# STATE OF TENNESSEE
## COMPTROLLER OF THE TREASURY

# Department of Finance and Administration

# Performance Audit Report

August 2013

**Justin P. Wilson**
**Comptroller of the Treasury**

TENNESSEE COMPTROLLER OF THE TREASURY

**Department of Audit**
**Division of State Audit**
**Risk-Based Performance Audit Group**

**DEBORAH V. LOVELESS, CPA, CGFM**
Director

**KANDI B. THOMAS, CPA, CFE, CGFM**
Assistant Director

**SHIRLEY A. HENRY, CPA, CGFM**
Audit Manager

**Jennifer Whitsel, CPA, CFE**
In-Charge Auditor

**Sam Alzoubi, CFE**
**Mark Collins, CFE**
**Angela Courtney**
**Eric Crawford**
**Divon Crutchfield, CPA**
**Andrew Moss**
**Harshil Patel**
**Sonja Yarbrough, CFE**
Staff Auditors

**Amy Brack**
Editor

**Amanda Adams**
Assistant Editor

---

**Comptroller of the Treasury, Division of State Audit**
1500 James K. Polk Building
Nashville, TN 37243-1402
(615) 401-7897

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The mission of the Comptroller's Office is to improve the quality of life for all Tennesseans by making government work better.

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STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
DEPARTMENT OF AUDIT
DIVISION OF STATE AUDIT
SUITE 1500
JAMES K. POLK STATE OFFICE BUILDING
NASHVILLE, TENNESSEE 37243-1402
PHONE (615) 401-7897
FAX (615) 532-2765

August 12, 2013

The Honorable Bill Haslam, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable Larry B. Martin, Interim Commissioner
Department of Finance and Administration
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

We have conducted a performance audit of selected programs and activities of the Department of Finance and Administration for the period July 1, 2010, through June 30, 2012.

Our audit disclosed certain findings which are detailed in the Objectives, Methodologies, and Conclusions section of this report. Management of the department has responded to the audit findings; we have included the responses following each finding. We will follow up the audit to examine the application of the procedures instituted because of the audit findings.

We have reported other less significant matters involving internal control and instances of noncompliance to the Department of Finance and Administration's management in a separate letter.

Sincerely,

Deborah V. Loveless

Deborah V. Loveless, CPA
Director

DVL/sah
12/078

State of Tennessee

# Audit Highlights

Comptroller of the Treasury | Division of State Audit

Performance Audit
**Department of Finance and Administration**
August 2013

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## AUDIT SCOPE

We have audited the Department of Finance and Administration for the period July 1, 2010, through June 30, 2012. Our audit scope included a review of internal control and compliance with the provisions of contracts or grant agreements in the Office for Information Resources, the Division of Benefits Administration, and the Division of Health Care Finance and Administration.

We conducted our audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Management of the Department of Finance and Administration is responsible for establishing and maintaining effective internal control and for complying with applicable laws, regulations, and provisions of contracts and grant agreements.

## AUDIT FINDINGS

**The Office for Information Resources Overbilled One State Agency for Services It Provided and Did Not Maintain Documentation Supporting the Development of Its Cost Models**

In our review of the monthly summary reports during our audit period, we found that these reports contained design flaws which contributed to overbilling one state agency $78,924.43. Additionally, we found that OIR did not maintain documentation to support its cost models used to develop monthly charge rates (page 9).

**Cover Tennessee Staff and the State's Contractor Failed to Identify 24 Ineligible AccessTN Members, Resulting in AccessTN Paying $1,476,309 in State Funds for Health Care and Premium Assistance Benefits for Individuals Not Entitled to Receive Services; They Also Failed to Ensure Application Packets Were Complete**

The Department of Finance and Administration (F&A) contracts with BlueCross BlueShield of Tennessee (BCBST) to make eligibility determinations for the state's AccessTN program and to administer health care coverage to eligible members. As part of our audit, we examined F&A's Cover Tennessee office's processes and procedures to determine applicants' eligibility for the AccessTN program and evaluated whether BCBST's enrollment decisions were appropriate. In our testwork, we identified 24 AccessTN members who were ineligible for program benefits, which cost the state $1,476,309 in health care services and premium assistance. In addition, we found that two members' application packets lacked sufficient information to determine if they were eligible for AccessTN benefits (page 20).

# Performance Audit
# Department of Finance and Administration

## TABLE OF CONTENTS


| | Page |
|---|---|
| **INTRODUCTION** | 1 |
| Post-Audit Authority | 1 |
| Background | 1 |
| **AUDIT SCOPE** | 3 |
| **PRIOR AUDIT FINDINGS** | 5 |
| **OBJECTIVES, METHODOLOGIES, AND CONCLUSIONS** | 5 |
| Office for Information Resources | 5 |
| Finding 1 – The Office for Information Resources overbilled one state agency for services it provided and did not maintain documentation supporting the development of its cost models | 9 |
| Division of Benefits Administration | 14 |
| Division of Health Care Finance and Administration | 18 |
| Finding 2 – Cover Tennessee staff and the state's contractor failed to identify 24 ineligible AccessTN members, resulting in AccessTN paying $1,476,309 in state funds for health care and premium assistance benefits for individuals not entitled to receive services; they also failed to ensure application packets were complete | 20 |
| **APPENDIX** | 28 |
| Business Unit Codes | 28 |

# Performance Audit
# Department of Finance and Administration

## INTRODUCTION

### POST-AUDIT AUTHORITY

This is the report on the audit of the Department of Finance and Administration. The audit was conducted pursuant to Section 4-3-304, *Tennessee Code Annotated*, which requires 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 in accordance with generally accepted auditing standards and in accordance with such procedures as may be established by the comptroller."

Section 8-4-109, *Tennessee Code Annotated*, authorizes the Comptroller of the Treasury to audit any books and records of any governmental entity that handles public funds when the Comptroller considers an audit to be necessary or appropriate.

### BACKGROUND

The Department of Finance and Administration's mission is to provide financial and administrative support services to enhance state government's ability to improve the quality of life for Tennesseans. The department also acts as the chief corporate office of state government. The Department of Finance and Administration (F&A) is organized into 12 divisions, which are described below.

The Division of Accounts is responsible for processing and recording all accounting entries in the state's centralized accounting system, preparing and distributing the state payroll, establishing state accounting policy, and preparing the *Comprehensive Annual Financial Report*.

The Division of Administration handles internal fiscal, personnel, billing, and information systems support issues for the department. This division also provides support services and grants to public and private agencies to promote the quality management of state resources through the following units: Audit and Consulting Services, Criminal Justice Programs, and Volunteer Tennessee.

The Division of Budget prepares and administers the Governor's annual budget, which estimates the revenue and expenditures required to run state government. The annual budget document details the estimates of revenue by source and the planned uses of that revenue by functional area of state government.

The Division of Benefits Administration manages and administers three health insurance programs, one each for employees and retirees of state government and higher education, local governments, and local education agencies, as well as the State Employee Wellness Program and the Employee Assistance Program.

The Division of Enterprise Resource Planning manages Edison, the state's enterprise resource planning system. Edison uses an integrated software package to perform administrative business functions such as financial and accounting, procurement, payroll, benefits, and personnel administration.

