

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

Department of Finance and Administration

**For the Year Ended
June 30, 2006**

STATE OF TENNESSEE

COMPTROLLER OF THE TREASURY

Department of Audit

Division of State Audit

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Nicole Williams

Staff Auditors

Amy Brack
Editor

Comptroller of the Treasury, Division of State Audit
1500 James K. Polk Building, Nashville, TN 37243-0246
(615) 401-7897

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**Department of Finance and Administration
For the Year Ended June 30, 2006**

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**Department of Finance and Administration
For the Year Ended June 30, 2006**

EXECUTIVE SUMMARY

Findings

- FINDING 1 As noted in prior audit findings in the previous six 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 6).
- FINDING 2 For the fourth year, TennCare's administrative appeals process needs improvement. Delays in the processing of appeals result in the state and the federal government incurring additional costs of providing services to enrollees until the results of the appeals are determined (page 8).
- FINDING 3 As noted in the prior nine audits, there have been weaknesses in internal control over TennCare eligibility. The current audit noted that TennCare paid for services provided to individuals with invalid social security numbers (page 10).
- FINDING 4 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 \$95, 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 14).
- FINDING 5 The Office for Information Resources has not implemented adequate controls over information security within two areas. The office has not complied with the state's policy regarding user access privileges, thereby increasing the risk that unauthorized individuals could access sensitive state systems and information (page 15).

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, 2006, and the State of Tennessee *Single Audit Report* for the year ended June 30, 2006. The scope of our audit procedures at the Department of Finance and Administration was limited. During the audit for the year ended June 30, 2006, 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 this 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

April 12, 2007

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, 2006, 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
06/083



STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
DEPARTMENT OF AUDIT
DIVISION OF STATE AUDIT

JAMES K. POLK STATE OFFICE BUILDING, SUITE 1500
NASHVILLE, TENNESSEE 37243-0264
PHONE (615) 401-7897 ♦ FAX (615) 532-2765

December 21, 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, 2006. 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 its major federal programs.

**Major Federal Program Administered by the
Department of Finance and Administration
For the Year Ended June 30, 2006
(in thousands)**

<u>CFDA Number</u>	<u>Program Name</u>	<u>Federal Disbursements</u>
93.778	Medical Assistance Program	\$4,381,428

Source: State of Tennessee's Schedule of Expenditures of Federal Awards for the year ended June 30, 2006.

The Honorable John G. Morgan
December 21, 2006
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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 21, 2006, on the State of Tennessee's financial statements for the year ended June 30, 2006. 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 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, prominent initial "A".

Arthur A. Hayes, Jr., CPA
Director

FINDINGS AND RECOMMENDATIONS

- 1. Although TennCare management continues to acknowledge its responsibility to take action in this matter, for the seventh 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 six 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’s comment to the most recent prior finding is noted below. Management’s comments for the five prior audit findings are exhibited on page 19 in the appendix to this report.

In the audit finding for year ended June 30, 2005, we reported that TennCare and the Plaintiff’s attorneys still have not reached an agreement for the Daniels’ class action lawsuit. 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.

According to TennCare management, TennCare 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 population. TennCare is in consultation with its attorneys to develop a new eligibility and disenrollment plan for the Daniels population. Until the time that a plan is approved by the court, TennCare plans to continue to abide by current court orders on who can be disenrolled.

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 159,897 non-dual SSI enrollees and approximately 169,897 dual SSI enrollees at June 30, 2006. Dual enrollees are enrollees receiving Medicaid (TennCare) and Medicare benefits. Of these, approximately 60,537 non-dual and 88,303 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 149,000 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 2006 is \$630.16 per month for non-dual enrollees and \$197.96 per month for dual enrollees. Based upon these average costs per enrollee, the approximate cost for the 60,537 non-dual and 88,303 dual enrollees who have lost SSI eligibility but remain on TennCare without a new determination of eligibility was \$458 million and \$210 million, respectively. As a result, the total amount paid for these enrollees is approximately \$668 million for year ended June 30, 2006.

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 that the state does not have a court-approved plan that has been agreed to by Plaintiffs' counsel in *Daniels*. The Deputy Commissioner will continue to work towards a court-approved proposal with Plaintiffs' counsel.

