

TennCare Administrative Appeals
February 24 Through March 31, 2003

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**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

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John G. Morgan
Comptroller

October 30, 2003

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

and

Mr. Manny Martins, Deputy Commissioner

Bureau of TennCare

729 Church Street, 5th floor

Nashville, Tennessee 37247

Ladies and Gentlemen:

Transmitted herewith is the performance audit of TennCare Administrative Appeals.
This audit was conducted pursuant to Section 4-3-304, *Tennessee Code Annotated*.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/ab
03-063

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit

TennCare Administrative Appeals

For the Period February 24, 2003, Through March 31, 2003

AUDIT OBJECTIVES

The objectives of the audit were to evaluate the efficiency and effectiveness of the TennCare Administrative appeals process and to recommend alternatives for administrative action that may result in more efficient and effective processing of TennCare administrative appeals.

ANALYSIS AND CONCLUSIONS

Inconsistent Application of Policy/Lack of Policy in Some Areas and Inconsistencies Regarding Appeal Time Frames

During our review, we identified areas in the appeals process where policy was not followed. In some instances, management specifically instructed staff to disregard established policy. We also identified areas in which management needs to establish and implement additional policies to address weaknesses in the administrative appeals process (page 15). In addition, we noticed that language in the TennCare rules which describes the time frame for submitting an appeal is not consistent with actual practice (page 17).

Untimely Processing of TennCare Administrative Appeals (Time Analyses and Backlogs/Delays)

Based on our analyses, TennCare is not processing administrative appeals in a timely manner due to a number of reasons. Additionally, by not processing appeals in a

timely manner, TennCare is not complying with federal regulations and is also paying to provide interim coverage until backlogged appeals are resolved (page 17).

Inadequate Tracking of TennCare Administrative Appeals (Tracking Systems and Recording Appeal Information)

TennCare does not have the ability to track appeals from the date an appeal is received until its final resolution. Furthermore, tracking systems used by the various units involved in processing administrative appeals are not integrated, making it difficult to obtain and analyze appeals data (page 24).

Scheduling Appeals for Hearing

We believe that a significant number of applicants/enrollees scheduled for a hearing do not want a hearing, even though they do not complete a form declining a hearing. TennCare does not adequately discern if an

applicant/enrollee actually wants to go to a hearing. As a result, a number of appeals that are scheduled for a hearing may be unnecessary and are, therefore, burdening the system, creating backlogs and untimely resolution of cases and negatively affecting the OGC's ability to track cases. In addition, withdrawn and dismissed appeals cost the state money (page 25).

No Follow-up on Appeals Sent to the Department of Human Services

The Bureau of TennCare has not followed up with DHS to ensure that appeals sent to the Department of Human Services have been addressed (page 27).

"Audit Highlights" is a summary of the audit report. To obtain the complete audit report, which contains all findings, recommendations, and management comments, please contact

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**Performance Audit
TennCare Administrative Appeals**

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
Purpose and Authority for the Audit	1
Objectives of the Audit	1
Scope and Methodology of the Audit	1
Issues Related to the Bureau of TennCare’s Administrative Appeals Process	2
Issues for Further Consideration	5
Overview of TennCare	6
Background	6
Eligibility Determination/Redetermination	6
Due Process/The Right to Appeal	7
The TennCare Administrative Appeals Process	8
Enrollment, Eligibility, and Redetermination Unit	8
Administrative Appeals Unit	9
Office of General Counsel	13
Administrative Law Judges/TennCare Hearing Officers	13
The Administrative Appeals Environment	13
ANALYSIS AND CONCLUSIONS	15
Policies and Procedures	15
Inconsistent Application of Policy/Lack of Policy in Some Areas	15
Inconsistencies Regarding Appeal Time Frames	17
Untimely Processing of TennCare Administrative Appeals	17
Time Analyses	18
Backlogs and Delays	22
Inadequate Tracking of TennCare Administrative Appeals	24
Tracking Systems	24
Recording Appeal Information	25
Scheduling Appeals for Hearing	25
No Follow-up on Appeals Sent to DHS	27

TABLE OF CONTENTS (Cont.)

	<u>Page</u>
RECOMMENDATIONS	28
Data Reliability	28
Policies and Procedures	29
Timeliness	29
Tracking Systems	29
Scheduling Appeals for Hearing	30
Appeals Sent to the Department of Human Services	30
TENNCARE MANAGEMENT’S COMMENT	30

Performance Audit TennCare Administrative Appeals

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of TennCare administrative appeals was conducted pursuant to Section 4-3-304, *Tennessee Code Annotated*, which authorizes the Department of Audit “to perform currently a post-audit of all accounts and other financial records of the state government, and of any department, institution, office, or agency thereof . . . [and to] perform economy and efficiency audits, program results audits, and program evaluations.”

OBJECTIVES OF THE AUDIT

The audit objectives were

1. to evaluate the efficiency and effectiveness of the TennCare administrative appeals process and
2. to recommend alternatives for administrative action that may result in more efficient and effective processing of TennCare administrative appeals.

SCOPE AND METHODOLOGY OF THE AUDIT

The Bureau of TennCare’s activities and procedures relating to administrative appeals were reviewed, with focus on procedures in effect at the time of fieldwork (February 24 to March 31, 2003). The audit was conducted in accordance with standards applicable to performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. The methods included

1. interviews with TennCare staff involved in the administrative appeals process;
2. interviews with administrative law judges and TennCare hearing officers;
3. reviews of bureau files, documents, and reports relating to administrative appeals;
4. reviews of statutes and state and federal rules and regulations; and
5. interviews with, and reviews of reports and documents from, the Pacific Health Policy Group.

Our scope was limited by flaws in the data provided by TennCare. We took steps to ensure these flaws did not affect our analyses and conclusions by omitting certain data from our test work. These flaws included

- invalid social security numbers,
- invalid dates,
- names and social security numbers not matching, and
- lost or missing data.

ISSUES RELATED TO THE BUREAU OF TENNCARE'S ADMINISTRATIVE APPEALS PROCESS

The objective of the administrative appeals process is to provide a fair hearing for TennCare Standard applicants and recipients whose claim for assistance under the program is denied or whose TennCare eligibility is terminated. This process also addresses appeals concerning cost-sharing disputes and coverage-effective dates of enrollees. The Bureau of TennCare is responsible for maintaining an appeals process that provides for notice to applicants/recipients of the opportunity for a fair hearing before the Bureau.

Issue Areas and Matters for Action:

- I. The TennCare administrative appeals process is not an effective or efficiently run process. The TennCare program has been and will continue to be faced with sometimes unforeseen challenges. When these events have occurred, the process has slowed even more; staff have not been prepared to handle increases in the volume of appeals, nor has management responded quickly to appeals process issues. Top management has not provided clear, comprehensive policies to address TennCare's constantly changing environment. See pages 15-17 for details regarding management's lack of policies and failure to follow established policies.

There were several preexisting characteristics of the appeals process that exacerbated the crisis that occurred when huge volumes of appeals were received after the massive eligibility redetermination efforts. In all cases, top TennCare management should have known that these weaknesses already existed and should have better prepared for the overwhelming increase in appeals received by the Bureau. It should have been no surprise that these factors would be detrimental to the appeals process. Those factors included the following:

- TennCare duplicates appeal-tracking efforts by maintaining multiple tracking systems; however, even with all of the tracking efforts, TennCare is unable to track an appeal from the date of receipt to its final resolution.
- The TennCare Enrollment, Eligibility, and Redetermination (EER) Unit tracks appeals by a TennCare case identification number, which identifies only the head of the household, rather than tracking the appeal by name of the person filing the appeal. This obviously makes it difficult for TennCare staff to locate the appeal by the appellant's name.

- TennCare’s Management Information System (TCMIS) experiences substantial downtime (on average, 17% for the audit period), which impedes the staff’s ability to process appeals.
- Top management did not react quickly to unexpected events. For example, when the volume of appeals received increased dramatically, TennCare did not own enough licenses for the ProLaw tracking system used by the Administrative Appeals Unit and the Office of General Counsel. Therefore, the Bureau could not utilize additional staff to compensate for the increase in appeals. As a result of inaction and indecision concerning whether to purchase more ProLaw licenses, the backlog of appeals has remained. Other examples include management’s indecision in handling appeals from enrollees who failed to respond to the eligibility redetermination effort and appeals from enrollees who have not suffered an adverse action and are currently still eligible. See pages 15-16 for discussion related to these appeals.
- TennCare management does not conduct routine and comprehensive analyses to identify weaknesses in the appeals process. Analyses performed by the auditors included the following:
 1. Average number of days to process an appeal in each unit.
 2. Number of administrative appeals withdrawn or dismissed.
 3. Average costs of interim TennCare coverage for appellants whose appeal is not resolved within the 90-day time frame. TennCare already maintains this information related to costs but does not use it to make the process more efficient.
 4. Average costs associated with scheduling an appeal for hearing (court reporters’ fees, lawyer travel, mailing costs). Although this cost information is also already available, TennCare does not track the costs of scheduling the hearing and thus cannot determine the total costs to the state for appeals that are withdrawn or dismissed. If management had been aware of the average costs associated with processing appeals for hearing, management might have been quicker to react to the unnecessary costs of scheduling hearings that are ultimately withdrawn or dismissed, and taken immediate action to address this issue. (Note: the auditors did not attempt to determine the average cost related to withdrawn or dismissed appeals.)
- The Pacific Health Policy Group (PHPG), a consulting group retained by TennCare to conduct an operational review of TennCare’s Office of General Counsel (OGC) and the Secretary of State’s Administrative Procedures Division, concluded in a June 2001 report that
 1. The number of appeals sent to hearing was growing to a level that exceeds historical experience.

2. Growth in the appeals was partly attributable to the “open” system whereby matters not normally considered for a fair hearing are forwarded to a hearing.
3. A significant portion of all scheduled hearings were not desired by the appellant, and they consequently withdrew or failed to show at the hearing. (Apparently applicants/enrollees file an appeal when what they really need is an explanation of why they are denied or terminated. In addition, some applicants/enrollees file appeals based on recommendation of an advocacy group or because they are confused by what they read in the newspapers.)
4. Average appeal processing times exceeded federal and state standards.

