

**Department of Finance and Administration**

**For the Year Ended  
June 30, 2000**

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STATE OF TENNESSEE  
**COMPTROLLER OF THE TREASURY**

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**John G. Morgan**  
Comptroller

April 30, 2001

The Honorable Don Sundquist, Governor

and

Members of the General Assembly

State Capitol

Nashville, Tennessee 37243

and

The Honorable C. Warren Neel, Ph.D, Commissioner

Department of Finance and Administration

State Capitol

Nashville, Tennessee 37243

Ladies and Gentlemen:

We have conducted a financial and compliance audit of selected programs and activities of the Department of Finance and Administration for the year ended June 30, 2000.

We conducted our audit in accordance with generally accepted government auditing standards. These standards require that we obtain an understanding of management controls relevant to the audit and that we design the audit to provide reasonable assurance of the Department of Finance and Administration's compliance with the provisions of policies, procedures, laws, and regulations significant to the audit. Management of the Department of Finance and Administration is responsible for establishing and maintaining internal control and for complying with applicable laws and regulations.

Our audit disclosed certain findings which are detailed in the Objectives, Methodologies, and Conclusions section of this report. The department's administration 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 the department's internal control and/or instances of noncompliance to the Department of Finance and Administration's management in a separate letter.

Sincerely,

John G. Morgan  
Comptroller of the Treasury

JGM/mb  
00/093

State of Tennessee

# Audit Highlights

Comptroller of the Treasury

Division of State Audit

Financial and Compliance Audit  
**Department of Finance and Administration**  
For the Year Ended June 30, 2000

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## AUDIT SCOPE

We have audited the Department of Finance and Administration for the period July 1, 1999, through June 30, 2000. Our audit scope included those areas material to the Tennessee Comprehensive Annual Financial Report for the year ended June 30, 2000, and the Tennessee Single Audit Report for the same period. These areas included the Medical Assistance Program (Medicaid/TennCare) and the statewide controls administered by the Department of Finance and Administration. In addition to those areas, our primary focus was on management's controls and compliance with policies, procedures, laws, and regulations in the areas of subrecipient monitoring, budgeting, real property and capital projects management, developmental center operations, and the financial integrity act. The audit was conducted in accordance with generally accepted government auditing standards.

## AUDIT FINDINGS

### **The Tennessee Insurance System Has Significant Problems Which Caused TIS and STARS Not to Reconcile\*\***

Daily activity recorded in the Tennessee Insurance System (TIS) does not agree with the corresponding State of Tennessee Accounting and Reporting System (STARS) accounting transactions, nor can it be reconciled (page 7).

### **Top Management Must Address TennCare's Administrative and Programmatic Deficiencies\***

The audit revealed many serious internal control deficiencies that have caused or exacerbated many of the TennCare program's problems (page 21)

### **The Division of Accounts' Post-Audit Review Process Needs Improvement**

Detailed testing of disbursement vouchers was not performed for each post-audit agency, and reviews of internal controls have not been performed once every three years as required by policy (page 9).

### **TennCare Management Information System Lacks the Necessary Flexibility and Internal Control\*\***

Management of the Bureau of TennCare has not adequately addressed critical information system internal control issues. This has contributed to a number of other findings in this report (page 26).

**TennCare Eligibility Verification Procedures Are Not Adequate\*\***

For the past six years, TennCare has failed to implement effective eligibility procedures for uninsured and uninsurable enrollees. TennCare's eligibility redeterminations were not performed adequately, consistently, or timely. TennCare had no eligibility policies and procedures manual. There was inadequate monitoring of SSI recipients. TennCare has inadequate staff to verify information of uninsurable applications (page 28).

**TennCare Should Develop Written Procedures to Reflect the Eligibility Procedures Used**

The Bureau of TennCare has not developed or distributed written policies and procedures that address and reflect eligibility procedures that are currently in place. For example, the Bureau has several adverse court orders, which hinder TennCare from adhering to the previously established TennCare rules and from adhering to federal regulations. Although TennCare has changed its informal policies and procedures in light of court orders, the Bureau has not developed written procedures to reflect the policies and procedures used (page 33).

**TennCare Made Payments on Behalf of Incarcerated Adults Resulting in \$5,710,336 in Federal Questioned Costs\***

TennCare does not have adequate controls in place to prevent capitation payments to managed care organizations and behavioral health organizations when enrollees become incarcerated. In addition, TennCare does not have a process to retroactively recover all capitation payments from the MCOs when enrollees are incarcerated (page 66).

**The TennCare Bureau Did Not Amend Its Cost Allocation Plan, Which Resulted in Questioned Costs of \$18,320,757\***

The Medicaid cost allocation plan has not been amended to cover the administrative costs associated with the Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Waiver program (page 62).

**Communication Between the Department of Children's Services and TennCare Has Been Inadequate, Resulting in Questioned Costs of Over \$4 Million\***

TennCare has paid the Department of Children's Services for services that were outside the scope of its agreement with the Bureau of TennCare during the year ended June 30, 2000 (page 35).