After consultation with Medicaid programs from neighboring states, a verification request form letter has been developed and implemented effective June 7, 2006, by the TennCare Director of Eligibility Services, to disenroll those persons who move out of state and receive Medicaid in another state. TennCare will continue to disenroll those persons who Plaintiffs' counsel has agreed that we may disenroll.

2. For the fourth year, TennCare still 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 three audits, TennCare's administrative appeals process is not sufficient to ensure management's compliance with the federal requirement governing timely resolution of administrative appeals. In January 2005, TennCare contracted with the Tennessee Department of Human Services (DHS) to process administrative appeals.

TennCare applicants and enrollees have the opportunity to appeal and have an administrative hearing regarding the denial of their application, access to insurance, 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 DHS. By policy and practice in effect during the audit period,

- DHS reinstates coverage for enrollees who have filed an appeal within 20 days of the adverse action and processes the appeal;
- DHS does not reinstate coverage for enrollees who have filed an appeal between the 21st and 40th days but processes the appeal; and
- DHS 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 administrative appeals be processed and resolved within 90 days of receipt of an appeal. According to DHS management, if DHS 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.

TennCare's comment to the most recent prior finding is noted below. Management's comments for the three prior audit findings are exhibited on page 21 in the appendix to this report. TennCare concurred with the prior-year finding and stated:

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 [Administrative Law Judges] 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.

During fieldwork, we selected a sample of 60 of 37,075 enrollees whose administrative appeal exceeded the 90-day federal requirement. Based on testwork performed, we found that for 14 of the appeals, the delays were beyond the control of DHS. However, for the remaining 46 administrative appeals we sampled (77%), neither TennCare nor DHS could provide a reasonable justification to exceed the 90-day requirement. According to DHS, the lack of timeliness resulted from the high volume of appeals received during the disenrollment process that took place in 2005. For 39 of the 46 appeals, it appears that TennCare may have incurred additional costs of providing services as a result of the delay.

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 should ensure that an assessment is made by the appropriate TennCare staff in order to determine if the controls implemented according to management's prior audit comments are resulting in timely resolution of appeals. DHS should be made aware of the results of the assessment, and TennCare should continue to work with DHS as necessary to identify any impediments to timely resolution and make changes to the process accordingly.

The Director of TennCare should ensure that other risks of noncompliance, fraud, waste, or abuse are adequately identified and assessed in the bureau's documented risk assessment. The Director should implement effective controls to ensure compliance with applicable requirements, and should assign staff to be responsible for ongoing monitoring of the risks and mitigating controls, and take action if deficiencies occur.

Management's Comment

We concur with this finding. Since the transfer of the administrative appeals process to DHS, we believe there has been improvement in the timeliness of the appeals being heard. However, the Bureau recognized 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 hearing dockets available.

While the Bureau does concur with the finding, we believe that the number of appeals over 90 days is directly related to the disenrollment and benefit changes that were implemented in FY2005-2006. TennCare disenrolled 170,000 adults and restructured the benefits of approximately 600,000 adults. In both situations, enrollees were given the right to appeal to DHS in accordance with CMS regulations. DHS and TennCare have already seen a more manageable trend of appeals in the current fiscal year.

Beginning in July 2006, all eligibility appeals processed by DHS are scheduled to be heard by hearing officers from DHS rather than administrative law judges from the Secretary of State. By streamlining the process such that an appeal is entirely processed from beginning to end by DHS without sharing responsibility for processing with another agency, this brings some important changes which directly impact the expeditiousness with which an appeal is handled. First, it reduces the cost of conducting the hearings to the State; and second, it provides DHS and TennCare with the ability to more closely monitor and control the number of hearing dockets available.

3. Management still has not assessed and mitigated the risks associated with ineffective controls over enrollees' social security numbers

Finding

As noted in the prior nine audits, the Bureau of TennCare continues to have internal control weaknesses related to enrollees' invalid and "pseudo" social security numbers.

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.

This issue was first reported in the audit for the year ended June 30, 1997. Management's comments for the eight prior audit findings are exhibited on page 23 in the appendix to this report.

In management's comment to the most recent audit for the year ended June 30, 2005, management concurred in part by stating,

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 notifies 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 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.

As a result of our testwork for the current audit, we determined that TennCare has implemented procedures to identify individuals with invalid social security numbers. Based on discussion with TennCare staff, we determined that they are following these 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 established 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 July, September, and December 2005, and March and June 2006. However, despite these procedures, TennCare continues to experience problems related to social security numbers for DCS children in adoption assistance.

