuracy and to ensure resolution of differences.

The interChange system was implemented on August 9, 2004, and represents a significant improvement in the technology, functionality and data available to the State of Tennessee for management of the TennCare program. The first priority in implementation of the new system was to prevent interruption in the flow of eligibility and enrollment information or the processing of claims and payments to providers so that care to recipients would not be jeopardized. As such, the payment of claims to the MCCs from invoice represents an intentional and necessary approach to minimize the impact of a new system implementation on provision of care. While the Bureau is paying MCCs based on invoice data and not currently paying MCCs directly based on encounter data, we have been able to load encounter data and have applied system edits and audits to that data. As a result, the Bureau has been able to identify and address issues in the encounter data and specifically with the duplicate claim audits. During the post-implementation stabilization period, the Bureau has continued to work with the MCCs toward the standardization and consistency of data and with EDS toward the resolution of outstanding processing issues.

Over the course of June and July 2005 and continuing through January 2006 as part of ongoing system development, the Bureau implemented a number of changes that have significantly improved the accuracy of the exact duplicate audits and reducing the number of exceptions that are not duplicates. During the latter half of the fiscal year ending June 30, 2006, the Bureau plans to produce duplicate claim reports for submission to the MCCs, based on system generated edits, validated by several sources. Payment for claims that are confirmed to be duplicates will be recouped by TennCare. The Bureau intends to produce a draft of these

reports in March 2006 for review, with the final version being distributed to the MCCs in May 2006. These reports will be produced on a quarterly basis until the Bureau implements payment from encounter.

Further, the Bureau intends to continue progress toward payment from encounter. Initial efforts through the remainder of the fiscal year ending June 30, 2006 will focus on validation, during the encounter release and acceptance process, of aggregate encounter totals against previously received and paid invoice totals, by MCC, by payment cycle, to confirm receipt of complete and accurate encounter data. Any discrepancies will require review of the detailed encounter data to confirm accurate processing and correct aggregate totals. Confirmed discrepancies will be reported to the MCCs with request for corrective action plans as appropriate. Although the Bureau currently withholds and/or recoups payments for invoiced claims not supported by claims detail data, the Bureau will begin to withhold and/or recoup payment for unsupported encounter data when the validation process is stabilized. Concurrently, we will undertake requirements definition and design of system changes to initiate payment to MCCs from the encounter acceptance process. Initial implementation, likely in late 2006 or early 2007, will focus on direct payment based on encounter with transaction level reporting back to the MCCs via an electronic remittance advice, including informational or soft edits and audits. Subsequent enhancement in the first half of 2007 will focus on rejecting or denying transactions based on specific hard edits.

**2. For the second year, TennCare failed to assess and mitigate the risks associated with inadequate provider disclosure requirements**

**Finding**

TennCare contracts with Managed Care Organizations (MCOs); the MCOs then contract with providers to provide services to TennCare enrollees. As noted in the prior audit, TennCare failed to ensure that provider requirements were met in accordance with the *Code of Federal Regulations*, Title 42, Part 455, Subpart B. The prior audit finding also addressed two other weaknesses. 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. Management successfully completed corrective actions to correct the latter weaknesses. Management concurred in part with the prior audit finding and stated in regard to the provider disclosure requirements:

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.

In response to the finding, TennCare amended the general MCO Contract and directed the MCOs, acting as fiscal agents for TennCare, to comply with the disclosure of information as required in the *Code of Federal Regulations*, Title 42, Part 455, Subpart B. TennCare did not monitor the MCOs to ensure that they complied with the new procedures. Our review revealed that the MCOs did not always obtain the required disclosures. The disclosure of information outlined in the regulation contains two subcomponents: disclosure of ownership and control information and disclosure of a conviction of a criminal offense.

Ownership and Control Information Disclosure

Our initial testwork revealed that for 25 of 33 providers tested (76%), there was insufficient or no evidence that MCOs obtained required ownership and control information from the providers.