II. Management has taken numerous steps to address the appeals process that have not only failed to correct existing problems, but have actually made matters worse. The following decisions were made in consultation with TennCare’s former Assistant Commissioner for Member Services (see pages 15-16).

- The Administrative Appeals Unit (AAU) Director instructed staff to cease date-stamping appeals received from the EER unit mailroom. This decision resulted in the Bureau’s inability to track appeals. According to the AAU Director, this decision was made so that staff would focus on processing the appeals rather than expending the time required for date-stamping the appeals.
- The AAU Director made the decision to stop sending acknowledgement letters to appellants confirming that their appeal had been received. As a result, applicants/enrollees who have filed an appeal have no idea whether the appeal has been received or where it is in the process until they receive a letter of disposition. This may cause applicants/enrollees to file duplicated appeals and further slow the process. Again, this decision was made so that time could be spent actually processing the appeals rather than preparing the letters.
- The AAU Director made the decision to process newly received appeals before older appeals since the older appeals were already beyond the federally required 90-day time limit to resolve appeals. Thus, the old appeals get even older, and applicants/enrollees file duplicated appeals, again slowing the process.

III. There was a failure among management in the EER, AAU, OGC, and top management sections of the Bureau of TennCare to adequately coordinate and plan activities so as to minimize negative consequences. (See pages 24-25.)

- The Director of TennCare has directed staff, on several occasions, to stop the task at hand and focus efforts on a different crisis. With the Director of TennCare frequently changing the staff’s priorities, lower-level staff are left confused and frustrated.

- A TennCare Office of General Counsel managing attorney released half of its administrative appeals docket space to the Medical Appeals Unit because administrative appeals were not being processed fast enough to get on available dockets. While this may have been appropriate temporarily, once appeals were prepared and ready for hearing, the OGC could not schedule the hearings because of the lack of available administrative appeals docket space.

IV. Our audit scope was limited by flaws in the appeals data provided by TennCare. As a result, we removed approximately 1,000 appeal records from our analyses. Because TennCare management and staff have not performed any analyses with the data, they were not aware of the flaws, which included

invalid social security numbers,
invalid dates,
names that did not match social security numbers, and
lost or missing data.

ISSUES FOR FURTHER CONSIDERATION

TennCare knows of future events that will have an adverse effect on the appeals process if management does not take immediate action to correct the weaknesses identified in this report. These events include a new system conversion; the new Health Insurance Portability and Accountability Act (HIPAA) regulations; upcoming changes in TennCare enrollee benefits; and finally, with the end of the Governor's grace period, an anticipated increase in the volume of appeals as enrollees' eligibility is terminated.

In other words, more potential crises are foreseeable. Statements that management cannot be expected to deal with crises should not be accepted as excuses in the future. The Governor should demand accountability at every level of TennCare. When problems are not identified and communicated to the head of TennCare, it should be determined who knew the problem, what they did to address it, and to whom it was communicated and when. All significant communications should be in writing.

Decisions made by the head of TennCare should be appropriately, timely, and clearly communicated in writing to all appropriate staff. Those decisions should be made after ensuring that all pertinent information has been received, or at least requested, and considered. That consideration should include a new sensitivity to, and recognition of the consequences of, the decision for the various offices in TennCare.

Top management's practice of uncoordinated actions, based on insufficient information, focused on only short-term issues must cease. The head of TennCare should take steps to ensure that he knows of the issues and problems in the program and should take immediate remedial action. It should be of no comfort to the head of TennCare or those he reports to that he did not know how bad things were. It should be of concern when the head of TennCare needs an outside source to inform him of things he should already know about.

OVERVIEW OF TENNCARE

Background

On January 1, 1994, Tennessee withdrew from the federal Medicaid program to implement a new health care reform plan called TennCare. The U.S. Department of Health and Human Services Centers for Medicaid and Medicare (CMS), formerly the Health Care Financing Administration (HCFA), granted Tennessee approval to implement a demonstration project under Section 1115 of the Social Security Act. Under this new plan, the state extended health care coverage not only to Medicaid-eligible Tennesseans, but also to uninsured and uninsurable persons, using a managed care system. The initial demonstration project ended on December 31, 1998, and the U.S. Department of Health and Human Services then approved a waiver extension for three years beginning January 1, 1999, through December 31, 2001. There have since been two waiver extensions — the first for the month of January 2002 and the second from February 1, 2002, through January 31, 2003. Before the second waiver extension expired, the U.S. Department of Health and Human Services approved a new TennCare demonstration project for five years, effective July 1, 2002, through June 30, 2007.

The new waiver separated TennCare into three products: TennCare Medicaid, TennCare Standard, and TennCare Assist. TennCare Medicaid includes the Medicaid population, while TennCare Standard includes the uninsured and “medically eligible” populations. (“Medically eligible” is a new term to describe persons previously referred to as “uninsurable.”) People eligible for TennCare Standard are adults below 100% of the federal poverty level (FPL), children below 200% FPL, as well as people who are “medically eligible.” TennCare Assist will help low-income persons buy insurance that may be available to them through their work or elsewhere. TennCare Assist will begin January 1, 2004, subject to legislative appropriations.

Eligibility Determination/Redetermination

The new TennCare waiver incorporates some significant changes regarding eligibility determination. Prior to July 2002, Medicaid eligibility was determined by the Department of Human Services (DHS), and eligibility for the demonstration population (uninsured and uninsurables) was determined by the Department of Health or the TennCare Bureau. As of July 2002, almost all eligibility determination activities were transferred to the Department of Human Services, thus creating a unified TennCare eligibility determination process.

All applicants for TennCare, except Supplemental Security Income (SSI) recipients and children in state custody, must complete a written application and be interviewed by a DHS caseworker at their local DHS office. (There is a DHS office in each of Tennessee’s 95 counties.) SSI applicants apply through the Social Security Administration and are automatically enrolled in TennCare Medicaid upon approval of SSI benefits. Children in state custody are enrolled through the Department of Children’s Services.

During the application interview, the DHS caseworker enters the applicant's information into the DHS system. The state's automated eligibility system (ACCENT) determines Medicaid eligibility by category based on the information entered by the DHS caseworker. Persons who are not eligible for TennCare Medicaid are screened for TennCare Standard. If the applicant lacks access to insurance, has income below the specified poverty level, and applied during the open enrollment period, that person may be eligible for the TennCare Standard Uninsured category. If the applicant meets all technical eligibility criteria for TennCare Standard but is ineligible solely because of excess income, the applicant is offered an opportunity to apply in the TennCare Standard Medical Eligibility category. These applicants must complete a special form and submit the form to the TennCare Bureau. "Medical eligibility" is then determined by a state-appointed health insurance underwriter, who decides if the applicant has a "qualifying medical condition" as described in TennCare policy. (Diseases/conditions listed in TennCare policy as "qualifying medical conditions" are serious or chronic conditions requiring continued monitoring and/or treatment. Because of the serious nature of these diseases/conditions, most Tennessee insurance companies may deny coverage to individuals with a medical history that includes one or more of these diseases/conditions.)

In July 2002, TennCare began the eligibility redetermination process. Between July 2002 and December 2002, TennCare notified and instructed all demonstration (uninsured and uninsurable) eligibles who were **already enrolled in TennCare** to visit their local DHS office to have their eligibility reviewed. The purpose of redetermination was to determine if persons already in TennCare are eligible for TennCare Medicaid or for TennCare Standard according to the new eligibility requirements in the new waiver. Those who were not Medicaid eligible or did not meet the criteria for TennCare Standard were disenrolled. (See page 14 for additional information about redetermination.)

Due Process/The Right to Appeal

If TennCare denies an application for non-Medicaid enrollment or determines that an enrollee will be disenrolled, it must notify the applicant/enrollee of such action in writing. The notice must contain the following elements:

- an explanation of the reasons for the denial of the application or for disenrollment, including a brief statement of the factual and legal basis on which it relied;
- an explanation of the circumstances under which the TennCare applicant or enrollee may appeal, including information about how to initiate an appeal; and
- an explanation of the TennCare applicant's or enrollee's right to retain counsel or other representation, as well as the right to submit documents or other information in support of a request for appeal.

Medicaid applicants and Medicaid-certified enrollees have the right to appeal denials of Medicaid eligibility to the Department of Human Services. (Because Medicaid appeals are handled by DHS, they were not included in the scope of the audit.) TennCare Standard applicants and enrollees have the opportunity to have an administrative hearing regarding denial of application, effective coverage date, cost-sharing disputes, and disenrollment from TennCare.

Appeals regarding TennCare Standard eligibility are called eligibility or **administrative** appeals and are addressed by the TennCare Bureau. (Enrollees also have the right to appeal actions that affect their TennCare-covered services and benefits. These types of appeals were not included in the scope of our audit.)

Appeals may be submitted verbally or in writing. Individuals wishing to file an oral appeal may call the TennCare Help Line. Written appeals may be submitted either on a TennCare Appeal Form or in a letter.

TennCare Standard applicants and enrollees have 40 days from the date of the adverse action to submit an appeal to the TennCare Bureau. For the purpose of this report, actions taken by TennCare to deny or terminate eligibility are referred to as adverse actions. (This policy is not incorporated in TennCare rules, however. See page 17 for additional information.) Individuals who are identified as seriously and persistently mentally ill (SPMI) or severely emotionally disturbed (SED) are allowed a longer time frame in which to appeal. Thus, by policy and practice in effect during the audit period,

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

Individuals who are identified as seriously and persistently mentally ill (SPMI) or severely emotionally disturbed (SED) are allowed one year from the date of termination to appeal loss of coverage. These individuals are allowed to appeal outside the appeal time frame for reinstatement and can receive coverage beginning with the date of the appeal if they were SPMI/SED-eligible at the time of termination.