We used computer-assisted audit techniques to search interChange for invalid and pseudo social security numbers. Our search revealed that 24,549 TennCare participants (excluding newborns under one year of age) had invalid or pseudo social security numbers in interChange

during the fiscal year ended June 30, 2006. Because there are valid reasons for issuing pseudo numbers, and because TennCare could have updated valid social security numbers for these participants, we selected a sample of 60 participants from this population for further examination. Our results of the 60 participants sampled revealed that:

- 35 participants had an updated current social security number;
- 6 participants did not have an updated social security number, but they were subsequently terminated from TennCare; and
- 13 participants were undocumented aliens or refugees who only received coverage for emergency medical services, which is required by federal law.

However, we did note the following problem:

- For 6 of the 60 participants (10%), we determined that neither TennCare nor its contractors had updated interChange or ACCENT to reflect valid social security numbers as of November 2006. All six enrollees were identified as receiving adoption assistance maintenance payments under Title IV-E. These enrollees have been on TennCare since at least September 2005.

The total amount paid during the audit period for the six individuals with uncorrected pseudo social security numbers was \$15,307. Federal questioned costs totaled \$9,716. The remaining \$5,591 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.

Recommendation

The Director of TennCare should continue to work with the Department of Children's Services to make the necessary system changes that will ultimately eliminate pseudo social security numbers for all children receiving adoption assistance and develop procedures to resolve the pseudo social security numbers for existing children.

The Director should ensure that other risks of noncompliance, fraud, waste, or abuse are adequately identified and assessed in the bureau's documented risk assessment. The Director should implement effective controls to ensure compliance with applicable requirements, assign staff to be responsible for ongoing monitoring of the risks and mitigating controls, and take action if deficiencies occur.

Management's Comment

We concur. 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 Social Security Number by Social Security Administration." 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 a valid number. If the valid number is not provided, the enrollee's coverage is terminated.

TennCare has been working with the Department of Human Services and the Department of Children's Services to resolve the outstanding issues related to pseudo social security numbers. DHS has established a process to periodically notify their county office staff of pseudo numbers that do not fit into the acceptable criteria. The county offices then must attempt to contact the enrollee and attempt to identify the correct number. If the enrollee is not cooperative or a valid number cannot be found, eligibility is terminated. County offices then report their actions to the Central Office.

DCS has established a process to eliminate the creation of pseudo social security numbers for children in custody and the Adoption Assistance program. However, the outstanding issue remains for the existing children with pseudo numbers. DCS initiated an outreach campaign this fall to identify and resolve previously issued pseudos. TennCare has seen a substantial decrease in the number of pseudo social security numbers since this outreach campaign has been implemented.

We believe the addition of these two processes along with the work already being performed by TennCare staff will drastically reduce the number of pseudo social security numbers on our system.

4. As noted in the prior four audits, a TennCare provider could not provide documentation to substantiate a claim for a service provided to a TennCare enrollee, resulting in unsupported costs to the TennCare program

Finding

A TennCare provider could not substantiate a fee-for-service claim for a service provided to a TennCare recipient, resulting in unsupported costs to the TennCare program. We tested a sample of 107 fee-for-service claims to determine the adequacy of documentation supporting the medical costs associated with these claims. We reviewed items such as medical records, cost plans, service logs, office visit and procedure notes, and physician orders to determine if the claims were adequately supported. Testwork revealed a problem with only one of 107 claims (<1%). Specifically, we noted the following:

- The provider for one Home and Community Based Services (HCBS) recipient overcharged TennCare for 21 transportation units. The provider could only substantiate five transportation units, or \$35 in charges; however, the provider billed—and the Department of Finance and Administration, Division of Mental Retardation Services, paid—\$183. TennCare subsequently reimbursed the Division of Mental Retardation Services for this amount.

This issue was first reported in the audit for the year ended June 30, 2002. Management's comment to the most recent prior finding is noted below. Management's comments for the three prior audit findings are exhibited on page 28 in the appendix to this report.

In the audit for the year ended June 30, 2005, management stated,

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.