The Office for Information Resources (OIR) provides direction, planning, resources, and coordination in managing the information systems needs of the state. OIR serves as staff to the Information Systems Council (ISC) and, under the ISC's guidance, provides technical direction, services, and infrastructure to the State of Tennessee. OIR provides for statewide data, voice, and video operations; information systems planning; information technology training; and security policy, direction, and protection. OIR also provides solutions development and support; manages the state's website; and operates two data centers that house a mainframe, distributed computers, and data storage.

The Office of Inspector General is responsible for helping to identify, investigate, and prosecute individuals who commit or attempt to commit fraud and/or abuse involving the TennCare program; recovering money lost due to fraud and abuse; and preventing fraud and abuse from occurring in the future.

The Division of Health Care Finance and Administration brings together the health care programs within the department to focus their efforts and ensure the best possible coordination of resources for maximum effectiveness and efficiency. The division includes the Bureau of TennCare, the Strategic Planning and Innovation Group, and the Office of e-Health Initiatives.

- The Bureau of TennCare is responsible for the administration of Tennessee's Medicaid waiver program. TennCare provides basic health care, mental health, and long-term care services to people who meet Medicaid eligibility requirements and to certain low-income children.

- The Strategic Planning and Innovation Group consists of the Cover Tennessee programs and the Health Insurance Exchange. Cover Tennessee offers health insurance to uninsured individuals in Tennessee. CoverTN, the centerpiece of the initiative, partners with the state, private employers, and individuals to offer guaranteed, portable, affordable basic health coverage for employees of Tennessee's small businesses, individuals, the self-employed, and the recently unemployed. Comprehensive coverage for children is provided through CoverKids, and chronically ill adults who have been turned down by insurance companies are covered through AccessTN. CoverRx is a statewide pharmacy assistance program designed to assist those who have no pharmacy coverage. The Health Insurance Exchange is an Internet-based alternative for Tennesseans to buy insurance in the individual and small-group markets.

- The Office of e-Health Initiatives, the single coordinating authority for the exchange of electronic health information in Tennessee, works to improve the health of Tennesseans by ensuring that health care providers have complete patient information at the point of care. The Office of e-Health Initiatives is modernizing how Tennessee health care providers access, manage, and share patient information to improve health care costs, delivery, and safety for Tennessee patients.

The Division of Shared Services Solutions delivers fiscal, procurement, and human resource support to small state agencies. Overseen by a board of small agency customers who contract for services and business partners, the division gives small agencies a chance to leverage economies of scale, strengthen internal controls through segregation of duties, and have easy access to specialized expertise.

The Division of Business Solutions Delivery provides resources, methodologies, and best practices to agencies in support of large, complex information technology implementations.

The Office of the State Architect provides staff support to the State Building Commission, whose responsibility is oversight of all building construction and renovation, demolition, and land and lease transactions for state government.

The Office of General Counsel provides legal support to the department.

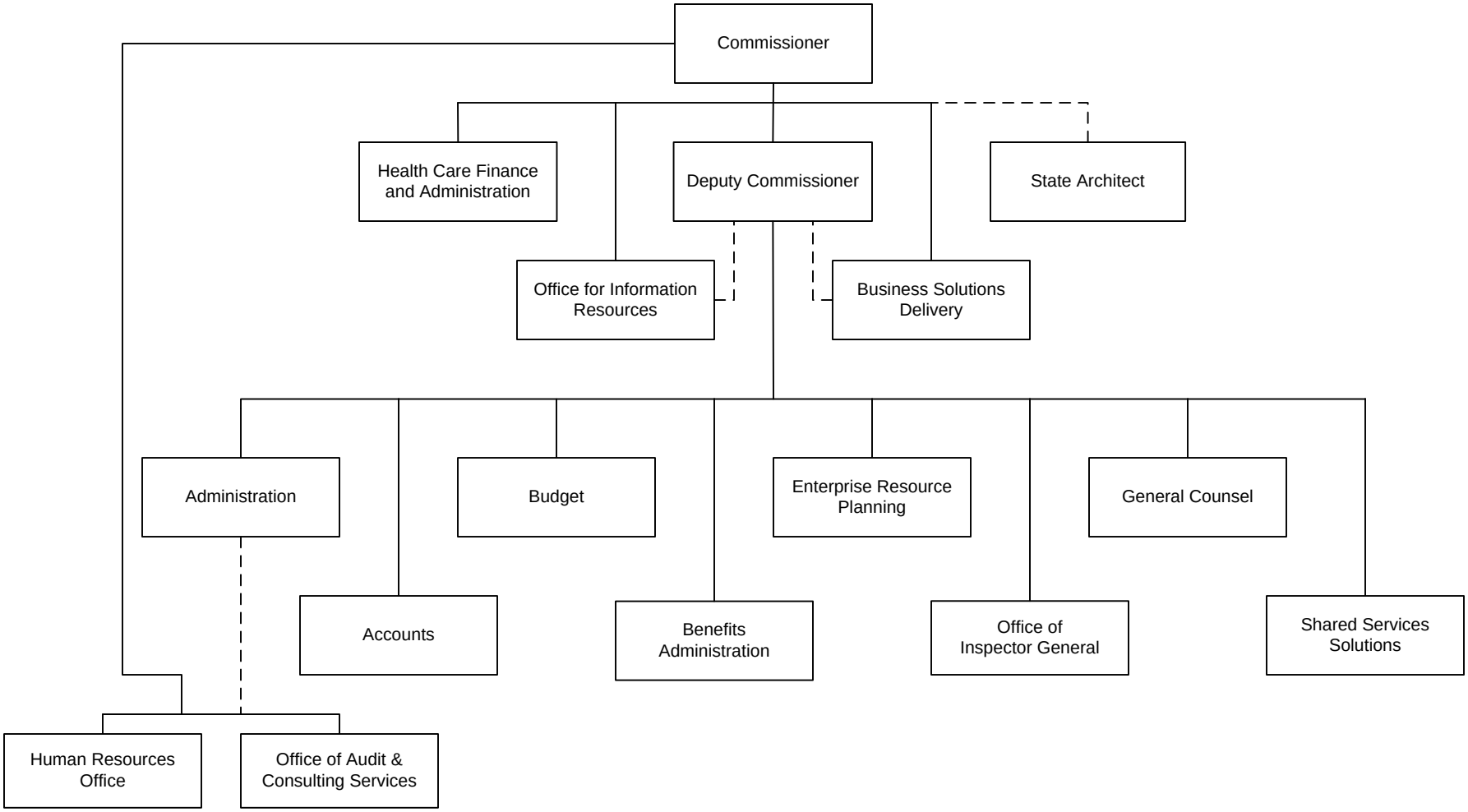
An organization chart of the Department of Finance and Administration is on the following page.

## AUDIT SCOPE

We have audited the Department of Finance and Administration for the period July 1, 2010, through June 30, 2012. Our audit scope included a review of internal control and compliance with the provisions of contracts or grant agreements in the Office for Information Resources, the Division of Benefits Administration, and the Division of Health Care Finance and Administration.

We conducted our audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Management of the Department of Finance and Administration is responsible for establishing and maintaining effective internal control and for complying with applicable laws, regulations, and provisions of contracts and grant agreements.

# Department of
# Finance and Administration
# September 2012



## PRIOR AUDIT FINDINGS

Section 8-4-109, *Tennessee Code Annotated*, requires that each state department, agency, or institution report to the Comptroller of the Treasury the action taken to implement the recommendations in the prior audit report. The Department of Finance and Administration filed its report with the Department of Audit on October 23, 2008.