The *Code of Federal Regulations*, Title 42, Part 455, Section 104, states, in part:

The Medicaid agency must require each disclosing entity to disclose the following information in accordance with paragraph (b) of this section: (1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more; . . . (b) Time and manner of disclosure. (1) Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information specified in paragraph (a) of this section to the State survey agency at the time it is surveyed. . . . (c) A Medicaid agency shall not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information as required by this section. (d) FFP [Federal financial participation] is not available in payments made to a provider or fiscal agent that fails to disclose ownership or control information as required by this section.

In January 2006, subsequent to the end of audit fieldwork, TennCare management obtained from the MCOs the required ownership and control information for 7 of 25 providers.

In February 2006, TennCare obtained the required ownership and control information directly from the remaining 18 providers.

Because TennCare did not ensure compliance with contract provisions of the general MCO contract for ownership and control information, the MCOs may not have been able to identify potential conflicts of interest. These conflicts could include the owners, members of the board of directors, or managing employees who have an ownership and control interest in the provider.

### Conviction of a Criminal Offense Disclosure

Our initial testwork also revealed that for 38 of 58 providers tested (66%), criminal disclosure language used by the MCOs in various documents did not meet the criminal disclosure requirements.

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.

In January 2006, subsequent to the end of audit fieldwork, TennCare management provided us with the criminal disclosure information obtained from the MCOs for 6 of 38 providers. TennCare management also obtained the criminal disclosure information directly from 27 of the 38 providers in February 2006. As of February 6, 2006, TennCare management or the MCOs could not obtain the required criminal disclosures for 5 of the providers.

Because TennCare did not ensure compliance with contract provisions of the general MCO contract for conviction of criminal offense disclosure, the MCOs may not have been able to identify providers who, through criminal convictions, may be ineligible to receive federal financial participation.

### **Recommendation**

The Director of TennCare should immediately obtain all required disclosures or should terminate existing agreements for those providers that fail to disclose ownership or control information. The Director should also ensure that MCOs comply with amendment 2-18tt. of the MCO General Contract, which requires the MCOs to obtain the ownership or control information and criminal disclosures from the providers in accordance with the requirements specified in the *Code of Federal Regulations*, Title 42, Part 455, Subpart B.

As part of a documented risk assessment, management should review and identify all critical regulations involving compliance requirements which require the loss of federal financial participation, if requirements are not met. Management should implement effective controls to ensure compliance with these requirements. Management should assign staff to be responsible for monitoring compliance and take action if deficiencies occur.

### **Management's Comment**

We concur. The existing Amended and Restated Contractor Risk Agreement, section 2-18.uu (previously section 2-18.tt) requires 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. The Bureau will conduct quarterly random reviews of the MCOs compliance with collecting provider Disclosure of Ownership and Control information as required by this CFR. The MCOs will be required to send in ownership and control disclosure information on providers from the randomly generated listing provided to them by the Bureau. To the extent that the MCO is found not be in compliance, the Office of Contract Compliance and Performance will require the MCO to submit a Corrective Action Plan for the deficiency and each provider deficiency will be assessed liquidated damages. Effective January 1, 2006, the monetary damage for failure to require and assure compliance with this requirement is \$5,000 per provider application. (See Amended and Restated CRA section 4-8.b.2 Class B 17).

### **3. Management did not have adequate network security controls, increasing the risk of unauthorized access to TennCare's management information system**

#### **Finding**

Auditors observed that management had not implemented adequate security controls over the network on which TennCare's management information system resides. Failure to provide such controls increases the risk that unauthorized individuals could access sensitive state systems and information.

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.

#### **Recommendation**

The Director of TennCare should ensure that all risks related to TennCare's system security controls are identified and assessed in the bureau's documented risk assessment activities. The Director should identify specific staff to be responsible for the design and

implementation of internal controls to prevent and detect exceptions timely. The Director should also identify staff to be responsible for the ongoing monitoring of compliance with all requirements and take prompt action should exceptions occur.

### **Management's Comment**

We concur. During the audit period, the Bureau hired a Systems Security Officer and a Chief Information Officer. The Systems Security Officer, under the direction and authority of the Chief Information Officer, will be responsible for defining and implementing a risk assessment program and for ensuring implementation and enforcement of appropriate controls. Beginning in May 2005, the Bureau implemented several staffing, organizational and procedural changes to improve the effectiveness of system and security administration.