THE TENNCARE ADMINISTRATIVE APPEALS PROCESS

As mentioned previously, non-Medicaid TennCare applicants and enrollees have the right to appeal eligibility denial or termination to the TennCare Bureau. Federal regulations (42 CFR 431.244) require that TennCare process and resolve administrative appeals within 90 days of receipt of an appeal. (See page 17 for additional information.) This section describes the administrative appeals process as observed by the audit team during fieldwork. (See pages 15-17 for our analysis of policies and procedures related to the administrative appeals process.)

Enrollment, Eligibility, and Redetermination Unit

The process begins when an appeal is received in the Enrollment, Eligibility, and Redetermination (EER) Unit mailroom located at 706 Church Street, Nashville, Tennessee. The EER Unit mailroom receives all mail/correspondence related to member services, such as address and/or name changes, managed care organization (MCO) change requests, general

correspondence, and administrative and medical appeals. The flow chart on page 10 illustrates EER Unit procedures for processing mail. (TennCare management developed the flow chart and provided it to the auditors after the end of audit fieldwork. However, the chart reflects procedures explained by management and observed by auditors during the audit.)

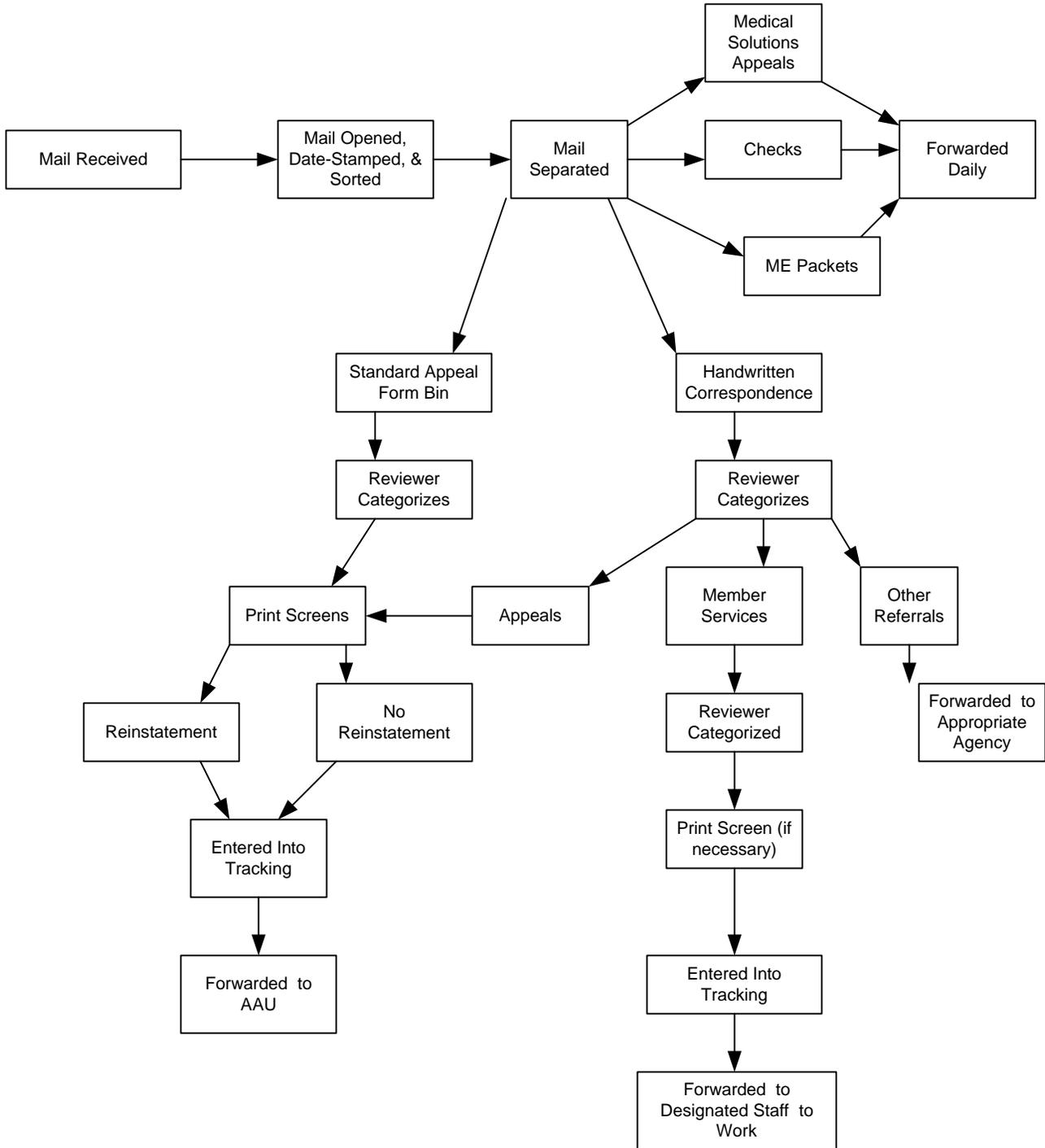
For the purposes of this report, we reviewed EER Unit mailroom procedures that are related to administrative appeals. Mail (including appeal information taken over the phone and documented by staff) is received and opened twice daily—in the morning and early afternoon—date-stamped, and sorted. (The date stamp is the date TennCare received the appeal and is the first day of the federally required 90-day resolution time frame.) Administrative appeals are forwarded to designated staff for review. Reviewers read the appeal, research TennCare and DHS systems to determine the nature of the appeal as well as the nature of the adverse action, and print all DHS and TennCare screens regarding the applicant/enrollee’s information. If an enrollee has appealed within 20 days of the adverse action, the reviewer reinstates the enrollee’s TennCare coverage. Next, reviewers batch appeals according to type, such as Denied Applications, No Responses (appeals from people who did not make an appointment with DHS during redetermination and were terminated from TennCare), etc., and place corresponding cover sheets atop the batched appeals. Reviewers then forward the batched appeals to EER Unit staff, who are responsible for entering appeal information in the EER Unit’s tracking system. When all appeals in a batch are entered into the tracking system, the batch is sent to the Administrative Appeals Unit for further processing.

Administrative Appeals Unit

The Administrative Appeals Unit (AAU) processes appeals received from the EER Unit related to current enrollees and new applicants for TennCare Standard. The flow-chart on page 12 provides a general overview of AAU procedures for processing administrative appeals. This flow chart was contained in the AAU’s *Policies and Procedures Manual*, which was given to the audit team during fieldwork.

Within the AAU are four units: Triage, Denied Applications, Redeterminations, and Hearing Prep. Each unit has a designated responsibility, and workflow is guided by each unit’s team leader.

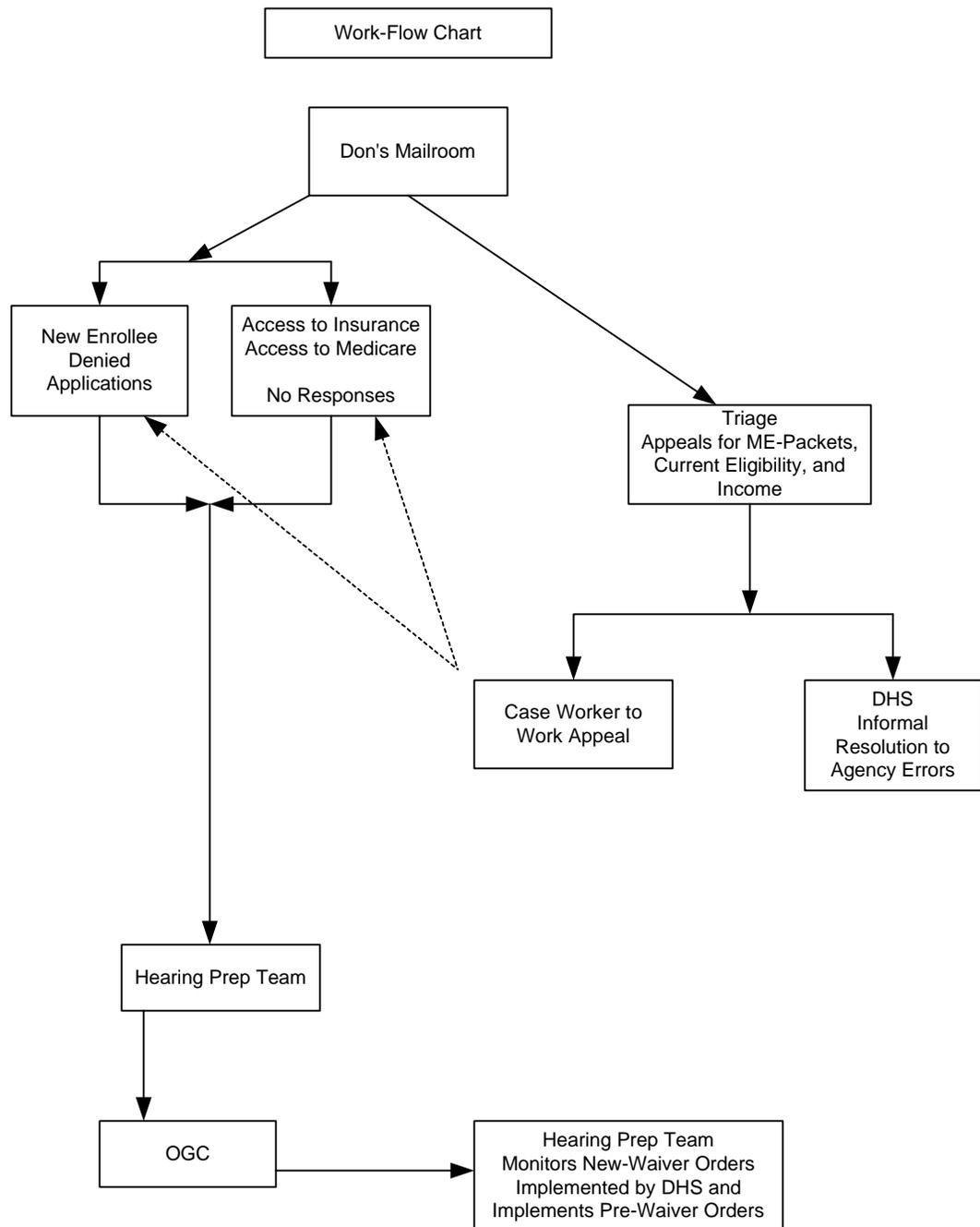
EER Unit Procedures for Processing Mail February 24 Through March 31, 2003



- Triage: The Triage unit receives appeals forwarded from the EER Unit mailroom. Staff sort appeals according to type and file appeals by date. In addition, Triage staff review appeals to determine if an applicant/enrollee needs a medical eligibility packet, or determine if an appellant/enrollee is currently eligible. (A “Currently Eligible” appeal is an appeal in which no adverse action has occurred, but the enrollee expects to lose TennCare coverage in the future.) Other appeals are forwarded to the Denied Applications or Redeterminations unit for processing.
- Denied Applications: This unit processes appeals by new applicants who have applied for TennCare Standard at DHS and were denied.
- Redeterminations: The Redetermination unit processes appeals from enrollees who have been selected to go to DHS for eligibility redetermination and failed to meet the requirements to remain eligible for TennCare Standard. (See page 14 for additional information about the redetermination process.) This unit is also responsible for terminating members who have access to insurance.
- Hearing Prep Unit: Staff in this unit prepare all administrative appeals that are to be sent to the Office of General Counsel (OGC) for hearing. Staff act as the state’s witness at hearings to testify and explain information contained in the appeal file. Staff also follow up on instructions from administrative law judges or TennCare hearing officers and monitor implementation of orders.