The prior financial and compliance audit report of the Department of Finance and Administration, which was released in May 2008 and covered the period April 1, 2005, through May 31, 2007, contained ten findings, all of which involved the Division of Mental Retardation Services (later renamed the Division of Intellectual Disabilities Services). We conducted a follow-up of all prior audit findings as part of a review covering the period June 1, 2007, through May 31, 2010. In the follow-up review, we determined that management had corrected four of the ten prior findings; the resolved findings concerned inadequate controls over the contract with the Community Services Network of West Tennessee, failure to collect available federal reimbursement for waiver services, arbitrary payments of housing subsidies without rules for eligibility, and improper employer-employee relationships.

On January 15, 2011, the General Assembly established the Division of Intellectual Disabilities Services as a stand-alone department, the Department of Intellectual and Developmental Disabilities. Therefore, we conducted a follow-up of the six unresolved prior audit findings as part of the audit of the Department of Intellectual and Developmental Disabilities, and the status of those findings is included in that audit report, which was released on April 25, 2013.

## OBJECTIVES, METHODOLOGIES, AND CONCLUSIONS

### OFFICE FOR INFORMATION RESOURCES

The Office for Information Resources (OIR) provides services to clients that are primarily state agencies, departments, and commissions, although it also provides some services to federal and local governmental entities. During the period July 1, 2011, through March 31, 2012, OIR had approximately 358 staff members, 34 of whom were contracted staff. The office is headed by a Chief Information Officer, who supervises a Deputy Chief Information Officer, Chief Technology Officer, and Chief Information Security Officer as well as Directors of Security, End Point Management, Procurement and Contract Management, Technology Financial Management, and Customer Relationship Management. The sections of OIR that provide services to state agencies are described below.

- *Security* - This section is responsible for drafting and overseeing the State Enterprise Information Security Policies, including oversight of the state's information systems security program. Other major functions and responsibilities include reviewing state contracts for security-specific concerns, responding to and resolving security system issues identified through internal and external audits, ensuring the availability of information technology security resources statewide, and collaborating with state agencies to mitigate IT security risks.

- *Enterprise Architecture and Research* - Maintains the state's enterprise architecture, including the standard products list, and performs research on new or proposed technology.

- *Data Centers* - Two centers operate around the clock and provide statewide hosting services for applications that run on the state's mainframe and distributed systems. In addition to hosting services, the data centers provide data storage management and limited production and print services.

- *Enterprise Command Center* - This section is responsible for oversight of the OIR Command Center, which provides continuous monitoring of the state's information systems network. This section also provides a Help Desk, which assists agencies with network operations and security issues.

- *Operations Project Management Office* - Provides infrastructure project management for all OIR projects and services.

- *Disaster Recovery Coordinator* - Supports agencies by providing guidance through the facilitation of the Disaster Recovery Task Force, support for the centralized disaster recovery repository, and consultation concerning technical solutions available for the different levels of disaster recovery offered for systems.

- *Change Management* - Responsible for ensuring that all changes to infrastructure and systems supported by OIR are planned, documented, scheduled, assessed, communicated, and tested prior to implementation of a change.

- *Network Services* - This section is responsible for the computer network infrastructure. The components supported include network security operations, server connectivity at the data centers, and infrastructure hardware such as cabling, routers, and switches.

- *End Point Management* - Includes the management and operation of several technical areas including e-mail, directory services for managing the state eDirectory and Active Directory operations, local area network management, end-point management, and cabling.

- *Enterprise Services* - Consists of data resource management, the state's Internet portal, MOSS/Sharepoint services, Middleware Support, Enterprise Content Management, website consulting, business intelligence, and testing support.

- *Geographic Information Systems* - Provides application development, application hosting, data sharing, and data management to state agencies and other users of spatial information, including counties and municipalities.

- *Procurement/Contracts/License Management/Sales* - Provides support for IT commodities contracts, OIR services contracts, and OIR endorsements.

- *Planning* - This section serves as staff to the Information Technology Assessment and Budget Committee and provides support, guidance, and training in project plan development, development of Three-Year Information Systems Plans, and IT-related requisition review and approval. The section is also responsible for the development and publication of the annual *Information Systems Statewide Plan*.

- *NetTN & Digital Media Services* - This section includes NetTN, Digital Media Services, Internet Protocol Telephony, Wireless Devices, and Telephone/Voice Support. NetTN is responsible for managing and overseeing the operations of the statewide network contract. Digital Media Services provides a wide variety of services including audiovisual systems, digital media, video conferencing, and desktop video.

The Office for Information Resources also functions as the oversight entity for the Equipment Replacement Fund (ERF) and the System Development Fund (SDF). The ERF was established to provide loans to state entities for the replacement of desktop-computer-related hardware and software with the loans being repaid over four years. The SDF, established to assist in funding the implementation of large systems and application development projects (in excess of $100,000), provides the up-front funds needed for implementation and allows state entities to repay the funds over a period not to exceed five years. OIR was also responsible for the Information Systems College Program, which was established to help offset some of the expenses involved in training information technology personnel from other state entities. The last time that funds from the program were used for training was in November 2009, and the Director of Fiscal Services stated that the program has been discontinued.

Billings to Departments and Agencies for Services Provided

OIR provides services to state departments and agencies (entities), which include telephone and Internet connections, information technology planning, security, manpower services (OIR staff/OIR contractor assisted technical services), and disaster recovery. In order to be compensated for the costs of providing services to the state entities, OIR develops cost models to establish a monthly charge rate to bill each entity for the services it receives. The charge rate may be a fixed amount or based on a unit cost (e.g., telephone lines) depending on the cost model.

The objectives of our review of OIR billings to state departments and agencies (entities) were to determine whether

- OIR had written policies and procedures in place that govern billing and the related rates;
- the rates charged by OIR were reasonable, justifiable, and based on actual cost models;
- procedures were in place to ensure timely billings and timely processing and delivery of the related services;
- procedures were in place to prevent and detect potential billing errors; and
- procedures were in place for OIR to follow up on billing questions and concerns and, where necessary, to provide refunds in a timely manner.

To accomplish our objectives, we

- interviewed key personnel;
- obtained and reviewed procedures related to OIR billings to state entities;
- obtained and reviewed listings of the rates that OIR charged to state entities;
- obtained and reviewed examples of cost models;
- performed a trend analysis of OIR expenditures covering fiscal years 2005 through 2012 and obtained explanations for significant and unusual items noted;
- performed analytical procedures on amounts billed to 10 entities for the period July 1, 2011, through March 31, 2012, and obtained explanations for significant and unusual items noted;
- examined a nonstatistical sample of 25 monthly billings for 10 entities (from a population of 90 monthly billings) for the period July 1, 2011, through March 31, 2012;
- scanned the monthly billing documents for unusual items and performed analytical procedures to determine if OIR correctly billed the entities for manpower services;
- attempted to trace assumptions for BlackBerry cost models to related support;
- obtained and reviewed copies of contracts for BlackBerry devices;

- performed analytical procedures to determine if the costs charged for BlackBerry devices were in accordance with the cost model;

- obtained and reviewed supporting documentation for new and discontinued services;

- obtained and reviewed documentation to support unusual billing situations; and

- obtained and reviewed documentation for refunds issued.