Beginning in June 2005 and ending in August 2005, the Bureau moved to new facilities and significantly improved many elements of physical and logical security. Given that the audit period and field work relevant to this particular finding preceded the move, the Bureau initiated verification of the system security findings in February 2006 in order to determine which issues remain open. The Bureau will work with the auditors to review the findings in detail and will define and implement appropriate remediation approaches or risk mitigation strategies. Any remaining open items, which cannot be adequately addressed by May 2006, and which have not already been approved through the security exception request process, will be documented and submitted for review to the auditors.

**4. For the third year, TennCare management ignored federal guidance and chose to improperly record administrative payments to Premier Behavioral Systems of Tennessee, resulting in federal questioned costs of \$3,254,103**

### **Finding**

For the third year, in order to maximize federal revenue, TennCare chose to ignore federal guidance and improperly record administrative payments to Premier Behavioral Systems of Tennessee as medical assistance payments, which resulted in TennCare claiming federal financial participation at a higher rate than allowed.

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 paying an administrative fee for these enrollees. In October 2004, TennCare resumed paying a monthly capitation payment to Premier, of which Premier is allowed to retain up to 10% for administrative expenses. For the administrative fee paid to Premier, TennCare is allowed to claim federal financial participation, but at a lower matching rate than for payments for medical assistance. 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 64.7057% medical

assistance rate. 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 the Chief Financial Officer and Deputy Chief Financial Officer contend that the amendment with Premier was designed to be a partial risk agreement, it is a non-risk agreement according to CMS.

In the audit for the year ended June 30, 2003, management did not concur with the 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 . . .

In the audit for the year ended June 30, 2004, TennCare management again did not concur that administration payments to Premier should be claimed at the lower matching rate and stated, "Regarding the federal percentage claimed for Premier administrative costs, we will continue to discuss our position with CMS and pursue a resolution." As of October 25, 2005, a resolution between TennCare and CMS had not been reached.

Current testwork revealed that TennCare made current-year payments totaling \$221,254,674 to Premier, of which 10% (\$22,125,467) is attributable to administration expenses. TennCare claimed the medical assistance rate of 64.7075% for all payments to Premier, including administration. This resulted in \$3,254,103 in federal questioned costs.

### **Recommendation**

The Chief Financial Officer (CFO) should ensure administrative payments to Premier are recorded properly 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 the higher matching rate is allowable.

## Management's Comment

We concur. TennCare contended that Premier was at risk based on their shared liability for costs in excess of \$5 million above the capitation rate on an annual basis. As part of broad settlement of negotiations with CMS on several issues, which have occurred over the last several years, we have brought this issue to closure and will return the funds as a part of the overall settlement. TennCare ceased claiming at the higher level July 1, 2005. As of January 1, 2006, Premier is at risk and the state can again claim the higher match rate for all payments to them.

### **5. Management still has not assessed and mitigated the risks associated with ineffective controls over enrollees' social security numbers and the reverification of enrollees' eligibility**

#### Finding

As noted in the prior eight audits, the Bureau of TennCare continues to have internal control weaknesses related to enrollees' invalid and "pseudo" social security numbers. Also, as noted in the prior two audits, the Bureau has been untimely in the reverification of enrollees' eligibility.

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 updates information in interChange, TennCare's management information system.

#### 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 [TennCare Management Information System].” 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 that “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.

In response to the finding reported in the 2004 audit, management concurred in part with this portion of the finding by stating:

. . .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. . . . 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 . . . .

In conducting testwork for the current audit, we determined that procedures have been implemented to identify individuals with invalid social security numbers. Based on discussion with TennCare staff, we determined that they are following the procedures relating to the reports for the pseudo social security numbers mentioned in management's comments in the 2003 audit. In addition, we determined that TennCare implemented a policy to send letters to individuals to verify or update the individual's social security number. According to TennCare staff, letters were mailed in February, March, and June 2005. However, these procedures have not been effective in resolving the weaknesses.