Management has developed several procedures to conduct medical necessity and post-payment reviews of fee-for-service claims, including HCBS claims, and has recovered inappropriate payments. However, we believe that because of the nature, complexity, and magnitude of the TennCare program, payments of this type may still exist. The total amount of questioned costs for the claim noted above was \$148 out of a total of \$67,308 tested. Federal questioned costs totaled \$95. The remaining \$53 was state matching funds. The total amount of

the population sampled was \$5,280,207,190. 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 to conduct post-payment reviews of medical records to detect overcharges by providers and recover overpayments when necessary. The Director should also clearly establish the expectation that the providers maintain adequate documentation to support services billed.

The Director should ensure that other risks of noncompliance, fraud, waste, or abuse are adequately identified and assessed in the bureau's documented risk assessment. The Director should implement effective controls to ensure compliance with applicable requirements, assign staff to be responsible for ongoing monitoring of the risks and mitigating controls, and take action if deficiencies occur.

Management's Comment

We concur. TennCare's Utilization Review Section within the Division of Developmental Disability Services continues to actively review 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 (as required by their contracts and/or provider agreements), and should act as a deterrent to discourage them from wrongful conduct.

5. The Department of Finance and Administration's Office for Information Resources has not implemented adequate controls over information security within two areas

Finding

The Department of Finance and Administration's Office for Information Resources has not implemented adequate controls over information security within two areas. The state's *Enterprise Information Security Policies*, Section 9. Access Control Policy, requires that "Access to the State of Tennessee's information resources shall be granted consistent with the concept of least privilege. All information processing systems owned by the State of Tennessee shall have an appropriate role-based access control system that ensures only legitimate users and/or systems have access to data resources that they are explicitly authorized to use." The auditors observed

significant conditions within two areas that violated this policy. Failure to consistently comply with this policy 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.

This finding is a reportable condition for purposes of the State of Tennessee Single Audit of federal financial assistance. This wording also appears 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 these conditions are remedied by the prompt development and implementation of effective controls (standards and procedures) to ensure compliance with stated policy. The Chief Information Officer should ensure that these controls include ongoing monitoring of their effectiveness. 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 with this finding. OIR has taken significant steps to ensure adequate controls over information security are effective. OIR is working on compliance plans internally to help close the gaps between security policy and technology practice and to further refine the definition of risk, adequacy, "secure" and their associated internal control objectives. This action will include the development and implementation of effective controls (standards and procedures) to ensure compliance with stated policy. The remediation of the controls identified herein is targeted for completion by the end of April 2007.

STATUS OF PRIOR AUDIT FINDINGS

State of Tennessee *Single Audit Report* for the year ended June 30, 2005

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

- the inappropriate recording of administrative payments to a Behavioral Health Organization as medical assistance payments;
- inadequate controls to prevent or detect duplicate payments made to Managed Care Contractors;
- inadequate controls related to provider disclosures related to ownership and control information, and criminal offense histories;
- compliance with the terms of the Home and Community Based Waiver regarding providers' voluntary reassignment of payment; and
- inadequate network security controls.

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;
- TennCare's untimely administrative appeals process;
- internal control over TennCare eligibility related to invalid social security numbers; and
- TennCare's providers not substantiating the medical costs associated with fee-for-service claims.

These findings are repeated in the *Single Audit Report* for the year ended June 30, 2006.

Most Recent Financial and Compliance Audit

Audit report number 05/046 for the Department of Finance and Administration, issued in February 2007, 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

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 circumventions 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 controls 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.

APPENDIX

Previous Responses From Management to Repeated Audit Findings Included in This Report

Current Finding

Although TennCare management continues to acknowledge its responsibility to take action in this matter, for the seventh 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

Management's Comments

For the Year Ended June 30, 2000

We concur in part. 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.

For the Year Ended June 30, 2001

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

The Director will ask the Attorney General to take action to bring this issue back before the court for final disposition. This request will be based, at least in part, upon the decision in Cureton v. Rudolph, in which the United States District Court for the Middle District of Tennessee, Nashville Division, held that the State is bound by disability decisions made by the Social Security Administration. Therefore, an enrollee is not entitled to a State hearing on an allegation of disability which has been declined or revoked by the SSA.

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.

For the Year Ended June 30, 2002

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.

For the Year Ended June 30, 2003

We do not concur. 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.