**TennCare Paid the Department of Children's Services Over \$13 Million for Services That Are Covered by and Should Be Provided by Behavioral Health Organizations**

TennCare has paid the Department of Children's Services for services that they also paid the behavioral health organizations to provide (page 42).

**TennCare-Related Activities at the Department of Children's Services Were Not Adequately Monitored\*\***

TennCare has not adequately monitored the Department of Children's Services. Although TennCare recognized the need for a strong monitoring effort and has contracted with the Department of Finance and Administration to provide this service, the monitoring effort still needs improvement (page 49).

**Monitoring of the Medicaid Waiver for the Home and Community Based Services for the Mentally Retarded Was Not Adequate\***

The TennCare Bureau's monitoring of the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled under Section 1915(c) of the Social Security Act (HCBS waiver) is inadequate to provide the federally required assurances of health and welfare and of financial accountability (page 52).

**TennCare Did Not Ensure Adequate Monitoring of the Medicaid Home and Community Based Services\***

The TennCare Bureau did not ensure that the Division of Mental Retardation Services complied with its contract monitoring requirements (page 56).

**TennCare Made Payments on Behalf of Full-Time State Employees, Resulting in Questioned Costs of \$367,476**

TennCare paid over \$500,000 in capitation payments on behalf of full-time state employees who are classified as uninsured or uninsurable in the TennCare Management Information System. These payments were made because TennCare has not used controls to prevent or recover payments on behalf of state employees (page 71).

**TennCare Did Not Recover Over \$800,000 in Payments Made on Behalf of Deceased Enrollees\*\***

Procedures for deceased enrollee payment recovery need improvement. TennCare does not retroactively recover payments made for deceased individuals that were made over one year before the date of discovery of death (page 69).

**Financial Integrity Act Reports Did Not Include TennCare**

Although executive Order 23 was issued on October 19, 1999, to transfer the TennCare program and its related functions and administrative support from the Department of Health to the Department of Finance and Administration, the reports filed by the department did not include TennCare's operations (page 124).

**TennCare Has Not Ensured an Adequate Process Is in Place for Approval and Review of Services for the Medicaid Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Waiver\***

TennCare has not ensured the Division of Mental Retardation Services (DMR) appropriately reviews and authorizes allowable services for recipients of the Medicaid Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Waiver. In addition, DMR does not adequately document the review and approval of services on the Individual Service Plan (page 63).

**TennCare Did Not Comply With the Special Terms and Conditions of the TennCare Waiver\***

Management did not comply with 9 of 24 applicable special terms and conditions (STCs) of the TennCare Waiver, and controls over compliance with the STCs need improvement. Federal financial participation in the program is contingent upon compliance with the STCs (page 95).

**Internal Control Over Provider Eligibility and Enrollment Was Not Adequate to Ensure Compliance\*\***

TennCare had numerous internal control weaknesses and noncompliance issues related to provider eligibility and enrollment including inadequate provider agreements, not reverifying Managed Care Organization and Behavioral Health Organization providers, and not following departmental rules (page 98).

\* This finding is repeated from the prior audit.

\*\* This finding is repeated from prior audits.

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"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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1500 James K. Polk Building, Nashville, TN 37243-0264  
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**Audit Report**  
**Department of Finance and Administration**  
**For the Year Ended June 30, 2000**

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**TABLE OF CONTENTS**

---

	<u>Page</u>
<b>INTRODUCTION</b>	1
Post-Audit Authority	1
Background	1
<b>AUDIT SCOPE</b>	2
<b>PRIOR AUDIT FINDINGS</b>	2
Resolved Audit Findings	4
Repeated Audit Findings	4
<b>OBJECTIVES, METHODOLOGIES, AND CONCLUSIONS</b>	5
Areas Related to Tennessee's Comprehensive Annual Financial Report and Single Audit Report	5
Finding 1 – The Tennessee Insurance System has significant problems which have caused TIS and STARS not to reconcile	7
Finding 2 – The Division of Accounts' post-audit review process needs improvement	9
Medical Assistance Program (Medicaid/TennCare)	10
Finding 3 – Top management must address the TennCare program's numerous and serious administrative and programmatic deficiencies	21
Finding 4 – TennCare Management Information System lacks the necessary flexibility and internal control	26
Finding 5 – Internal control over TennCare eligibility is not adequate	28
Finding 6 – TennCare should develop written procedures to reflect the eligibility procedures used	33
Finding 7 – Because communication between TennCare and Children's Services has been inadequate, TennCare incorrectly reimbursed the Department of Children's Services for services that were unallowable, inadequately documented, or not performed, resulting in federal questioned costs of \$4,357,292	35