We used computer-assisted audit techniques to search interChange. Our search revealed that 10,637 TennCare participants had invalid or pseudo social security numbers during the fiscal year ended June 30, 2005. We had eliminated participants that appeared to be newborns (less than one year old). From this population, a sample of 25 participants was selected for testwork. Results indicated that, of the 25 participants, TennCare or its contractors had correctly updated TCMIS or ACCENT subsequent to July 2005 to reflect valid social security numbers for 6 participants. However, for 19 of the 25 participants (76%), we noted that neither TennCare nor its contractors had updated TCMIS or ACCENT to reflect valid social security numbers as of November 2005.

The total amount paid during the audit period for the 19 individuals with uncorrected pseudo social security numbers was \$14,054. Federal questioned costs totaled \$8,565. The remaining \$5,489 was state matching funds. The amount of questioned costs could not be determined for the remaining 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 year ended June 30, 2003. In that audit, we reported that one of 126 enrollees tested was not reverified annually. 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 . . . .”

In the audit for the year ended June 30, 2004, we determined that there were procedures in place to ensure that Medicaid cases are reviewed on a timely basis; however, problems existed 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.

During the current audit, for the year ended June 30, 2005, we tested a sample of TennCare enrollees to determine if the enrollees were reverified annually. Of the 33 enrollees tested, testwork revealed three enrollees (9%) were not reverified annually. Management did not begin the reverification process for these individuals during the required 12-month period.

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 three enrollees after the date the enrollees should have been reverified was \$6,066. Federal questioned costs in the sample totaled \$3,847. The remaining \$2,219 was state matching funds.

### **Recommendation**

The Director of TennCare 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 ensure that risks as noted in this finding are adequately identified and assessed in the bureau's documented risk-assessment activities. The Director should identify specific staff to be responsible for the design and implementation of internal controls to prevent and detect exceptions timely. The Director should also identify staff to be responsible for ongoing monitoring for compliance with all requirements and taking prompt action should exceptions occur.

### **Management's Comment**

#### Invalid and Pseudo Social Security Numbers Again Discovered

We concur in part. We recognize that individuals without valid social security numbers are being enrolled in Medicaid and TennCare Standard. According to the *Code of Federal Regulations*, Title 42, Part 435, Section 910(f), "The agency must not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by SSA". The federal regulation allows that individuals may be deemed eligible if they meet the categorical eligibility requirements and may not have a social security number. To be compliant with this regulation, TennCare assigns pseudo numbers for nine months. If within those nine months, the enrollee does not supply a valid social security number, TennCare has established a notice process which is referenced in the finding. This process notices an individual and gives the individual an opportunity to provide the valid number. If the valid number is not provided, the enrollee's coverage is terminated.

The audit finding states that 10,637 participants had invalid or pseudo social security numbers during the fiscal year ended June 30, 2005. Our analysis of this amount disclosed that 4,121 cannot obtain SSNs as they are illegal/undocumented aliens and/or refugees and are individuals who TennCare is required by Federal regulations to cover for emergency services. Additionally, 3,063 participants had their eligibility terminated by June 30, 2005. Another 2,553 were DCS kids in Foster Care and/or CISA Adoption who have a pseudo SSN for security reasons to protect from potential harm.

The finding further notes that based on the auditor's sample, "for 19 of the 25 participants (76%), we noted that neither TennCare nor its contractors had updated TCMIS or ACCENT to reflect valid social security numbers as of November 2005". While it is accurate that valid social

security numbers had not been updated in TCMIS or ACCENT, it should be noted that eight (8) of the 19 individuals in the sample had their eligibility terminated by December 31, 2004 and three (3) additional individuals had their eligibility terminated by June 30, 2005. Of the eight (8) individuals remaining eligible, all are children who are participating in the DCS Adoption Assistance program. The Bureau believes that this shows clear improvement in the State's ability to identify invalid and pseudo numbers and terminate eligibility when valid numbers are not available.