Based on the procedures performed, we determined that

- OIR had written procedures in place that govern billing and the related rates;

- the rates charged by OIR were not always reasonable, justifiable, and based on actual cost models (see finding 1);

- procedures were in place to ensure timely billings and timely processing and delivery of the related services;

- procedures were not in place to prevent and detect potential billing errors (see finding 1); and

- procedures were in place for OIR to follow up on billing questions and concerns and, where necessary, provide refunds in a timely manner.

## 1. The Office for Information Resources overbilled one state agency for services it provided and did not maintain documentation supporting the development of its cost models

### Finding

Based on cost models it developed, the Office for Information Resources (OIR) billed state departments and agencies (entities) monthly for the services it provided, such as telephone and Internet connections and manpower services (OIR staff/OIR contractor assisted technical services). In our review of the monthly summary reports during our audit period, we found that these reports contained design flaws which contributed to overbilling one state agency $78,924.43. Additionally, we found that OIR did not maintain documentation to support its costs models used to develop monthly charge rates.

### Overbillings and Duplicate Billings for Manpower Services

To determine the accuracies of OIR's billings to state entities that use OIR services, we reviewed ten entities which OIR billed for services. From those ten entities, we examined a sample of 25 monthly summary reports for the period July 1, 2011, through March 31, 2012. Although we determined that the charges listed on the summary reports were supported, we

decided to examine charges for manpower services in closer detail. According to OIR personnel, OIR bills entities based on the number of hours an OIR employee or contractor works on a particular project for the entity. OIR also charges an administrative fee of 5% of the actual cost paid for these services.

We examined nine monthly summary reports to the Department of Labor and Workforce Development (DLWD) between July 1, 2011, and March 31, 2012, which involved manpower services. Based on our testwork, we found that OIR overbilled or duplicate billed the DLWD for manpower services due to system design flaws in Edison and did not have compensating controls in place to ensure that OIR did not overbill or duplicate bill DLWD (or other entities) for manpower services.

The Director of OIR Administration stated that the information used in the monthly summary reports is based on time charged by the OIR contractors to each project in Edison. The Director stated that there has been a flaw in the process of pulling the time recorded in Edison to the billing system tables, resulting in duplicate charges to entities. The time capture problems occurred when a contractor worked on multiple projects during a pay period. When the contractors recorded time to multiple projects, the billing system picked up the total number of hours on the timesheet as opposed to just the total number of hours charged to each project. The Director of OIR Administration stated that he was well aware of this issue and was working to solve it; however, he was not sure how OIR or Edison could correct the issue. The Director of OIR Administration stated that the contractors were told to submit a separate timesheet for each project, but some contractors did not complete their timesheets in this manner. Even though the Director of OIR Administration was well aware of the processing flaw, the OIR Financial Director stated that no one in OIR Financial Management was currently reviewing the manpower charges before sending the billings to the entities.

Based on our testwork, we found that OIR overbilled DLWD at least $7,174.50 as a result of errors and duplicated billings totaling $71,749.93. Also, based on our discussion with DLWD management, DLWD unknowingly passed these overcharges on to various federal and state funded programs as shown in the table below.

| **State or Federal** | **Grant/Funding Program** | **Amount** |
|---|---|---|
| Overbillings Due to Errors | | |
| State | DLWD's administrative cost | $ 3,562.50 |
| Federal – ARRA | Development of the Southeast Consortium for Unemployment Benefits system to administer the Unemployment Insurance Program | 3,612.00 |
| | Total overbillings due to errors | $ 7,174.50 |

Duplicate Billings

| | | |
|---|---|---|
| Federal – ARRA | Non-personnel services/overhead | $ 6,138.83 |
| Federal | Salaries and other costs to work on the Unemployment Insurance Program supplemental budget request | 18,082.84 |
| Federal | Wagner Peyser Grant program | 47,528.26 |
| | Total duplicate billings | $71,749.93 |
| | Total | $78,924.43 |

We found that $75,361.93 was charged to federal grants and programs, of which $9,750.83 came from grants awarded under the American Recovery and Reinvestment Act of 2009 (ARRA). The remaining $3,562.50 consisted of state funds. After we informed OIR and DLWD management, OIR credited $87,273.55 in manpower services to the department, as of June 2012, which included the $78,924.43 shown above and additional amounts for other periods.

**Cost Model for BlackBerry Devices Not Supported**

OIR uses cost models to determine the rates it bills to entities for the services OIR provides them. The rates established are intended to recover the costs that OIR incurs to provide the services. The cost models include hardware and software depreciation; annual hardware and software maintenance fees; salaries and benefits of employees who manage the service, including leave; direct and indirect overhead; and other direct costs, including, but not limited to, floor space, server racks, and firewalls. After OIR calculates the total cost to provide a service, it determines the rate based on a four-year recovery period. The Chief Information Officer, OIR Financial Director, and Deputy Commissioner must approve all new rates and rate changes before they take effect. The Financial Director then submits rates to the Budget Office for approval.

In our review of the BlackBerry cost model developed in fiscal year 2010 and in place during the audit period, we asked the OIR Financial Director and the Executive Director of OIR's NetTN section to provide us with supporting documentation for the "Unit Price" column on the cost model. The OIR Financial Director stated that OIR technical personnel provided him with this information when it was originally developed, but he no longer had the documentation. The Executive Director of NetTN provided us with purchase order documentation; however, we were not able to agree the unit price information in the purchase orders to the unit price information on the cost model. In addition, the Executive Director was not sure where any additional support, such as invoices, might be located because he started in his position during fiscal year 2012. Therefore, we could not determine the validity of the data used in estimating the related BlackBerry cost.

During our audit field work, OIR approved a new cost model in May 2012, retroactive to February 2012. This cost model listed $43.57 a month per user for BlackBerry usage. When comparing the information on this cost model to support, we noted the following issues:

- The cost model showed $380 per month for a SQL (Structured Query Language) shared server, but OIR charged $400 per month to state entities on the monthly billings during fiscal year 2012, $20 more than the amount included in the cost model. According to the OIR Financial Director, this was an oversight on his part; he should have used $400 as the cost for the server when preparing the cost model.

- OIR could not provide adequate supporting documentation for the "Unit Price" or "Annual Cost" columns for the "Production Servers" and "Microsoft Windows Server 2003 License & software assurance" items. The Executive Director responsible for these items provided us with screen prints of purchase order information from the Tennessee On-Line Purchasing System, the state's previous purchasing system, but he could not provide the invoices listing the amount the state actually paid. According to the Executive Director of OIR's End Point Management section, no other documentation exists due to the state's densification initiative and reduction in paper records.

Because OIR provides state entities with services necessary to perform daily operations for the citizens of Tennessee, OIR has a duty to ensure that what it charges for these services is accurate and is based on actual, supported cost models that allow OIR to effectively carry out its own operations without burdening entities with overcharges.

## Recommendation

Until such time that OIR corrects the system design errors relating to manpower services, the Commissioner should ensure that his staff develops a process to review and approve the monthly summary reports sent to state entities for various OIR services to eliminate overbillings and duplicate billings. If issues arise, the Commissioner should ensure that appropriate staff investigate and correct the issues before billing the entities for services.