Because circumstances differ according to appeal type, caseworkers in each unit research an appeal using criteria established in policy for that particular appeal type. In general, however, AAU caseworkers review all information provided by the appellant. If the applicant/enrollee provided new or additional information that may affect eligibility, the appeal is sent to DHS for review. (See pages 27-28 for additional information on appeals sent to DHS.) The AAU caseworker prints all appropriate screens from the TennCare and DHS system for the file. If the AAU caseworker determines that DHS made a mistake, the appeal is returned to the Triage unit for processing and sent to DHS for correction. If the AAU caseworker determines that the applicant/enrollee has failed to meet the technical requirements to be eligible for TennCare Standard, the AAU caseworker compiles a case chronology, which details the history of the appeal. Once the case chronology is complete, the caseworker enters the appeal information in the AAU’s tracking system. The AAU tracking system generates a letter to the applicant/enrollee explaining the reason for the adverse action and notifies the applicant/enrollee that a hearing will be scheduled. The appeal is then forwarded to the Hearing Prep unit, where the staff prepare the appeal for hearing and forward a copy of the file to the Office of General Counsel.

**Administrative Appeals Unit
 Procedures for Processing Administrative Appeals
 February 24 Through March 31, 2003**



Office of General Counsel

The OGC receives appeals forwarded by the AAU. (Appeals that have not been sent to DHS or otherwise closed are sent to the OGC for hearing. See pages 25-27 for information about appeals scheduled for hearing.) Staff date-stamp appeals upon arrival and sort appeals according to the city where the hearing will occur. Legal assistants prepare appeals for hearing, obtain docket numbers from the Secretary of State's Administrative Procedures Division, send notices of hearing to the appellants, and enter all relevant information into the OGC's tracking systems. (See pages 24-25 for information about tracking systems used by the different units.) The OGC's *Policies and Procedures Manual* directs the processing of appeals at this level. However, the OGC does not have a flow chart that illustrates the procedures for processing an administrative appeal for hearing.

The OGC must send a Notice of Hearing one month before the scheduled hearing date. The Notice of Hearing informs the appellant of the date, time, and location of the hearing.

Administrative Law Judges/TennCare Hearing Officers

Eligibility appeals are heard by administrative law judges (ALJs) from the Secretary of State's Administrative Procedures Division or hearing officers from the TennCare Administrative Hearing Unit. An applicant/enrollee can appear before an ALJ or hearing officer or have the hearing by phone. After hearing the appeal, the ALJ or hearing officer then renders an Initial Order (i.e., decision) which upholds or reverses the adverse action. Initial Orders automatically become Final Orders within 15 days. An individual has the right to appeal the ALJ's or hearing officer's decision to a designee appointed by the Commissioner of the Department of Finance and Administration. (The audit team did not review appeals of an Initial Order to the Commissioner's designee.)

When the Initial Order becomes a Final Order and is not appealed to the Commissioner's designee, the OGC legal assistant logs the Order into the OGC's tracking systems. Copies of the Order are sent to the AAU, the DHS Medicaid/TennCare Policy Unit, and the DHS office in the county where the applicant/enrollee resides. The applicant/enrollee also receives written notice of the judge's/hearing officer's decision. As mentioned previously, staff in the AAU's Hearing Prep Unit monitor implementation of the Order by DHS.

THE ADMINISTRATIVE APPEALS ENVIRONMENT

Although TennCare has been in operation since January 1, 1994, TennCare did not have adequate due process procedures in place for enrollees to protect their rights when denied services or terminated from the program. As a result, on May 5, 2000, the United States district court issued a Temporary Restraining Order (TRO), prohibiting TennCare from terminating or interrupting the TennCare coverage of an uninsured or uninsurable enrollee unless the enrollee has been afforded notice and an opportunity for a hearing. In reaction, TennCare did not terminate any uninsured or uninsurable member for any reason other than a voluntary termination per the member's request or by death. In addition, TennCare stopped mailing reverification notices to enrollees in November 2000, which ceased the face-to-face

reverification process. (Reverification is the process by which TennCare evaluated the ongoing eligibility status of TennCare enrollees under the old waiver.)

During the fiscal year ended June 30, 2001, TennCare terminated enrollees who requested in writing to be disenrolled and enrollees who died. TennCare also implemented court-approved policies and procedures for terminating incarcerated persons, enrollees with access to insurance coverage from other sources, and individuals who are no longer residents of Tennessee. On March 12, 2001, TennCare entered into an Agreed Order and a Settlement Agreement. When all requirements in the Agreed Order and Settlement Agreement were met, TennCare could begin reverifying uninsured and uninsurable recipients. As of November 14, 2001, the requirements of the Agreed Order and Settlement Order had been met, and the Court had approved TennCare's process for reverification. TennCare resumed the reverification process in December 2001.

In the spring of 2002, the U.S. Department of Health and Human Services approved a new TennCare waiver, and TennCare prepared to transition to the new program. During the transition period (July 1, 2002 – December 31, 2002), all non-Medicaid enrollees as of June 30, 2002, were to go through the redetermination process. As mentioned previously, the purpose of the redetermination process was to update eligibility information, to screen individuals for Medicaid eligibility, and to disenroll those who did not meet the criteria of the new program.

Since June 2002, TennCare has sent redetermination notices to approximately 594,000 enrollees. Of that number, approximately 39,000 were denied TennCare Standard and 144,000 were terminated from TennCare for not responding to the redetermination notice (i.e., failing to make an appointment with DHS to have their eligibility reviewed). The remaining have either been approved for Medicaid or TennCare Standard or are still pending.

Changes in the new TennCare waiver and redetermination (and the subsequent disenrollment of enrollees from TennCare) have resulted in a significant increase in the number and type of administrative appeals submitted to TennCare. From July 1, 2002, through March 6, 2003, TennCare received over 50,000 administrative appeals. In comparison, TennCare received approximately 14,000 administrative appeals during entire fiscal year 2001-2002.

Additionally, some appeal types (i.e., reasons for appeal) are the specific result of redetermination, creating issues which management and staff have not previously encountered, thus complicating the appeals process. These new appeal types/issues include "No Responses," "Currently Eligibles," and "ME Outs." These specific appeals are described below.

- Appeals from enrollees who did not respond to their redetermination notification and did not make or keep an appointment with DHS to have their eligibility reviewed are categorized as "No Responses." If an enrollee can demonstrate a "good cause" for not making or keeping an appointment with DHS, the AAU advises the enrollee to make another appointment with DHS for eligibility redetermination. If the enrollee could not demonstrate "good cause," TennCare processes the appeal for hearing. To ensure that enrollees who did not respond to their redetermination notices are truly not eligible, the Governor established a "grace period" which gives these enrollees one year (until March 31, 2004) to visit a DHS office for eligibility redetermination. (See page 17 for additional information.)

- Enrollees who file an appeal even though no adverse action has yet occurred (i.e., eligibility has not been terminated) are classified “Currently Eligible.” (See page 17 for additional information.)
- “ME Outs” are appeals in which an AAU caseworker determined that an applicant/enrollee who has been denied coverage or terminated should have received a medical eligibility packet from DHS. During appeal review, an AAU caseworker determined that the applicant/enrollee could qualify as “medically eligible” and sent a medical eligibility packet to the applicant/enrollee for the individual to complete and to submit for eligibility consideration.

TennCare management realizes that the increase in administrative appeals, as well as the new appeal issues, have burdened the appeals process, which is no longer effective. As a result, TennCare management requested that the Comptroller’s Office evaluate the administrative appeals process; identify areas of weakness, backlogs, and delays; and provide recommendations for improvement. The results of our evaluation are on pages 15-28.

ANALYSIS AND CONCLUSIONS

POLICIES AND PROCEDURES

Inconsistent Application of Policy/Lack of Policy in Some Areas

TennCare management is responsible for establishing and implementing policies and procedures for processing administrative appeals. Policies serve as definite courses or methods of action, which guide present and future decisions, as well as assist in the consistent treatment of issues by management and staff. During our review, however, we identified areas in the appeals process where policy was not followed. In some instances, management specifically instructed staff to disregard established policy. We also identified areas in which management needs to establish and implement additional policies to address weaknesses in the administrative appeals process. The areas we identified are listed below.

- Enrollment and Eligibility Redetermination (EER) staff do not consistently log appeals sent daily from the EER Unit mailroom to the Administrative Appeals Unit (AAU). EER Unit staff are to record the number of appeals sent daily from the EER Unit to the AAU in a logbook maintained in the EER Unit. However, we found that EER Unit staff do not consistently record the number of appeals sent daily to the AAU. An EER Unit staff member also records the number of appeals sent daily to the AAU on a spreadsheet. We reconciled the numbers of appeals sent daily from the EER Unit to the AAU that were recorded in the logbook with the numbers recorded on the spreadsheet and found that the numbers did not match. EER Unit staff could not explain this variance, and the audit team could not determine if the EER Unit accurately records the number of appeals sent daily to the AAU.