The Department of Children's Services is continuing to work on system changes that will eliminate the need to pseudo numbers for children in state custody and in adoption assistance. Currently, the changes are scheduled to be completed by March 2006. While this will resolve the issue going forward, TennCare will need to work with DCS to resolve the existing eligible children who have a pseudo number for security reasons.

#### Enrollees Not Reverified

We concur with this part of the finding. The Bureau will work with DHS to implement more effective methods of insuring Medicaid and TennCare Standard eligible individuals have their eligibility redetermined every twelve months.

#### **6. As noted in the prior three audits, TennCare has failed to fully comply with the Home and Community Based Services Waiver for the mentally retarded and developmentally disabled by not allowing waiver providers the option of direct payments from TennCare**

#### **Finding**

As noted in the prior three 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*, 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. 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 was not paying DMRS the same amount that DMRS paid providers.
- TennCare allowed DMRS to combine services without waiver approval.

TennCare has taken action and corrected the last two issues. In addition, TennCare received approval from the Centers for Medicare and Medicaid Services (CMS) to pay providers through

the DMRS system. However, that approval was contingent upon TennCare following federal requirements regarding providers' options for voluntary reassignment of payment rights.

We requested clarification from the U.S. Department of Health and Human Services, CMS, regarding voluntary reassignment of payment rights. The Department of Health and Human Services' CMS officials stated:

. . . reassignment of payment must be voluntary. Any provider wishing to enroll and be paid directly by TennCare must be allowed to do so. The approved waiver specifies that providers may voluntarily reassign their right to direct payments to the Division of Mental Retardation Services. Providers who chose not to voluntarily reassign their right to direct payments will not be required to do so. TennCare will enroll the providers and will pay them through the same fiscal agent as the rest of the Medicaid program.

According to TennCare's waiver agreement, waiver providers are required to submit claims for reimbursement of services to DMRS. DMRS reviews each claim to ensure the providers' requests for reimbursement are for authorized services and pays the providers. DMRS then submits all claims electronically to TennCare for adjudication and reimbursement. The waiver also stipulates that providers who voluntarily reassign payment rights to DMRS will receive the total reimbursed payment made by TennCare to DMRS.

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

We partially concur. 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. . . .

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

We do not concur. . . . TennCare is implementing a new Management Information System which will have the capability to allow direct provider payment for services provided through the HCBS waivers should TennCare and DMRS, from a policy perspective, choose to have a direct payment system.

In response to the previous audit finding for the year ended June 30, 2004, management indicated that TennCare received approval from CMS to pay through the DMRS system and stated:

. . . The renewals of the waivers effective on January 1, 2005, admittedly after the end [of the] audit period, include approvals of TennCare to reimburse DMRS for payments made by them to providers. . . .

Management's response did not address the requirements of voluntary reassignment.

However, based on discussions with TennCare management, the claims format currently used by HCBS providers cannot be processed through TennCare's Management Information System, interChange, implemented in September 2004. Therefore, TennCare is not able to allow providers the option of receiving payment directly from TennCare. The provider agreements and other documentation regulating the waiver's operations in effect during the audit period required providers to accept payment from DMRS since direct payments through TCMIS were not possible.

### **Recommendation**

The Director of TennCare should consider processing claims through TennCare's Management Information System, or the Director should obtain forms from the providers evidencing that the Bureau gave providers the option of receiving payment from TennCare or voluntarily reassigning their payment rights to DMRS.

### **Management's Comment**

We concur. The TennCare computer system has the capability to accept and process claims submitted directly by HCBS providers participating in the MR waiver programs as it does all other providers of services. However, TennCare made a conscious decision not to exercise this option for HCBS services as it would require these providers to submit HIPAA compliant claims which they are not currently submitting to DMRS. This would also require a significant commitment of staff resources to train the providers in the new billing system. We are currently researching the necessary steps that it would take to make direct billing and payment a more workable option in the current environment.

- 7. For the third year, TennCare has not mitigated the risks associated with delays in processing administrative appeals, which results in the state and the federal government incurring additional costs of providing services to enrollees until the results of the appeals are determined**

### **Finding**

As noted in the previous two audits, TennCare's administrative appeals process is not sufficient to ensure management's compliance with the federal requirement governing timely resolution of administrative appeals.