The Chief Information Officer should ensure that cost models are based on adequate supporting documentation. The Chief Information Officer should ensure that supporting documentation is maintained in accordance with applicable retention procedures or as long as the cost model is in place, whichever period is longer.

## Management's Comment

### Overbillings and Duplicate Billings for Manpower Services

We concur with the finding and recommendation as it relates to manpower services.

When Edison was first implemented, the process called for contractors to only key time to one work order for a given billing cycle and to have all timesheets approved by the 10th of the following month so that the system could properly calculate the billing. After the time is keyed into sPro, the timesheets are summarized and staged to the billing table. In the event that there are multiple billing rows for a contractor, the time is doubled. If the time has not been approved by the 10th of the following month, the time is not included on the billing summary table. The doubling issue was first discovered by the OIR Financial Services staff during the early days of the Edison system. Staff in OIR Financial Services knew how to review queries to detect and then correct the doubling error before the cost allocation processes were run.

Edison now provides OIR staff with the results of a query of the summary billing file to review prior to cost allocation running. OIR staff was instructed on how to correct the billing summary table by adjusting the original sPro entries. OIR Financial staff has notified OIR project managers to avoid having contractors key multiple work orders on timesheets. Edison staff also review the queries prior to running cost allocation to bill the agencies to ensure that duplicate billings do not occur.

The contract for IT contractors is in the process of being moved to the Department of General Services Central Procurement Office (DGS-CPO) and is presently out for bid. Once the new contract has been awarded, DGS-CPO will work with the new vendor to determine the business process around the new contract. In the event that this business process still utilizes the Edison sPro functionality, Edison staff will then determine if the issues above can be addressed by adding additional edits to the system.

**Cost Model for BlackBerry Devices Not Supported**

We concur that adequate supporting documentation should exist for each cost model, and OIR is in the process of developing a repository to house all current cost models.

However, it should be noted that cost models are developed to recover the costs of our services. They include anticipated revenues and expenditures based on projections. Actual recovery can increase or decrease based on the number of people using the service, licensing costs, maintenance costs, and a myriad of other uncontrollable factors.

OIR is an Internal Service Fund and cannot make a profit. We monitor service recovery after each fiscal year. If we find that we are over-recovering or under-recovering for a particular service, we adjust the respective cost model to reflect the appropriate charge based on actual prior year demand and cost conditions.

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OIR Funds

The objectives of our review of the OIR funds were to determine whether

- OIR properly administered and accounted for the Equipment Replacement Fund (ERF), System Development Fund (SDF), and Information Systems (IS) College Program; and

- monies from the ERF, SDF, and IS College Program were spent in accordance with the purposes for which they were established.

To accomplish our objectives, we

- interviewed key personnel;

- obtained and reviewed information regarding the establishment of the funds and related policies and procedures; and

- reviewed revenue and expense transactions.

Based on the procedures performed, we determined that

- OIR properly administered and accounted for the Equipment Replacement Fund (ERF), System Development Fund (SDF), and IS College Program; and

- monies from the ERF, SDF, and IS College Program were spent in accordance with the purposes for which they were established.

## DIVISION OF BENEFITS ADMINISTRATION

In the Division of Benefits Administration, we focused on the state's health insurance plans offered to state and local government employees, including public higher education employees and teachers, and on the state's pharmacy benefits manager, which oversees the prescription medication component of the health insurance. The state is self-insured but contracts with BlueCross BlueShield of Tennessee (BCBST) and Cigna to administer the medical plans and with CVS Caremark to manage the pharmacy benefits component. These contractors process all claims, make all claim payments to providers, provide employees with access to a network of providers, and carry out all utilization management functions.

### State Health Insurance Plans

The objectives of our review of the state health insurance plans were to determine whether

- the Division of Benefits Administration properly monitored the contracts with BCBST and Cigna for the provision of administrative services for the plans;

- the Division of Benefits Administration reconciled claims payments and draws for medical claims to the transactions in the applicable insurance funds;

- the Division of Benefits Administration transmitted proper eligibility files to the administrative services contractors;

- the amounts paid to contractors for the provision of administrative services for the plans were reasonable and accurate;

- the Division of Benefits Administration had established procedures to adequately and accurately evaluate member satisfaction levels with the administrative services contractors and network providers; and

- the Division of Benefits Administration assessed liquidated damages outlined in the BCBST and Cigna contracts, if applicable.

To accomplish our objectives, we

- interviewed key department personnel to gain an understanding of the state health insurance plans and the contractors that service the plans;

- interviewed key department personnel and reviewed contracts, reports, and other supporting documentation to determine whether the Division of Benefits Administration properly monitored BCBST and Cigna's administrative responsibilities;

- examined the process used by the Division of Benefits Administration to reconcile the contractors' claims payments and draws for medical claims to the transactions in the insurance funds;

- interviewed key department officials and examined documentation to determine if the division transmitted proper eligibility files to the contractors;

- interviewed key personnel in the Office of Business and Finance within F&A to gain an understanding of the invoice process for paying the contractors' administrative fee and tested the invoices for one month to determine if the payments were reasonable and accurate;

- interviewed key personnel in the Division of Benefits Administration to examine their procedures to adequately and accurately evaluate member satisfaction levels with BCBST and Cigna; and

- examined liquidated damages to determine if Benefits Administration properly assessed damages when appropriate.

Based on the procedures performed, we determined that

- the Division of Benefits Administration property monitored the contracts with BCBST and Cigna for the provision of administrative services for the plans;

- the Division of Benefits Administration reconciled claims payments and draws for medical claims to the transactions in the applicable insurance funds;

- the Division of Benefits Administration transmitted proper eligibility files to the administrative services contractors;

- the amounts paid to contractors for the provision of administrative services for the plans were reasonable and accurate;

- the Division of Benefits Administration had established procedures to adequately and accurately evaluate member satisfaction levels with the administrative services contractors and network providers; and

- the Division of Benefits Administration assessed liquidated damages outlined in the BSBST and Cigna contracts, if applicable.

Pharmacy Benefits Manager

The objectives of our review of the pharmacy benefits manager were to determine whether

- the Division of Benefits Administration monitored Caremark's provision of pharmacy benefit management services to ensure that Caremark met all contractual financial and performance guarantees;

- the Division of Benefits Administration properly reconciled pharmacy claims data to the amounts it reimbursed Caremark for pharmacy claims;

- the amounts paid to Caremark for administrative services were reasonable and accurate;

- the Division of Benefits Administration assessed the liquidated damages outlined in the state's contract with Caremark for the provision of pharmacy benefit management services, if applicable;

- the Division of Benefits Administration had established procedures to monitor the accuracy and completeness of pharmacy rebates remitted to the state by Caremark;

- the Division of Benefits Administration had established and implemented procedures to address any questions or complaints that members of the state's plans might have regarding members' prescription benefits; and

- the amounts paid to network pharmacies for prescription drug claims agreed to the amounts Caremark drew from the state's insurance funds.