- AAU staff stopped date-stamping appeals received in the AAU from the EER Unit. From November 2002 through late March 2003, staff were instructed by the AAU Director to cease the date-stamping of appeals received. The AAU Director stated that the decision was made to stop date-stamping appeals because the volume of appeals arriving in the AAU was so heavy that staff could not keep up with stamping them. As a result of this decision, we were not able to (nor can TennCare) determine the amount of time an appeal remained in the EER Unit after it was closed in the EER tracking system until it was sent to the AAU, nor could we determine the amount of time an appeal remained in the AAU before it was sent to the Department of Human Services (DHS) or to the Office of General Counsel (OGC). (See page 19 for additional information.) Date-stamping was recently resumed because the AAU Director realized it was important to know how many days appeals stayed in the EER Unit mailroom.
- AAU staff do not record appeals that are received daily in the AAU from the EER Unit. During fieldwork, we did not find evidence that AAU staff log in the types and number of appeals as they arrive from the EER Unit. Therefore, there is no way to reconcile the number of appeals sent daily from the EER Unit mailroom to the number received by the AAU.
- The AAU no longer sends acknowledgement letters to applicants/enrollees informing them that their appeal has been received. Although policy provides for a form letter and one exists, the AAU Director decided to stop sending acknowledgement letters in the fall of 2002. According to the AAU Director, the procedure was halted because the volume of appeals overwhelmed the AAU. Also, staff no longer enter appeal information into the AAU's tracking system until the appeal "is ready to be worked" (see the next bulleted item) and by then, the caseworker knows if the appeal is going to hearing or if the appeal has been sent to DHS. As a result, applicants/enrollees who have filed an appeal have no idea whether the appeal has been received or where it is in the process until they receive a letter of disposition (i.e., the appeal has been sent to DHS or to OGC for hearing) from the AAU. This may cause applicants/enrollees to file duplicate appeals and further impede the process.
- AAU staff do not enter appeal information into the ProLaw tracking system in a timely manner. According to AAU Triage Unit procedures, staff should enter appeal information into tracking after the appeal has been processed, then give the appeal to the appropriate team leader. However, Triage Unit staff sort appeals that arrive from the mailroom and distribute most of them to the Denied Applications Unit or the Redeterminations Unit. (See pages 8-13 for additional information on appeal procedures.) AAU staff in these units do not enter appeal information into the tracking system until the caseworker has completely reviewed the case. As a result, an appeal may be unaccounted for in the AAU's ProLaw tracking system for a number of days. We found this to be true during our file reviews. Of 60 appeals selected, 15 were not in the AAU's tracking system at the time of fieldwork because they had not been processed.
- AAU staff process current appeals before older appeals. AAU policies direct staff to "pick up batches of appeals from Triage storage by the oldest date on the shelf."

However, the AAU Director instructed staff to work current appeals first in order to resolve them within the 90-day time frame. The AAU Director stated that since the older appeals are already past the 90-day deadline, staff should focus on processing current appeals in a timely manner. (See pages 17-24 for information about processing appeals in a timely manner.)

- TennCare management has not established policies for processing certain appeals. During the audit period, AAU management had not received guidance on how to handle the “No Response” appeals that were not processed prior to the Governor’s “grace period” announcement. Also, no policy exists for processing “Currently Eligible” appeals. As a result, these appeals have not been processed.

Inconsistencies Regarding Appeal Time Frames

During our review, we noticed that language in the TennCare rules which describes the time frame for submitting an appeal is not consistent with actual practice. More specifically, TennCare rules state that if an enrollee

appeals within 10 days from receipt of the letter of termination, coverage will be continued/reinstated pending the outcome of the appeal. Appeals received within 30 days (from receipt of the notice) will be processed by the TennCare Administrative Appeals Unit and the Office of General Counsel in accordance with the appropriate policies and procedures. . . . Appeals received by the Bureau after the 30th day (from receipt of the notice) are automatically denied as “untimely.”

As discussed on page 8, TennCare allows applicants/enrollees to appeal within 40 days of the date of the adverse action (eligibility denial or termination). By practice, TennCare allows 10 days for mail delivery. Therefore, for enrollees who appeal within 20 days of termination, coverage will be continued/reinstated pending the outcome of the appeal.

UNTIMELY PROCESSING OF TENNCARE ADMINISTRATIVE APPEALS

Federal regulations mandate that TennCare resolve an administrative appeal within 90 days of receipt of an appeal. If an administrative law judge (ALJ) or hearing officer has not issued an order within that time frame or the AAU has not otherwise closed the appeal, TennCare must provide interim coverage to the applicant/enrollee. Based on our analyses, TennCare is not processing administrative appeals in a timely manner due to a number of reasons. The TennCare Director is aware that administrative appeals are not processed in a timely manner.

We not only analyzed data provided by TennCare to determine timeliness, but also tried to pinpoint areas of backlog and delay and determine why these backlogs are occurring. Due to flaws in the data provided by TennCare (see page 1), we made certain adjustments when making our calculations. For example, we did not use records with invalid dates or records in which dates were not in chronological order.

Time Analyses

TennCare provided us with a database of mail that was recorded as administrative appeals received in the EER Unit mailroom. Using codes that indicate administrative appeals, we extracted appeals received from July 1, 2002, through March 6, 2003. Our calculations show that TennCare received 50,813 administrative appeals in the mail during that time frame. TennCare does not have one uniform system to track an appeal from beginning to end, with all relevant steps in between. (See pages 24-25 for information about tracking systems.) As a result, we used the data provided to us by TennCare to calculate timeliness. TennCare has not conducted such analyses.

The EER Unit mailroom tracks these appeals by recording the event date (i.e., the date received), which is the date stamped on the appeal when it is opened/received in the mailroom, and the EER Unit closed date, which is actually the date an EER staff person enters the appeal in the EER tracking system. Using data provided by TennCare, we determined the average number of days to process an administrative appeal in the EER Unit (i.e., the average number of days from the event date to the closed date). However, we were not able to test all appeal records because some contained bad data [bad data consisted of dates that were incomplete or appeared to contain typographical errors] while others did not have closed dates. Tables 1 and 2 show the number of appeals received in the EER Unit mailroom from July 2002 through March 2003, the number of records omitted from our analyses due to bad data, the number of appeals that did not have closed dates, and the number of appeals we tested for timeliness. Table 1 is the Schedule of Appeals Tested for all appeal types except “Currently Eligibles,” and Table 2 is the Schedule of Appeals Tested for “Currently Eligible” appeals. We separated the “Currently Eligibles” from the rest of the appeals because adverse action had not yet occurred, and TennCare did not have a policy for processing these appeals.

Table 1
Schedule of Appeals Tested

All Appeal Types Except “Currently Eligibles”
July 2002 – March 2003

Month	Number of Appeals Received in the EER Unit	Number of Records That Have Bad Data	Number of Appeals That Did Not Have Closed Dates	Number of Appeals Tested for Timeliness
July 2002	1,700	2	109	1,589
August 2002	2,038	2	55	1,981
September 2002	2,621	11	19	2,591
October 2002	4,792	2	59	4,788
November 2002	11,690	8	143	11,662
December 2002	12,333	32	97	12,288
January 2003	4,022	2	54	4,003
February 2003	2,794	4	26	2,784
March 2003	182	0	2	176

Table 2
Schedule of Appeals Tested

“Currently Eligibles”
July 2002 – March 2003

Month	Number of Appeals Received in the EER Unit	Number of Records That Have Bad Data	Number of Appeals That Did Not Have Closed Dates	Number of Appeals Tested for Timeliness
July 2002	0	0	0	0
August 2002	0	0	0	0
September 2002	2	0	0	2
October 2002	23	0	0	23
November 2002	761	0	8	753
December 2002	4,856	2	89	4,765
January 2003	2,218	4	27	2,187
February 2003	754	4	1	749
March 2003	27	0	0	27

After omitting records with bad data and excluding appeals that did not have closed dates, we were able to test 99% of the records for all appeal types except “Currently Eligibles,” and we were able to test 98% of the records for “Currently Eligible” appeals. The results of our time analysis (i.e., the average number of days to process an administrative appeal in the EER Unit) are presented in Table 3. As Table 3 shows, when the volume of appeals increased, so did the average number of days it took to process an appeal [for all appeal types except “Currently Eligibles”]. This relationship did not hold true for “Currently Eligible” appeals because it took an average of 105 days to process the two “Currently Eligible” appeals received in September. Because no policy existed for handling “Currently Eligible” appeals, EER Unit staff had no direction concerning how to process them.

Table 3

Average Number of Days to Process an Administrative Appeal in the EER Unit
July 2002 – March 2003

Month	All Appeal Types Except “Currently Eligibles”		“Currently Eligible” Appeals	
	Number of Appeals Tested	Average Number of Days From Event Date to Closed Date	Number of Appeals Tested	Average Number of Days From Event Date to Closed Date
July 2002	1,589	1	0	N/A
August 2002	1,981	1	0	N/A
September 2002	2,591	1	2	105
October 2002	4,788	2	23	70
November 2002	11,662	20	753	18
December 2002	12,288	13	4,765	16
January 2003	4,003	17	2,187	20
February 2003	2,784	6	749	7
March 2003	176	6	27	7

During our fieldwork, the AAU was not date-stamping or logging the appeals received from the EER Unit mailroom, and none of the data we obtained included a date on which the AAU received an appeal. Therefore, neither the auditors nor any level of TennCare management [and TennCare has never conducted such analyses] can determine how long an appeal remained in the EER Unit after staff closed the appeal in the EER Unit tracking system before it was sent to the AAU. Furthermore, since AAU staff record the EER event date as the opened date in the AAU tracking system, no level of TennCare management can determine how long an appeal remained in the AAU before it was sent to DHS or to the OGC.