Auditor's Rebuttal

Management has stated "we do not concur"; however, nowhere in its response has management taken issue with any statements made in the finding or the recommendation. As stated in the audit finding, management concurred with this repeated condition the past two years and concurred in part with this issue in a finding for year ended June 30, 2000. Management acknowledges in their response that TennCare still does not have a court approved plan to terminate these enrollees. Currently, individuals who have lost their SSI eligibility remain on TennCare for services indefinitely until the individuals die, move out of state and receive Medicaid in another state, or request in writing to be disenrolled. In light of the state's budget problems and the high costs of TennCare to the citizens that ultimately pay these costs, efforts should continue to be made to obtain a court approved plan to allow termination of these enrollees.

For the Year Ended June 30, 2004

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.

Current Finding

For the fourth year, TennCare still 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

Management's Comments

For the Year Ended June 30, 2003

We concur in part. 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.

Auditor's Comment

A performance audit report dated October 30, 2003, regarding TennCare's administrative appeals process describes the extent of problems with the appeals process, most of which are within the TennCare Director's ability to correct.

For the Year Ended June 30, 2004

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.

Current Finding

Management still has not assessed and mitigated the risks associated with ineffective controls over enrollees' social security numbers

Management's Comments

For the Year Ended June 30, 1997

We concur. . . . We do acknowledge that some enrollees may at some period in their enrollment history have a pseudo number for the reasons described in the finding. This is due to the state's wish to provide needed care to children as soon as possible. The reverification project...will help ensure that valid numbers are obtained for enrollees when available and measures can be taken to contact the enrollee at a later date to obtain a social security number when the number is not available upon birth or enrollment.

For the Year Ended June 30, 1998

We concur. . . . The Health Departments included information in their training that addressed validation of Social Security Numbers and obtaining a valid number for enrollees with pseudo numbers. As stated in this audit finding, pseudo Social Security number assignments will continue to occur for newborns because TennCare does not want to delay a child's access to health care because they haven't received an official Social Security number.

For the Year Ended June 30, 1999

We concur. . . . [Management did not address the pseudo social security numbers issue in their comment.]

For the Year Ended June 30, 2000

We concur in part. . . . 4. Pseudo Social Security Numbers. It is our intent to address this issue as part of our planning for the new TCMIS.

For the Year Ended June 30, 2001

We concur. 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). The TCMIS assignment of pseudo social security numbers occurs for newborns to the system through the uninsured/uninsurable process. Currently, any adds to the TCMIS will also assign pseudo social security numbers for any record added to the system received from eligibility determination by external entities such as the Department of Human Services (DHS) and the Social Security Administration (SSA).

For the Year Ended June 30, 2002

We concur in part. 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. Effective July 1 2002, all eligibility determinations are made by DHS where eligibility information is entered into the ACCENT system. If a number is blank or invalid, ACCENT does an automatic front end match of SSNs entered into the system and provides an 'alert' to the case worker if an adjustment needs to be made. DHS also has a systems report of individuals for those that cannot be matched (usually newborns) that workers are to check. DHS also uses State online Query (SOLQ) to verify a number if an individual does not have a card. ACCENT does not allow two individuals to use the same SSN.

Auditor's Rebuttal

Regarding the invalid or pseudo social security numbers again discovered, it is not clear from management's comments which part of the issue management does not concur.

For the Year Ended June 30, 2003

Invalid and Pseudo Social Security Numbers

We concur in part. As described below, procedures have been implemented to continue to identify and correct invalid and pseudo social security numbers (SSN) through research and outreach activities or through the annual redetermination process. The TCMIS assignment of pseudo social security numbers (SSN) occurs correctly when newborns are entered into the system prior to issuance of a social security number and when emergency benefits are provided for illegal/undocumented aliens, since they cannot obtain an SSN legally. Illegal/undocumented alien cases are the only cases that will never have a 'real' SSN. Except for the aforementioned cases, TennCare requires that DHS have the enrollee/applicant's SSN unless there is documentation presented to DHS that an enrollee/applicant has applied for an SSN. Under federal regulations, a service to an eligible enrollee/applicant cannot be denied while waiting for an SSN; however, DHS is expected to provide updates to TennCare for SSNs once they are obtained. As part of our follow-up to this finding, we will work with DHS to ensure procedures for such cases are being handled appropriately.