To accomplish our objectives, we

- interviewed key departmental personnel and reviewed the Caremark contract, reports, and other supporting documentation to determine whether the Division of Benefits Administration effectively monitored Caremark's financial and performance guarantees;

- examined the process the Division of Benefits Administration used and reviewed the supporting documentation to determine if the division properly reconciled pharmacy claims data to the amounts it reimbursed Caremark for pharmacy claims;

- reviewed the Caremark contract and interviewed key personnel in the Office of Business and Finance within F&A to gain an understanding of the invoice process for paying the contractor's administrative fee and tested the invoices for the period July 1, 2010, through April 30, 2012, by comparing the invoice amounts to member eligibility reports to determine if the amounts paid to Caremark for administrative services were reasonable and accurate;

- examined liquidated damages to determine if the Division of Benefits Administration properly assessed damages;

- interviewed key personnel to gain an understanding of Benefits Administration's monitoring process to determine the accuracy and completeness of pharmacy rebates;

- reviewed the division's procedures to address any questions or complaints from members regarding the prescription benefits; and

- tested a nonstatistical sample of 60 paid claims (from a population of more than 10.7 million claims) and compared the amount Caremark reimbursed the pharmacies to the amount the Division of Benefits Administration reimbursed Caremark.

Based on the procedures performed, we determined that

- the Division of Benefits Administration monitored Caremark's provision of pharmacy benefit management services to ensure that Caremark met all contractual financial and performance guarantees;

- pharmacy claims data and the amounts reimbursed to Caremark for pharmacy claims were properly reconciled;

- the amounts paid to Caremark for the provision of pharmacy benefit management services were reasonable and accurate;

- the liquidated damages outlined in the state's contract with Caremark for the provision of pharmacy benefit management services were assessed when applicable;

- the Division of Benefits Administration had established procedures to monitor the accuracy and completeness of pharmacy rebates remitted to the state by Caremark;

- the Division of Benefits Administration had established and implemented procedures to address any questions or complaints that members of the state's plans might have regarding members' prescription benefits; and

- the amounts reimbursed to network pharmacies for prescription drug claims under the plans agreed to the amounts Caremark drew from the state's insurance funds.

## DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION

In the Division of Health Care Finance and Administration (HCFA), we focused on the Access Tennessee program, which is a responsibility of the Cover Tennessee office within that division. Section 56-7-2901, et al., *Tennessee Code Annotated*, the *Access Tennessee Act of 2006*, established the Access Tennessee (AccessTN) health insurance pool to make health insurance coverage available to uninsurable Tennesseans. The program provides comprehensive health insurance options and operates as a high-risk pool for those who have been denied insurance previously due to disqualifying medical conditions. Premiums are based on weight, tobacco use, and age and may range from 150% to 200% of comparable commercial rates. For individuals that qualify, AccessTN provides premium assistance of up to 80% of members' monthly premiums. According to enrollment data provided by Cover Tennessee staff, AccessTN had 3,890 members in July 2010 and 3,092 members in April 2012.

The state contracts with BlueCross BlueShield of Tennessee (BCBST) to serve as the Plan Administrator for the AccessTN program. Under the program, the state is subrogated to members' legal rights to recover any payments the plan makes for covered services when the illness or injury resulted from the action or fault of a third party, which means it has the right to recover any and all amounts equal to the plan's payments from: the insurance of the injured party; the person or company (or combination thereof) that caused the illness or injury, or their insurance company; or any other source, including uninsured motorist coverage, medical payment coverage, or similar medical reimbursement policies. Members are required to notify the administrator promptly if they are involved in an incident that gives rise to subrogation rights and to cooperate with the administrator to protect the state's rights. As the Plan Administrator, BCBST is responsible for protecting these subrogation rights.

The objectives of our review of the Access Tennessee program were to determine whether

- HCFA staff properly reconciled claims data and the amounts reimbursed to BCBST for claims paid to providers;

- HCFA staff properly monitored BCBST's performance under its contract for the provision of administrative services for AccessTN;

- AccessTN members met the eligibility requirements for participation in AccessTN;

- AccessTN members that received premium assistance met the eligibility requirements for premium assistance;

- Cover Tennessee management had established procedures to monitor the accuracy and completeness of pharmacy rebates remitted to the state by BCBST; and

- Cover Tennessee management monitored subrogation recoveries to verify that third-party recoveries were remitted to AccessTN and that the amounts appeared reasonable and accurate.

We interviewed key department personnel to gain an understanding of HCFA's procedures and controls over the AccessTN program and reviewed supporting documentation. We reviewed and analyzed medical claims and prescription claims reconciliation procedures for claims invoices paid in April 2012. We examined the contract with BCBST to determine what deliverables the contractor was required to submit to the state and examined the reports and other information to ensure the state properly monitored BCBST. We reviewed and analyzed Cover Tennessee's monthly data match procedures for members enrolled in AccessTN during March 2012 and performed an independent comparison for March 2012 to evaluate the effectiveness of the procedures in identifying members who were potentially ineligible for coverage. From the population of 3,092 AccessTN members with at least one day of coverage through AccessTN during April 2012, we selected a nonstatistical sample of 60 members and reviewed documentation supporting the members' eligibility for coverage through AccessTN and for premium assistance, if applicable. We also reviewed the entire population for April 2012 to identify and test members who were 65 years old or older to determine their eligibility for Medicare, which could impact their eligibility for AccessTN.

We interviewed Cover Tennessee management to determine how they monitor audits of pharmacy rebates relating to pharmacy expenditures for AccessTN members. We also interviewed Cover Tennessee management to document their monitoring of third-party recoveries by BCBST and obtained a listing from BCBST of all subrogation cases closed from January 1 to December 31, 2011, to determine if the recovery amounts were reasonable and accurate.

Based on the procedures performed, we determined that

- HCFA staff properly reconciled claims data and the amounts reimbursed to BCBST for claims paid to providers, with minor exceptions;

- HCFA staff properly monitored BCBST's performance under its contract for the provision of administrative services for AccessTN, with the exception of eligibility (see finding 2);

- some AccessTN members did not meet the eligibility requirements for participation in AccessTN and, consequently, premium assistance (see finding 2);

- Cover Tennessee management had established procedures to monitor the accuracy and completeness of pharmacy rebates remitted to the state by BCBST; and

- Cover Tennessee management monitored subrogation recoveries to verify that third-party recoveries were remitted to AccessTN and that the amounts were reasonable and accurate.

**2. Cover Tennessee staff and the state's contractor failed to identify 24 ineligible AccessTN members, resulting in AccessTN paying $1,476,309 in state funds for health care and premium assistance benefits for individuals not entitled to receive services; they also failed to ensure application packets were complete**

**Finding**

The Department of Finance and Administration (F&A) contracts with BlueCross BlueShield of Tennessee (BCBST) to make eligibility determinations for the state's AccessTN program and to administer health care coverage to eligible members. The state pays BCBST an administrative fee per member per month to administer the program. The department also contracted with Patient Services, Inc. to provide eligibility determinations for premium assistance; effective October 15, 2010, F&A closed the premium assistance program to new applicants. As part of our audit, we examined F&A's Cover Tennessee office's processes and procedures to determine applicants' eligibility for the AccessTN program and evaluated whether BCBST's enrollment decisions were appropriate. We found that the Cover Tennessee office had not established policies and procedures to periodically review BCBST's eligibility determinations to ensure that BCBST complied with AccessTN's eligibility requirements. In our testwork, we identified 24 AccessTN members who were ineligible for program benefits, which cost the state $1,476,309 in health care services and premium assistance. In addition, we found that two members' application packets lacked sufficient information to determine if they were eligible for AccessTN benefits.