The OGC provided Excel spreadsheets that included information such as the EER event date, the date received at OGC, the date opened at OGC, the hearing date, and the order date/closed date. Before we tested the average number of days between each point in the process, we omitted records with bad data and appeals that did not have closed dates. Table 4 shows the number of appeals received at OGC from July 2002 through February 2003, the number of records omitted from our analyses due to bad data, the number of appeals that did not have order/closed dates, and the number of appeals we tested for timeliness.

Table 4
Schedule of Appeals Tested in OGC
July 2002 – February 2003

	July 2002	August 2002	September 2002	October 2002	November 2002	December 2002	January 2003	February 2003
Number of Appeals Received at OGC	1,085	930	417	743	537	432	1,094	1,611
Number of Records With Bad Data	353	277	91	130	68	31	23	12
Number of Appeals That Did Not Have Order/Closed Dates	94	178	120	288	223	211	1,016	1,596
Number of Appeals Tested	638	475	206	325	246	190	55	3

After omitting records with bad data and excluding appeals that did not have order/closed dates, we were only able to test 31.2% of the records provided by OGC. Of 6,849 appeals received at OGC from July 2002 through February 2003, 3,726 (54.4%) did not have order/closed dates at the time of fieldwork and were excluded from test work. An additional 985 records (14.4%) were not tested because of bad data. Table 5 shows the results of our time analysis for the records we tested.

Table 5
Analysis of Administrative Appeals Received at OGC
July 2002 – February 2003

	July 2002	August 2002	September 2002	October 2002	November 2002	December 2002	January 2003	February 2003
Number of Appeals Tested	638	475	206	325	246	190	55	3
Average Number of Days From Event Date to OGC Received Date	27	23	34	51	58	71	82	96
Average Number of Days From OGC Received Date to OGC Opened Date	9	12	11	13	14	13	12	10
Average Number of Days From OGC Opened Date to Hearing Date	54	51	40	45	26	None had hearing dates	None had hearing dates	None had hearing dates
Average Number of Days From Hearing Date to Order Date	15	15	24	2	59	None had hearing dates	None had hearing dates	None had hearing dates
Average Number of Days From Event Date to Order Date/Closed Date	90	98	101	118	131	132	136	106

(Note: An appeal can have an order date but no hearing date if the appeal was resolved before a hearing date was set. Likewise, an order date can occur before the hearing date if the appeal was resolved before going to hearing. As a result of these circumstances, the average number of days from event date to order date/closed date does not necessarily represent total of each column in Table 5.)

Because our calculations are averages, some appeals may have been resolved before the 90-day deadline and some after. However, our results indicate that on average, TennCare met the 90-day federal requirement for processing an administrative appeal only for the month of July. The table also shows that

- the average number of days from event date to OGC received date steadily increased from July 2002 through February 2003;
- on average, the three appeals received at OGC in February 2003 that we tested had already exceeded the 90-day deadline before arriving at OGC; and

- no appeals received at OGC during December 2002, January 2003, and February 2003 had hearing dates.

At the request of the auditors, the OGC provided a report listing the number of administrative appeals that have not been processed within 90 days. This March 2003 report was generated from ProLaw and shows that 7,861 appeals are outside the 90-day time frame, substantiating our analysis presented in Table 5. Of the 7,861 appeals, approximately 2,000 have been received at OGC. The OGC report contains appeals that have been received in the AAU and have been entered into ProLaw, the AAU's tracking system. Since the AAU and OGC share the database, the report was able to capture appeals for both units.

When TennCare fails to resolve an appeal within 90 days, the applicant/enrollee is given interim TennCare coverage. The Bureau estimates the average cost of TennCare coverage per member per month for fiscal year 2003 as \$240.47. The OGC report listed the number of days each appeal was past the 90-day deadline, so we determined how much TennCare may have paid in interim coverage by converting the number of days each record was past its 90-day deadline into months and then multiplying the number of months by \$240.47. According to our results, if all of the people on the list received interim coverage, TennCare will have paid approximately \$1.7 million. **This figure does not include the costs for reinstating these people for filing an appeal in a timely manner.** We also tried to determine if these people actually received interim coverage by sampling 260 of the 7,861 names on the list. We found that 28 of the 260 did not have interim coverage. We did not determine why these 28 have not received interim coverage.

As our analyses show, by not processing appeals in a timely manner, TennCare is not complying with federal regulations and is also paying to provide interim coverage until backlogged appeals are resolved.

Backlogs and Delays

As mentioned on pages 13-15, a significant reason for the backlogs is the volume of appeals resulting from the redetermination process. Other factors, some preexisting, have also exacerbated the problem. These factors are summarized below.

- Changes in tracking systems. The AAU began using ProLaw in late December. This occurred earlier than scheduled because the old tracking system, an Access database, was crashing and data integrity was compromised. As a result, staff had to learn a new system, which staff claim is slower than the previous tracking system. Also, staff in both the AAU and EER had to rekey data that had been lost as a result of system crashes. The TennCare Director realized this was a problem and mentioned it to the audit team at the beginning of the audit.
- Multiple tracking efforts. The EER Unit, AAU, and OGC use different systems to record and track appeal data. (See pages 24-25 for additional information.) Because these systems are not integrated, staff in the different units enter the same information in their respective tracking systems, therefore duplicating tracking efforts.

- TennCare’s Management Information System (TCMIS) downtime. A significant amount of time for EER and AAU staff is spent reading and updating information recorded in TCMIS screens. When staff cannot perform these functions because the system is unavailable, the process slows. We determined that on average (Monday through Saturday, excluding holidays) TCMIS was down 17.52% of the time between June 24, 2002, and March 15, 2003.
- Staffing and equipment needs. Management in the EER Unit, the AAU, and OGC all report the need to increase staff and obtain more equipment. Specifically, these needs include more staff (to be able to process all the appeals that have been received); additional ProLaw licenses (because staff cannot access ProLaw without a license and not all staff have a license); and more computers (if additional staff are hired) and printers (because staff in the AAU share printers which are overburdened by the size of print jobs). Staff in the EER and AAU work overtime and often take files home. Unfortunately, a box of appeals ready for archive was stolen from the employee who had taken the appeal files home to prepare for archival. In a March 2003 memo to the TennCare Director, the former assistant commissioner for member services described staffing and equipment needs, such as those listed above, and requested additional staff and equipment to meet the challenges resulting from the volume increase. In addition, in October 2002 and March 2003, the TennCare Director requested that the Department of Personnel allow TennCare exemption from the hiring freeze in order to address staffing needs.
- Changing priorities. Management has directed staff, on several occasions, to stop the task at hand and focus efforts on a different area. In one instance, all staff participated in processing “No Response” appeals because management considered them a priority. Later, when management no longer considered “No Responses” a priority, staff resumed processing other appeals. In another instance, AAU staff processed approximately 1,300 appeals for “good cause,” as directed by management. Letters notifying appellants to return to DHS to reapply for eligibility were printed, stuffed in envelopes, and were ready to be mailed. However, before all boxes were sent, management decided not to send letters because management wanted to treat these appeals differently. We found 9 boxes containing “good cause” letters and estimate that approximately 900 letters were not sent. In these instances, we did not find written documentation from TennCare management regarding these changes. It appears these directives are issued by word of mouth.
- Docket space. The ability of the OGC to schedule hearings is limited by docket space and by the number of ALJs and hearing officers. As of March 13, 2003, the OGC could not schedule any hearings until May 2003 because no docket space was available until then. However, the APD assistant director stated that TennCare released half of its allotted docket space for administrative appeals and gave it to the medical appeals unit because administrative appeals were not being processed fast enough to get on available dockets.

INADEQUATE TRACKING OF TENNCARE ADMINISTRATIVE APPEALS

TennCare does not have the ability to track appeals from the date an appeal is received until its final resolution. Tracking systems used by the various units involved in the administrative appeals process are not integrated. Furthermore, we found it difficult to obtain the information we needed in a format that could be easily analyzed and the method in which the EER Unit and the OGC record appeal information problematic.

Tracking Systems

The EER Unit records appeal information in an Oracle database, while the AAU and OGC use ProLaw. Because the AAU and EER have different tracking systems that are not integrated, AAU staff must reenter the same information [that EER staff have already recorded in its tracking system] in ProLaw. Since the AAU only started using ProLaw in December, we did not have access to information prior to then because data from July through November were recorded in the old tracking system. We were told an attempt to convert appeal data from the old tracking system, an Access database, into ProLaw was not successful. We did not obtain any information from the AAU's old tracking system because so many systems crashes have compromised the integrity of the data (i.e., data were lost and not recovered). In addition to ProLaw, AAU staff also use Excel spreadsheets to record appeals sent to DHS (see page 27) and "good cause" letters sent to enrollees. (See page 14 for a description of "good cause.")

The OGC also tracks appeals using Excel spreadsheets, ABACUS, and ProLaw. OGC's managing attorney stated that neither ABACUS nor ProLaw could generate the type of reports, such as an inventory of cases received at the OGC, that help OGC staff analyze the number and type of cases received. So staff enter information in Excel spreadsheets that is useful to OGC management. As mentioned on page 20, we obtained electronic versions of these spreadsheets for our analysis. The months July 2002 through October 2002 were complete with hearing dates and order dates. The November 2002 through February 2003 records had not been updated because staff have been too busy processing appeals and have not had time to enter the data. However, OGC staff had recorded hearing dates and order dates in ABACUS. We asked OGC to convert the ABACUS files for those months into Excel spreadsheets. We then reconciled and merged the spreadsheets to give us complete information for November 2002 through February 2003.

In addition, the OGC's managing attorney provided copies of reports generated by Excel for previous fiscal years that show numbers of cases, types of cases, resolution, etc. He said these reports were useful for analyzing appeals that have been received at the OGC. However, time constraints due to the increase in appeals have prevented staff from compiling such information this year.

There is still no single, comprehensive mechanism for tracking an appeal from the very beginning to the final disposition/resolution. None of the tracking systems show how long an appeal remains in the AAU. While we found the OGC Excel spreadsheets provide the most complete information, they are still inadequate. As a result, TennCare management cannot (and

has never been able to) adequately analyze appeals as they go through the system to identify weaknesses in the process.