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 21<sup>st</sup> and 40<sup>th</sup> days but processes the appeal; and
- TennCare does not process appeals received after the 40<sup>th</sup> 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 fiscal year 2003 audit 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.

Management concurred with the prior-year finding and stated:

. . . 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 . . . .

As noted in management's comments, the administrative appeals process moved to DHS on January 4, 2005; however, TennCare did not amend the contract with DHS to include the scope of these services. According to management on October 21, 2005, TennCare is currently working on the amendment with DHS.

During fieldwork, we selected a sample of 26 of 15,920 enrollees whose administrative appeal exceeded the 90-day federal requirement. Based on testwork performed, we found that for 7 of 26 administrative appeals (27%), the delays were attributed to factors beyond the Bureau of TennCare's and DHS' control. However, for 18 of 26 administrative appeals (69%) that exceeded the 90-day federal requirement, neither TennCare nor DHS could provide documentation to explain and/or justify the delays. One of 26 administrative appeals files could not be located (4%); therefore, the auditor was unable to determine if the reason for the delay was beyond the control of TennCare and DHS.

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 or DHS' control. 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.

The Director of TennCare should ensure that risks identified in this finding are adequately assessed in the bureau's documented risk assessment activities. The Director should identify specific staff to be responsible for the design and implementation of internal controls related to the appeals process to prevent and detect exceptions timely. The Director should also identify staff to be responsible for ongoing monitoring for compliance with all requirements and taking prompt action should exceptions occur.

### **Management's Comment**

We concur with this finding. Since the transfer of the administrative appeals process to DHS, we believe there has been improvement in the timelines of appeals being heard. DHS has

instituted a streamlined process that should provide the state with opportunity to provide enrollees a hearing within the 90 day timeline. However, the Bureau also recognizes that there continue to be issues outside of TennCare that postpone hearings from occurring in a timely manner, such as an enrollee requesting an extension as well as the limited number of ALJ dockets to hear appeals. DHS and TennCare will continue to work together to identify ways to improve the efficiency of the administrative appeals process.

DHS has also added additional reporting mechanisms to ensure that both TennCare and DHS are aware of any appeal that is not processed within 90 days. TennCare has assigned staff to monitor this report. In July 2006, all appeals will not only be processed by DHS, but will also be heard by hearing officers within DHS. This change will further streamline the appeals process and will shorten the timeframes for hearing all eligibility appeals in the future.

**8. Although TennCare management continues to acknowledge its responsibility to take action in this matter, for the sixth 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, thus increasing the costs of the TennCare program**

**Finding**

As noted in prior audit findings in the previous five 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 audit finding for the 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 an 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.

In the previous audit finding for year ended June 30, 2004, we reported that TennCare and the Plaintiff's attorneys still have not reached an agreement for the Daniels' class action lawsuit. TennCare legal counsel 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, TennCare will implement the court-approved plan. Management concurred with that finding and stated:

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.

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.

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, 2005. Dual enrollees are enrollees receiving Medicaid (TennCare) and Medicare benefits. Of these, approximately 55,000 non-dual and 74,000 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 129,000 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 2005 is \$601.55 per month for non-dual enrollees and \$329.13 per month for dual enrollees. Based upon these average costs per enrollee, the approximate cost for the 55,000 non-dual and 74,000 dual enrollees who have lost SSI eligibility but remain on TennCare without a new determination of eligibility was \$397 million and \$292 million, respectively. As a result, the total amount paid for these enrollees is approximately \$689 million for year ended June 30, 2005.

### **Recommendation**

The Director of TennCare should finalize a plan that would allow TennCare to determine if terminated SSI recipients are still eligible for TennCare and terminate ineligible enrollees. That plan should then be submitted to the court for approval.

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.

### **9. 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 six 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. We tested a sample of 107 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 only one of 107 claims (<1%) paid by TennCare. Specifically, the following issue was noted:

- The provider for one HCBS enrollee overcharged TennCare for two transportation units and seven units of day habilitation services. Documentation was supplied by the provider to support \$329 in charges; however, the provider had billed \$383.