According to Section 56-7-2908(e)(1)(A), *Tennessee Code Annotated*, a person is not eligible for coverage through AccessTN if "The person has or obtains health insurance coverage substantially similar to or more comprehensive than a pool [AccessTN] policy, or would be eligible to have coverage, if the person elected to obtain it . . ." with a few exceptions.

We examined the data-match procedures used by Cover Tennessee staff for one month to determine if their procedures were effective in identifying AccessTN members who also had access to the state's health insurance programs for state employees, local government employees, or teachers thus making them ineligible for AccessTN. We also selected a sample of AccessTN members from one month of the scope period and reviewed each one's application and supporting documentation to determine if the member was eligible for enrollment in the

program. In addition, we reviewed the entire population of members for the sample month and tested those members who were 65 years old or older to determine if they were eligible for the federal Medicare Part A and Part B programs, which would disqualify them from participation in AccessTN. The specific details and results of our work are discussed below.

**Ineligible Members Identified in Data Match**

Each month an Administrative Services Assistant (ASA) in the Program Integrity Unit in the Cover Tennessee office performs a data match to determine if any AccessTN members are enrolled in the state's insurance plans. To perform the match, the ASA obtains a file of all individuals enrolled in the state's insurance plans from the department's Division of Benefits Administration and a file of AccessTN members from BCBST.

To evaluate the effectiveness of the data-match procedures, we performed an independent comparison for March 2012 to determine if we obtained the same results as the ASA. For this testwork, we compared the Social Security numbers of AccessTN members enrolled during March with the list of individuals enrolled in the state's insurance plans during the same month. The ASA identified one match that staff needed to evaluate; however, based on our results, we found an additional 14 matches requiring follow-up by staff that the ASA failed to identify. When we followed up on these additional matches, we were able to adequately resolve 11 of the 14 matches based on additional information provided by staff; however, we found that 3 of these 14 members (21%) were not eligible for AccessTN because they were eligible for insurance coverage through the state's local government insurance plan or the teacher insurance plan. When we discussed our results with the Director of CoverKids, she initially stated that these individuals were still eligible for AccessTN because they worked for counties and the state does not contribute toward their counties' insurance plans; however, after her further research, the Director informed us that they planned to terminate these individuals' AccessTN coverage on August 31, 2012, because the members were not eligible for AccessTN coverage.

According to the Director of CoverKids, the ASA's data match failed to identify these 14 members because of errors in the formulas used to match the two lists; however, she could not identify the exact cause of the errors. The Director also stated that the Cover Tennessee office is currently planning to collaborate with the Bureau of TennCare in the future, so that staff within TennCare will perform these monthly data match procedures and report their results to Cover Tennessee. The total cost of health care services and premium assistance for these three individuals was $39,668.

**Ineligible Members Identified in Sample Testwork**

We tested a sample of 60 AccessTN members who had coverage for at least one day in April 2012 to determine if the members were eligible for AccessTN. Based on our testwork, we found that BCBST enrolled 6 of 60 members in our sample (10%) who were not eligible for coverage in April 2012. We also reviewed the entire population of AccessTN members in April 2012 and tested those members who were 65 years old or older (who were not already tested in the original sample) to determine if they were eligible for the federal Medicare Part A and Part B programs, which would disqualify them from participation in AccessTN. The 65 years old or

older group included 21 individuals. We found 15 AccessTN members who also qualified for Medicare. Based on our testwork, we found that BCBST failed to identify or classify 12 of the 15 members as ineligible because of their federal program eligibility. The other three members should have been deemed ineligible because they did not provide supporting documentation to BlueCross BlueShield verifying their permanent residency. The specific results of our testwork related to the 21 ineligibles we found (6 from the sample of 60 and 15 from our testwork on the 21 members who were 65 years old or older) are discussed below.

- Two of 21 members were enrolled in AccessTN during the first 12 months of AccessTN; however, their applications indicated they had ongoing coverage under the Health Insurance Portability, Availability and Renewability Act (HIPARA), which would have disqualified them per Section 56-7-2908, *Tennessee Code Annotated*. At the time these members applied, AccessTN's Board of Directors approved a policy allowing these individuals to enroll in AccessTN, even though this policy conflicted with the eligibility requirements. The Board of Directors subsequently revised this policy, and individuals with health insurance coverage under HIPARA were no longer permitted to enroll in AccessTN, but Cover Tennessee staff did not remove these three individuals from the program.

- Two of 21 members submitted "Attending Physician's Statements" but did not indicate they suffered from one of the medical conditions, such as heart disease or cancer, that demonstrated they were uninsurable. According to AccessTN's Plan of Operations and in each application for coverage, individuals enrolling in AccessTN must submit documentation demonstrating that the individuals are uninsurable.

- Fourteen of 21 members were ineligible because they met the basic eligibility requirements for Medicare Part A and Part B.

- Three of 21 members did not meet the permanent residency requirements to obtain AccessTN benefits because they had not worked or obtained 40 qualifying quarters since January 1, 1997. Section 56-7-2908, *Tennessee Code Annotated*, requires that all AccessTN members be citizens of the United States, except that individuals who are qualified aliens, such as refugees, asylees, and certain permanent residents, are also eligible for coverage through AccessTN. These individuals provided documentation they were permanent residents. However, they did not provide documentation that they worked or obtained 40 qualifying quarters of coverage as defined under Title II of the Social Security Act.

**Incomplete Application Packets**

Based on our sample testwork discussed above, we also found that BCBST approved 2 of 60 members for AccessTN (3%) even though the applications were incomplete. Specifically, we noted the following:

- one member did not answer the question whether or not her employer offered group health coverage or paid the cost of insurance; and

- the other member applied for AccessTN based on the Tennessee HIPARA eligibility requirement but did not provide a certificate of creditable coverage or other proof of prior insurance showing she had 18 months of combined health coverage.

Because the applications were incomplete, BCBST should not have approved the applicants' enrollment in AccessTN.

As of June 30, 2012, the 24 individuals noted above were ineligible for participation in AccessTN yet the individuals were enrolled in AccessTN and received benefits from six months to over five years. The state expended $996,783 in medical and prescription claims and $479,526 in premium assistance for these members for a total of $1,476,309.

Management within the Cover Tennessee office relied on BCBST to fulfill their contractual duty to enroll individuals in AccessTN based on the appropriate eligibility requirements. However, management within the Cover Tennessee office failed to exercise oversight responsibility to ensure BCBST met its contractual obligation relating to enrollment.

By failing to ensure individuals are properly enrolled in the AccessTN program, the state is at risk of paying for services on behalf of individuals who are not eligible to receive them. In addition, eligible individuals may be prevented from receiving the health care services they need since the AccessTN funds are limited.

## Recommendation

The Executive Director of Cover Tennessee should work with its contractor responsible for eligibility determinations to ensure the contactor is fully aware of AccessTN's eligibility requirements and that the contractor makes accurate determinations. The Executive Director should also ensure that eligibility monitoring procedures such as the data-match procedures are working effectively to identify ineligible members. Once he determines a member is ineligible, he should terminate the member from the program immediately.

## Management's Comment

The Division of Health Care Finance and Administration (HCFA) was created on April 1, 2011. The oversight of the Cover Tennessee programs, which includes AccessTN, was transferred to HCFA from the Division of Benefits Administration at that time.