Recording Appeal Information

In addition to TennCare's inability to track appeals, we discovered during fieldwork that the method in which information is recorded is problematic. For example, the EER Unit tracks an appeal by the TennCare case identification number. The head of household is the first name listed in the appeal record, even if the head of household is not the applicant/enrollee involved in the appeal. In some instances, the first person whose name is listed in the appeal record is not on TennCare. Also, the appeal record may include several members in a household who are appealing for different reasons, which may lead to an inaccurate representation of appeals received. Auditors had difficulty locating some records because an appeal was tracked by a different name in the EER's tracking system than in the AAU's tracking system.

By the time the EER Unit staff enter appeal information into Oracle, all DHS and TennCare screens have been printed. Therefore, staff have all information about the applicant/enrollee actually involved in the appeal. According to the EER Unit manager, prior to the development of the Oracle database, the EER Unit used Excel to record information about TennCare enrollees. In the pre-Oracle tracking system, the records contained all information about an enrollee, not just appeal data (i.e., an MCO change request, address change, etc.). To ensure duplicate records did not exist for an enrollee, records were tracked by TennCare case identification number. When the EER Unit changed to Oracle, appeal information was recorded separately from other information. However, EER Unit staff continued to track appeal records by case identification number because "records were always tracked that way," and the EER Unit Director did not request a change.

Information recorded in the OGC spreadsheets that explains the outcome of a hearing is not consistent. For example, to describe that the applicant/enrollee was successful in the appeal, the spreadsheet may state, "petitioner prevailed," "coverage continues," or "coverage reinstated." Instead of using a specific code or a single description to indicate a particular outcome, staff enter the outcome in narrative form. As the audit team experienced, this impedes tracking efforts.

SCHEDULING APPEALS FOR HEARING

We believe that a significant number of applicants/enrollees scheduled for a hearing do not want a hearing, even though they do not complete a form declining a hearing. Our review of TennCare policies and procedures for processing appeals and scheduling appeals for hearings; interviews with an OGC attorney, administrative law judges, and TennCare hearing officers; and analyses of withdrawn and dismissed cases indicate that TennCare does not adequately discern if an applicant/enrollee actually wants to go to a hearing.

As explained on page 7, TennCare rules and policy afford applicants and enrollees an opportunity for a fair hearing when TennCare eligibility is denied or terminated. If an

applicant/enrollee files an appeal within the appropriate time frame and the AAU fails to resolve the appeal in favor of the applicant/enrollee (i.e., does not send the appeal to DHS for further processing as mentioned on page 27), the appeal is forwarded to the Office of General Counsel (OGC) for hearing.

Applicants/enrollees are notified in a letter from the AAU of their right to a fair hearing. Those who do not want a hearing can decline the hearing by completing a form that is included in the notification and return the form to the AAU. In that event, the AAU closes the appeal, and the OGC does not schedule a hearing. Applicants/enrollees who do not return the form, as well as those specifically requesting a hearing, are scheduled for a hearing and are notified in writing by the OGC when a hearing is scheduled. The Notice of Hearing letter identifies the time and location of the hearing, informs the applicant/enrollee of the right to be represented by counsel at his or her own expense, and contains a statement of the legal authority under which the hearing will be held and a short and plain statement of the position asserted by TennCare. An administrative law judge or TennCare hearing officer will hear the case and issue a final ruling.

We interviewed 18 of 20 administrative law judges, the assistant director for the Secretary of State’s Administrative Procedures Division, and all three TennCare hearing officers to determine if TennCare appropriately schedules appeals for hearing. Several administrative law judges stated that TennCare could do a better job in determining if an applicant/enrollee really wants a hearing because a number of appeals are withdrawn or dismissed when the applicant/enrollee fails to show. A majority of the ALJs and hearing officers stated, and the OGC managing attorney agrees, that TennCare could resolve some appeals instead of scheduling them for a hearing. In the opinion of some ALJs and hearing officers, some cases they hear are not valid appeals or the issue in question should not be appealable. The OGC attorney mentioned that the process could be improved by creating a resolution unit somewhere in the process before appeals get to the OGC and has expressed this opinion in a March 2003 e-mail to TennCare’s General Counsel. The TennCare assistant commissioner for member services stated that he would consider establishing a procedure to resolve appeals earlier in the process but that TennCare must be mindful of court orders regarding an applicant’s/enrollee’s due process and fair hearing rights.

Our analyses of cases docketed for ALJs and hearing officers substantiate the opinions of the ALJs that a significant number of appeals are withdrawn or dismissed. Table 6 shows the number of docketed appeals for both ALJs and hearing officers and the number of those appeals that were withdrawn or dismissed. (A docket is a list of appeals that have been scheduled for hearing at a specific time.) At the time of fieldwork, TennCare hearing officers heard mostly denied application appeals and some redeterminations appeals.

Table 6

Administrative Appeals Withdrawn or Dismissed

	Number of Docketed Appeals	Number and Percent of Docketed Appeals Withdrawn or Dismissed
ALJ Cases July 1, 2002-March 18, 2003	5,392	1,648 (30.6%)
Hearing Officers January 28, 2003-March 31, 2003	770	41 (5%)

The cost for an appeal that has been withdrawn or dismissed is the same as if the appeal had been heard. Costs include an APD filing fee (fee for filing with the Secretary of State's Administrative Procedures Division), a court reporter's fee, and travel costs for lawyers and witnesses, as well as mailing, copying, and other administrative costs. There is no filing fee for TennCare hearing officers. TennCare does not track these costs and, thus, cannot determine the cost of hearings for administrative appeals to the state. Although TennCare provided us with estimates of some of these costs, we could not accurately calculate the costs of hearings.

The Pacific Health Policy Group (PHPG) stated similar conclusions in a June 2001 report, *Operational Review of the Office of General Counsel and Administrative Procedures Division*. PHPG is a consulting group that was retained by TennCare to conduct an operational review of TennCare's OGC and the Secretary of State's Administrative Procedures Division. PHPG concluded that

- the number of appeals forwarded to hearing is growing to a level that exceeds historical experience;
- the growth in TennCare appeals is at least partly attributable to the adoption of an "open" system whereby matters that would normally not be considered for a fair hearing are nevertheless being forwarded to hearings;
- a significant portion of all scheduled hearings are not desired by the appellant, who consequently either withdraws the appeal or fails to show at hearing; and
- the above events have resulted in average processing times that exceed federal and state standards.

As a result of our review, we conclude that a number of appeals that are scheduled for a hearing may be unnecessary and are, therefore, burdening the system, creating backlogs and untimely resolution of cases (see pages 17-24) and negatively affecting the OGC's ability to track cases (see pages 24-25). In addition, withdrawn and dismissed appeals cost the state money. We recommend that TennCare review the policies for scheduling appeals for a hearing to determine the most cost-effective method for resolving appeals while protecting applicants' and enrollees' due process rights.

NO FOLLOW-UP ON APPEALS SENT TO DHS

Prior to July 1, 2002, the AAU had authority to reverse adverse actions (i.e., a denied application or termination of coverage), if such determinations were made during AAU appeal review, and approve eligibility. For example, if the AAU determined that an enrollee should not have been terminated, the AAU had authority to approve eligibility and reinstate coverage. Because of changes in the new TennCare waiver, which became effective July 1, 2002, the AAU now must send appeals to DHS if an AAU caseworker determines the adverse action was not appropriate. (If an AAU caseworker decides to uphold the adverse action, the appeal is processed in the AAU and sent to OGC for hearing.) Under this new arrangement, the AAU must rely on DHS to address the appeal issue and approve eligibility, if appropriate. However,

the AAU does have the responsibility for following up with DHS to ensure these appeals have been addressed.

When researching an administrative appeal, AAU caseworkers determine the nature of the appeal, as well as the nature of the adverse action, by reviewing an applicant's/enrollee's information in the DHS and TennCare systems. If the caseworker determines that the appeal contains new information (i.e., information that was not provided to the DHS caseworker at the time of application or eligibility redetermination) that may have a bearing on the applicant's/enrollee's eligibility, the appeal is sent to DHS for processing. If the caseworker determines that DHS made a mistake during processing, the appeal is sent to DHS for correction. For example, a DHS caseworker may not have accurately calculated family size or may have failed to distribute a medical eligibility packet.

Designated AAU staff track appeals sent to DHS in Excel spreadsheets. From July 1, 2002, through January 19, 2003, the AAU sent 1,388 redetermination appeals to DHS; and from July 1, 2002, through February 11, 2003, the AAU sent 717 denied applications appeals to DHS. In addition, approximately 900 appeals considered "DHS issues" are being held in the AAU Triage Unit. As of March 26, 2003, these 900 appeals have not been processed or entered into the AAU's tracking system. The AAU Director states that DHS will not accept these appeals because DHS caseworkers are overwhelmed with processing redeterminations. At the time of fieldwork, the AAU Director had not received direction from TennCare's assistant commissioner for member services concerning how to handle the 900 unprocessed appeals.

We are concerned that appeals sent to DHS may be getting lost in the process once they are returned to DHS because, even though the capability exists, no one in the AAU is tracking these appeals after they are sent to DHS. For instance, AAU staff can run a daily report and age the "Returned to DHS" appeals so that those cases that have not been addressed timely can be expedited to hearing with an ALJ who will subsequently order DHS action. At the time of fieldwork, AAU staff were not following up on the "Returned to DHS" appeals. Because of the volume of appeals received in the AAU, the AAU Director said staff have not had time to follow up with DHS to determine if these appeals are being addressed. Furthermore, because the AAU is experiencing a severe backlog of appeals, some "DHS issues" might not have been identified yet because they are sitting in batches waiting to be reviewed. (See pages 17-24 for more information on appeals backlogs.)

RECOMMENDATIONS

The following are recommendations the TennCare Bureau may wish to consider to address the issues mentioned in this report.

Data Reliability

- Management should periodically analyze data to identify and correct errors.