The total amount of questioned costs for the claim noted above was \$54 out of a total of \$994,490 tested. Federal questioned costs totaled \$35. The remaining \$19 was state matching funds. The total amount of the population sampled was \$6,719,502,441. 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 likely questioned costs exceed \$10,000 for this condition.

### **Recommendation**

The Director of TennCare should continue the process of post-payment reviews of medical records to detect overcharging by providers and should continue to ensure that adequate documentation exists to support services billed.

### **Management's Comment**

We concur. TennCare has now fully staffed its Utilization Review Section within the Division of Developmental Disability Services. This section has been actively reviewing medical records to assure not only documentation to support the services billed exists, but also that the provider is compliant with programmatic requirements. Since such reviews of detailed documentation at the providers' offices are performed on a sample basis, the possibility will always exist that a claim may not have adequate documentation to support the services billed that wasn't detected in our sample reviews. However, the fact that we are actively reviewing medical records should serve as a reminder to providers of the need to fully document the services they provide, and should act as a deterrent to discourage them from embellishing their billings.

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## STATUS OF PRIOR AUDIT FINDINGS

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### State of Tennessee *Single Audit Report* for the year ended June 30, 2004

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

- control over the recording of land and buildings in the Land Inventory System;
- control over certain areas in the Office for Information Resources;
- an \$8 million check erroneously sent to a provider;
- the timely approval of contracts;
- unallowable payments to the Department of Children's Services, Behavioral Health Organizations, and others;
- recovery procedures for payments on behalf of deceased enrollees;
- TennCare's untimely payment of claims;
- the use of estimates rather than actual expenditures to claim federal financial participation for enrollees in an Institution for Mental Diseases; and
- controls over access to the TennCare Management Information System.

#### **Repeated Audit Findings**

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

- 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 related to invalid social security numbers and timely reverification of enrollees;
- TennCare's untimely administrative appeals process;

- the inappropriate recording of administrative payments to a Behavioral Health Organization as medical assistance payments;
- TennCare’s providers not substantiating the medical costs associated with fee-for-service claims;
- inadequate controls preventing or detecting duplicate payments made to Managed Care Contractors;
- inadequate controls related to provider disclosures related to ownership and control information, and criminal offense histories; and
- compliance with the terms of the Home and Community Based Waiver regarding allowing providers voluntary reassignment of payment.

These findings will be repeated in the *Single Audit Report* for the year ended June 30, 2005.

#### 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.

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## **OBSERVATIONS AND COMMENTS**

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### **MANAGEMENT’S RESPONSIBILITY FOR RISK ASSESSMENT**

Auditors and management are required to assess the risk of fraud in the operations of the department. The risk assessment is based on a critical review of operations considering what frauds could be perpetrated in the absence of adequate controls. The auditors’ risk assessment is limited to the period during which the audit is conducted and is limited to the transactions that the auditors are able to test during that period. The risk assessment by management is the primary method by which the department is protected from fraud, waste, and abuse. Since new programs may be established at any time by management or older programs may be discontinued, that assessment is ongoing as part of the daily operations of the department.

Risks of fraud, waste, and abuse are mitigated by effective internal controls. It is management’s responsibility to design, implement, and monitor effective controls in the department. Although internal and external auditors may include testing of controls as part of their audit procedures, these procedures are not a substitute for the ongoing monitoring required of management. After all, the auditor testing is limited and is usually targeted to test the effectiveness of particular controls. Even if controls appear to be operating effectively during

the time of the auditor testing, they may be rendered ineffective the next day by management override or by other circumstances that, if left up to the auditor to detect, will not be noted until the next audit engagement and then only if the auditor tests the same transactions and controls. Furthermore, since staff may be seeking to avoid auditor criticisms, they may comply with the controls during the period that the auditors are on site and revert to ignoring or disregarding the control after the auditors have left the field.

The risk assessments and the actions of management in designing, implementing, and monitoring the controls should be adequately documented to provide an audit trail both for auditors and for management, in the event that there is a change in management or staff and to maintain a record of areas that are particularly problematic.

## **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.