Analysis of the auditor's complete group of 14,687 individuals indicated that 3,448 of these enrollees continue with pseudo SSNs and currently exceed 1 year of age or are not an illegal/undocumented alien or refugee. The remainder of the group had been corrected by TennCare in the normal course of operations.

As stated by the auditors, their testwork on a sample of 60 individuals in the group indicated that 13 enrollees' SSNs had been corrected by September 30, 2003 and 42 additional enrollees had been terminated from the program by December 31, 2003. Of the 42 terminations, 37 of them occurred by the end of the audit period, June 30, 2003. Many of the terminations resulted because the enrollee failed to respond to the redetermination notice. Enrollees were

given 90 days to contact DHS to schedule appointments. In December 2002, TennCare delayed terminating individuals that were scheduled for termination due to “no response” because of a federal court order. These enrollees were later termed in March 2003. Terminating eligibility is an appropriate process that is in addition to any other steps TennCare takes to update and replace pseudo social security numbers. The redetermination/renewal process is a mechanism designed to assure enrollees remain eligible and that TennCare has current and correct information.

The process to identify and correct invalid or pseudo social security numbers begins with the eligibility process. Eligibility determinations are made by DHS where eligibility information is entered into the ACCENT system. If a number is blank or invalid, ACCENT does an automatic front end match of SSN’s entered into the system and provides an ‘alert’ to the case worker if an adjustment needs to be made. DHS also has a systems report of individuals for those that cannot be matched (usually newborns) that workers are to check. DHS also uses State on-line Query (SOLQ) to the Social Security Administration’s database to verify a number if an individual does not have a card. ACCENT does not allow two individuals to use the same SSN.

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.

Department of Human Services

Invalid and Pseudo Social Security Numbers

We concur. The department will continue to monitor invalid and missing social security numbers to ensure that all individuals have valid numbers and that this information is transferred

to the TennCare system. Data matching is automatically done when a social security number is entered into ACCENT and an alert is sent to the caseworker if the number is invalid or incorrect. Reports are also used to identify individuals for whom an incorrect or no social security number has been entered.

The department is required to document a valid social security number for each applicant. In the case of an individual who does not have a social security card, caseworkers are to assist the applicant in applying for a social security number and documenting that an application for a social security number has been made. The application for a social security number allows for the approval of program benefits. When the social security number is received, the client must report the number to DHS. The department does not enter information in the social security number field for the file created for the TennCare TCMIS system until the receipt of the social security number from the client.

Auditor's Rebuttal

Invalid and Pseudo Social Security Numbers Again Discovered

It is not clear with which part management does not concur. Management agrees that there continue to be 3,448 enrollees with invalid social security numbers.

For the Year Ended June 30, 2004

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.

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.

Current Finding

As noted in the prior four audits, a TennCare provider could not provide documentation to substantiate a claim for a service provided to a TennCare enrollee, resulting in unsupported costs to the TennCare program

For the Year Ended June 30, 2002

TennCare Division of Long Term Care

We concur with regard to Home and Community Based Services claims. Adequate documentation was not provided to auditors to document provision of services billed. We do not know at this point if the documentation did not exist or if it was just not provided. We have obtained information regarding the claims tested and have provided this information to DMRS. DMRS regional office staff are assisting in researching whether there is sufficient documentation to support the claims paid. If the documentation does not exist, recoupments will be initiated as appropriate.

For the Year Ended June 30, 2003

HCBS MR Waiver Services

We concur that providers did not submit documentation to the auditors as requested. It is unclear whether documentation did not exist or whether it was not provided to the auditors to properly document the provision of billed services. Audit findings will be provided to the Division of Mental Retardation Services (DMRS) for review and appropriate resolution. DMRS

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 perform monitoring activities to ensure the implementation of corrective actions. Corrective actions will include recovery of funds for claims that are not supported.

To increase the number of staff to perform quality monitoring and utilization review, the TennCare Division of Developmental Disability Services hired a Unit Manager for the Quality Monitoring and Utilization Review Unit on October 15, 2003, and hired two additional full-time quality monitoring surveyors on September 1, 2003, and October 1, 2003. Efforts are currently ongoing to fill the one remaining vacant quality monitoring surveyor position. Another position in the Division of Developmental Disability Services will be converted to a quality monitoring surveyor position and will be filled as soon as possible. It is anticipated that the remaining vacancies will be filled by July 1, 2004.

For the Year Ended June 30, 2004

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.