Policies and Procedures

- The Enrollment and Eligibility Redetermination (EER) Unit needs to consistently log the number and type of appeals sent daily to the Administrative Appeals Unit (AAU).
- The AAU needs to consistently stamp all appeals on the date received.
- AAU management needs to log the number and type of appeals received daily from the EER Unit/mailroom.
- TennCare needs to notify appellants, in writing, that an appeal has been received.
- The AAU should enter all appeals into ProLaw during triage.
- TennCare management needs to work with the EER, the AAU, and the Office of General Counsel (OGC) to develop policies for addressing certain types of appeals, such as “No Responses” and “Currently Eligibles.” These policies need to be written and provide specific guidance to staff.
- TennCare should make appropriate changes in the rules regarding the time frame in which to file an appeal to ensure language is consistent with policy.

Timeliness

- TennCare should evaluate the administrative appeals process, identify areas where backlogs and delays are occurring, and take measures to reduce these backlogs and delays.
- Where feasible, TennCare should address the staffing and equipment concerns expressed by EER, AAU, and OGC management.
- Management should evaluate the administrative appeals process, develop a strategy for dealing with all types of appeals, and adhere to this strategy as much as possible. Management should carefully consider the impact that changing priorities have on the process. Any changes should be communicated in writing, with clear guidance to staff.

Tracking Systems

- TennCare should develop an integrated tracking system that follows an appeal throughout the entire process, from the received date to the final disposition. This information should be reviewed on a regular basis to identify weaknesses in the process.
- TennCare should consider the method by which the EER Unit records appeal information in Oracle. Management should consider tracking appeals by the name of the appellant, not by the first name listed on the Case ID.

Scheduling Appeals for Hearing

- TennCare should reexamine policies for scheduling an appeal for a hearing and ensure that an appellant wants to go to a hearing prior to placing the case on a docket and scheduling a hearing.
- TennCare should explore opportunities to resolve appeals early in the process, thereby reducing the number of appeals sent to OGC. However, these opportunities should not limit an appellant's/enrollee's due process rights.

Appeals Sent to the Department of Human Services

- The AAU should follow up on appeals sent to the Department of Human Services to ensure these appeals are being processed. AAU staff should notify management if it appears that these appeals are not being addressed in a timely manner, and management should take measures to expedite the resolution of these appeals.

TENNCARE MANAGEMENT'S COMMENT

Background

Understanding the urgent need to change the TennCare Appeals Process, the Deputy Commissioner of the Division hired, in March of 2003, a new Assistant Commissioner for Member Services and a new staff attorney to revise the appeals system within the Member Services Division. In making the selections, the Deputy Commissioner made it clear that the two individuals were to review, address, and change the system. Those changes were to include, at a minimum, a more efficient flow of appeals with sufficient checks on the process to ensure prompt administration and proper tracking.

Staff began the immediate process of charting out the entire flow of the appeals process, beginning with the triaging of mail and running until the final implementation of Orders from the Administrative Law Judges and Hearing Officers. Staffing patterns were reviewed, informal checks were conducted, and appeals were tracked. That review yielded several concerns, many of which were discovered by the Auditors from the Comptroller's Office.

On May 2, 2003, the Assistant Commissioner for Member Services convened management staff for a retreat to discuss redesigning the TennCare applicant and enrollee appeals systems. Participating in this retreat were representatives of all divisions of the TennCare Member Services Division (including staff from the mail room, information line, Administrative Appeals Unit, and TennCare Solutions Unit) and the TennCare Office of General Counsel. In addition, staff from TennCare's Internal Audit Division and TennCare's Policy Unit, and representatives of the TennCare Consumer Advocacy Program and the Tennessee Justice Center participated. The goal of the retreat was to design a system that would work, both from an enrollee and a State standpoint.

Reorganization of TennCare Appeals Division

As an outcome of the May 2 retreat, the TennCare Appeals Division was redesigned and restructured. It went from a three (3) unit division to a six (6) unit division, with an emphasis on streamlining the administration and resolution of appeals. In this process, the three triage units that received correspondence/appeals concerning enrollment and medical services issues were merged into one unit now known as the Triage Administrative Resolution Unit, where appeals could be timely opened and enrollees, if filing appropriately, could be quickly entered back on to the TennCare eligibility roles. The organization of the case-working divisions of the Member Services Division was changed from primarily supporting a flow of paper documentation to that of providing interventions and resolutions of problems experienced by applicants and enrollees.

The current structure of the TennCare Member Services Appeals Division now has the following six units, reflecting the many opportunities throughout the appeals process for informal resolution:

- Member Services Call Center Phone Line Unit (The “Hotline,” the unit specifically designed to answer members/applicants’ questions over the phone.)
- Triage Administrative Resolution Unit (All mail comes to this unit, including faxes, hard copy correspondence, e-mail and appeals taken by the call center. This unit will resolve matters submitted by applicants/enrollees if the resolution can be accomplished purely by TennCare Bureau administrative action.)
- Administrative Appeals Resolution Unit (Eligibility related appeals that cannot be resolved by in-house action in Triage are sent here for evaluation and resolution, if possible.)
- TennCare Solutions Resolutions Unit (Medical services related appeals come here for evaluation and resolution, if possible.)
- Trouble Shooting Unit (This unit handles special projects for the other divisions, as necessary. Currently, Trouble Shooting has taken on the task of reviewing our backlog cases so that the other units can focus on current cases.)
- Hearing Oversight & Compliance Unit (Eligibility related appeals that cannot be resolved are sent here for preparation for hearing. In addition, orders issued as a result of hearings are implemented by this unit, in conjunction with the TennCare Bureau and DHS, as appropriate.)

In order to address concerns about communications between divisions, the Member Services Management Team (consisting of the heads of each of the six divisions, the assistant commissioner and the assistant commissioner’s deputy) meets at least weekly to discuss issues/problems to assure corrective action and planning are timely undertaken. At least twice a month, the TennCare Bureau Policy Director and the TennCare Bureau Interagency Liaison meet with the management team to resolve issues and plan for corrective action and new initiatives. At least monthly, the Assistant Commissioner also participates in meetings with all Members

Services staff to assure that communication lines among management and staff are open and working.

In July 2003, after consideration of the recommendations made at the May 2 retreat, it was also determined that appeal-tracking would be maintained in one tracking system, ProLaw. This will eliminate the duplication of data input into two distinct systems and allow for appeals to be tracked from receipt to final resolution. Within ProLaw, appeals will be tracked by case and SSN to assure that all members in a household with appeals can be accounted for. ProLaw will provide various reports to assure that staff is handling cases efficiently and timely. And with one seamless tracking system, dates will be preserved in ProLaw to document when individual cases are transferred between units. TennCare Solutions Unit already has ProLaw in place. The tentative TARU, AAU and HOC implementation timeline for ProLaw implementation is October 2, 2003.

As a part of this process, all existing processes, policies, and procedures are being examined for potential revision or replacement. Procedures are/have been developed as a part of this restructure of the Member Services Division.

The TennCare Bureau is vitally aware of the importance of the appeals process. The thousands of appeals raised each month represent an individual with a problem, question, or concern. It is our responsibility to handle these matters in a fair and timely manner. And we must do so in a way that appropriately carries out the functions and the mission of the Bureau of TennCare.

Response to Audit Recommendations

The Appeals Division is transitioning quickly to better handle the overall number of appeals received. We have attempted, through this narration, to generally lay out the groundwork for those changes. More specifically, the Division would respectfully submit the following action steps that have been taken in response to your recommendations:

Data Reliability:

- Processes are being finalized within each unit to check the movement of appeals through the system. This “check” system is designed to prevent errors from being made. A monitoring process is also currently being set up to periodically check the data in files and to review the materials for errors.

Policies and Procedures:

- Our triage unit is currently logging the receipt of an appeal and the type of appeal daily into ProLaw.
- Systems are being established so that TennCare can monitor the dates that appeals are received and the dates that the appeals are transferred between units.

- Pursuant to policy, TennCare is establishing processes and procedures to always notify appellants, in writing, of the receipt of their appeal.
- A troubleshooting division has been established to deal with certain types of appeals that need additional research and/or work. For example, the State receives hundreds of appeals that are unclear as to the purpose of the Appeal. The new Appeals Process is designed to immediately transfer these particular appeals to our Troubleshooting Division to research, work, and attempt to resolve the Appeal.
- All procedures are being reviewed to be sure that they are consistent with all Bureau policies and rules and regulations governing the program. In addition, Member Services staff is reviewing Bureau Policies with the Bureau Policy Director to assure that policies are current and achieve the goals and requirements of the TennCare program.

Timeliness:

- All backlogged cases are being worked. Procedures, with a developed tracking system, should help management identify backlogs and delays in the process.
- A revised appeals workflow process has required revised staffing patterns. Management is currently reviewing staffing concerns with the intent of determining what areas are overstaffed and which are understaffed. Reviews will be made on a periodic basis to identify areas where staff may need to be transferred. Equipment concerns are also being addressed.
- The TennCare Bureau understands the need for consistent policy and better communication. Weekly staff meetings with management as well as monthly staff meetings with all divisions are being held in order to better communicate changes. Also, updates by e-mail are being used to get important information out quickly to staff.

Tracking System:

- The tracking system used by AAU is being expanded and re-designed so that all appeals, from beginning to end, can be tracked appropriately.
- Steps are being taken to identify each appeal properly, instead of by way of the first name on the Case ID. Each separate appeal is to be tracked.

Scheduling Appeals for Hearing:

- With a renewed focus of talking to enrollees about their appeals, the new workflow process and expanded and enhanced tracking system is specifically designed so that appeals can be informally resolved prior to hearing. The

TennCare Bureau in its efforts to resolve appeals, however, wants to be extremely careful that enrollees/applicants understand that they, in fact, have due process rights and that they can, if they so choose, pursue an appeal.

Appeals Sent to the Department of Human Services:

- A series of meetings between TennCare and DHS have resulted in short term solutions and long term discussions on the best process for handling and following up on appeals sent to DHS. Currently, any information passed to DHS from the TennCare Appeals Division is documented so that proper records are kept at TennCare.

The TennCare Member Services Division is committed to fully developing and implementing an appeals process that functions correctly and that is efficient. We will continue to work as a group to make that happen.