The audit has pointed to three areas where AccessTN can improve performance, all of which the AccessTN staff have addressed. The first is to improve the data-match process to reduce the possibility of human error. These improvements address three of the 26 members in the audit finding. The second improvement is to carry out routine random sampling of AccessTN applications, which will address applications like the nine members with incorrect or incomplete applications the audit found—eight of these applications were originally processed

before April 1, 2011. The third improvement is to modify the application instructions in order to avoid some of the issues identified in the audit of incorrect or incomplete applications.

The audit has recommended a new interpretation of the AccessTN enabling legislation that would prohibit people who are eligible to "buy in" to Medicare Part A and purchase Medicare Part B and D from being AccessTN eligible. There are 14 AccessTN members who would be eligible to buy in to Medicare of the 26 members in the finding. We will ask the AccessTN board to address this recommendation in the first meeting that follows the publication of the audit.

Our detailed responses to the auditor's finding are below.

**Ineligible Members Identified in Data Match**

We concur. AccessTN's documented monthly data-match procedures should have identified the three members that were found in the audit; however, Cover Tennessee's Program Integrity staff did not correctly perform the data-match procedures. We have corrected this problem by moving from a manual data-match process conducted using Microsoft Access database software to an automated data match in a Structured Query Language (SQL) database. We are leveraging the data-match processes and knowledge of the Bureau of TennCare's Information Technology Team to improve these program integrity processes. The increased technological sophistication and automation of AccessTN's data-match process should significantly reduce the opportunity for human error.

Prior to the audit, AccessTN performed a data match against records of state employees, Local Education Agency members, and others who were enrolled in state-supported coverage. As recommended by the auditor, the Program Integrity staff now checks for AccessTN members who are eligible for coverage through State Benefits Administration, whether or not the coverage is state supported and whether the member enrolled in State Benefits Administration waived coverage. When these AccessTN members are found in the data match, they will be disenrolled from the program.

**Ineligible Members Identified in Sample Testwork**

**Two of 21 members who were enrolled in AccessTN during the first 12 months of the program (2007) under a provision in the statute for TennCare disenrollees [TCA 56-7-2908 (i)] were enrolled outside the allowable two-month period in statute.**

We concur. Under TCA 56-7-2908 (i), Access TN's Board of Directors was given explicit statutory authority to "waive any eligibility restriction set forth in statute or adopted by the Board for any individual disenrolled from TennCare standard category on or after August 1, 2005" for an initial two-month period. The Board approved an eligibility standard allowing TennCare disenrollees to apply for AccessTN coverage between March 1 and April 30, 2007, through a "TennCare Portability" provision. This eligibility provision was removed from the AccessTN application in October 2007, and is no longer an issue.

One of the two members identified as ineligible has already left the program. We plan to include the remaining member in a disenrollment plan timed to coincide with changes to the AccessTN eligibility rule at the beginning of calendar year 2014.

**Two of 21 members submitted "Attending Physician's Statements" but did not indicate they suffered from one of the medical conditions, such as heart disease or cancer, that demonstrated they were uninsurable.**

We concur. We have communicated with the contractor its responsibility to both collect the necessary diagnosis information and ensure that forms are appropriately completed, or not allow the applicant to enroll in AccessTN.

One of the two members identified as ineligible has already left the program. We plan to include the remaining member in a disenrollment plan timed to coincide with changes to the AccessTN eligibility rule at the beginning of calendar year 2014.

**Fourteen of 21 members were ineligible because they met the basic eligibility requirements for Medicare Part A and Part B.**

We concur that the auditor's recommendation that members of AccessTN who are eligible to "buy in" to Medicare Part A and purchase Medicare Part B and D should be disenrolled from AccessTN warrants consideration by AccessTN's Board of Directors. Under TCA 56-7-2908 (e)(1)(A), a person shall not be eligible for AccessTN if they can obtain health insurance coverage "substantially similar to or more comprehensive than a pool policy." If a person 65 years or older who meets certain citizenship requirements is not eligible for premium-free Medicare Part A benefits due to their work history, they are eligible for Medicare Part A buy-in. An individual would have to buy Medicare Parts A, B, and D in order to obtain coverage that is substantially equal to AccessTN. We will place the issue of Medicare eligibility on the agenda for the Board's next meeting following the publication of this audit.

Six of the fourteen members found ineligible are no longer in the program. Dependent on the Board's decision, the remaining eight members may be included in a disenrollment plan.

**Three of 21 members did not meet the permanent residency requirements to obtain AccessTN benefits because they did not provide documentation that they had worked or obtained 40 qualifying quarters since January 1, 1997.**

We concur. These members failed to indicate that they worked the required 40 qualifying quarters, nor did they provide documentation of this work.

AccessTN has created a revised AccessTN application to clarify the required documentation. The directions now explicitly state that the supporting documentation must be included for the application to be processed. The instructions provide additional examples of acceptable documentation that certain applicants must provide, including how applicants may obtain proof of the 40 qualifying quarter hours worked using detailed earnings records available through the Social Security Administration.

The revised application will be implemented for use by July 1, 2013. The contractor will train all customer service representatives who process AccessTN applications on the proper use of this revised application before implementation. All updated information will also be added to AccessTN's website.

The three members found ineligible all remain in the program. AccessTN staff will advise these members that they will be disenrolled unless they can provide the necessary documentation for the 40 qualifying quarters worked at the time of the application.

Because these members are also over the age of 65, their eligibility as potential Medicare-eligible will be addressed by the AccessTN Board at the first available meeting following the release of the audit. AccessTN staff will contact members after the Board meeting depending on how the Board votes since these members may potentially be disenrolled based on a new AccessTN eligibility requirement that members not be eligible for Medicare Part A or Medicare Part A buy-in.

**Incomplete Application Packets**

**One member did not answer the question whether or not her employer offered group health coverage or paid the cost of insurance.**

We concur. We have communicated to the contractor its responsibility to ensure an applicant's forms are appropriately completed and all boxes are checked, as required, prior to enrolling the applicant in AccessTN.

AccessTN staff has requested and received a statement from the member attesting she was denied coverage through her employer at the time of application. Therefore, the member was eligible for AccessTN at the time of application and will be allowed to remain on the program.

**One member applied for AccessTN based on the Tennessee HIPARA eligibility requirement but did not provide a certificate of creditable coverage or other proof of prior insurance showing she had 18 months of combined health coverage.**

We concur. While the member did have the policy number and dates of her prior insurance written in the application, which did add up to 18 months, the member did not include proof of 18 months of coverage (for example, attaching a certificate of credible coverage). This member has already left the program.

The Cover Tennessee Executive Director will continue to work with the contractor to achieve accurate eligibility determinations. In an effort to further ensure this accuracy, AccessTN has developed a process for conducting a semi-annual random sampling of applications. The Cover Tennessee Executive Director will continue to monitor the effectiveness of the data-match process as well. If a member is determined to be ineligible during these processes, the AccessTN staff and the Cover Tennessee Program Integrity staff will terminate the member's eligibility from the program. The auditor recommended that termination process

happen “immediately”; however, AccessTN must follow the existing termination process in order to protect the interest of the state, including the mitigation of any unnecessary legal exposure.

# APPENDIX

## BUSINESS UNIT CODES

Department of Finance and Administration business unit codes:

317.01 Division of Administration
317.86 Benefits Administration
317.99 Division of Accounts
318.65 TennCare