---

## TABLE OF CONTENTS (CONT.)

---

	<u>Page</u>
Finding 8 – TennCare incorrectly reimbursed the Department of Children’s Services over \$13 million for services that are covered by and should be provided by the behavioral health organizations	42
Finding 9 – TennCare should exercise its responsibility to ensure the Department of Children’s Services’ new payment rates are reasonable and have been approved by the Health Care Financing Administration (The old rates set by the Department of Children’s Services were not based on an understandable methodology)	46
Finding 10 – TennCare continues to pay adjusted rates that may not be appropriate without written approval and clarification of grant requirements	47
Finding 11 – TennCare has not adequately monitored TennCare-related activities at the Department of Children’s Services	49
Finding 12 – TennCare did not ensure that case management services provided by the Department of Children’s Services were adequately documented	50
Finding 13 – TennCare’s monitoring of the Medicaid Waiver for Home and Community Based Services for the Mentally Retarded has not been adequate	52
Finding 14 – TennCare should ensure that the Division of Mental Retardation Services provides adequate monitoring of the Medicaid Home and Community Based Services	56
Finding 15 – Claims for services provided to the mentally retarded and developmentally disabled have not been paid in accordance with the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled	58
Finding 16 – The TennCare Bureau’s failure to establish a cost allocation plan resulted in federal questioned costs of \$18,320,757	62
Finding 17 – TennCare has not ensured that adequate processes are in place for approval of the recipient and for the review and payment of services under the Medicaid Home and Community Based Services Waiver	63
Finding 18 – TennCare paid capitation payments and fee-for-service payments on behalf of incarcerated enrollees, resulting in federal questioned costs of \$5,710,336	66

---

## TABLE OF CONTENTS (CONT.)

---

	<u>Page</u>
Finding 19 – TennCare did not recover over \$800,000 of capitation payments and fee-for-service claims paid to managed care organizations and providers for deceased individuals	69
Finding 20 – TennCare made payments on behalf of full-time state employees, resulting in federal questioned costs of \$367,476	71
Finding 21 – TennCare continues to disregard its own rules regarding overpayments to providers and needs to improve processing of Medicare cross-over claims	73
Finding 22 – TennCare did not require contractors and providers to make necessary disclosures concerning suspension and debarment	76
Finding 23 – Controls over access to the TennCare Management Information System need improvement	77
Finding 24 – TennCare should ensure adequate contracts and effective monitoring of contracts	80
Finding 25 – As required by law, fraud should be reported to the Comptroller of the Treasury	82
Finding 26 – TennCare committed funds without approval	83
Finding 27 – TennCare has not ensured adequate monitoring of the graduate medical schools	84
Finding 28 – TennCare needs to improve policies and procedures for accounts receivable	86
Finding 29 – Policies and procedures for accrued liabilities still need improvement	88
Finding 30 – Controls over checks should be strengthened	90
Finding 31 – Controls over financial change requests should be strengthened	92
Finding 32 – TennCare allowed providers to submit old claims and did not pay provider claims in a timely manner	93
Finding 33 – The Bureau’s overall compliance with the special terms and conditions of the TennCare program needs improvement	95
Finding 34 – Internal control over provider eligibility and enrollment was not adequate to ensure compliance with Medicaid provider regulations	98
Finding 35 – TennCare did not comply with federal regulations and the Tennessee Medicaid State Plan concerning unnecessary utilization of care and services and suspected fraud	105

---

## TABLE OF CONTENTS (CONT.)

---

	<u>Page</u>
Finding 36 – TennCare did not comply with audit requirements for long-term care facilities	107
Finding 37 – TennCare has not established a coordinated program for ADP risk analysis and system security review	110
Finding 38 – TennCare did not follow its own rules and has not revised its rules	112
Finding 39 – Controls over the eligibility of state-only enrollees need improvement	114
Subrecipient Monitoring	115
Finding 40 – Labor charges related to monitoring were not supported	116
Budgeting	118
Real Property and Capital Projects Management	119
Developmental Center Operations	120
Finding 41 – Recordkeeping for equipment is inadequate	121
Finding 42 – Residents’ payroll was not calculated correctly	123
Financial Integrity Act	123
Finding 43 – The Department of Finance and Administration’s Financial Integrity Act reports did not include TennCare	124
<b>OBSERVATIONS AND COMMENTS</b>	126
Title VI of the Civil Rights Act of 1964	126
Title IX of the Education Amendments of 1972	126
Review of Nursing Home Taxes	127
Auditor’s Comment Regarding TennCare	127
<b>APPENDIX</b>	129
Divisions and Allotment Codes	129
TennCare Material Weaknesses and Questioned Costs Summary	130
Departmental Funding Sources	133
General Fund Expenditures	133
OIR Total Billable Services	134
TennCare Dollars Paid by Claim Type	134

# **Department of Finance and Administration For the Year Ended June 30, 2000**

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## **INTRODUCTION**

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### **POST-AUDIT AUTHORITY**

This is the report on the financial and compliance audit of the Department of Finance and Administration. The audit 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 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 mission of the Department of Finance and Administration is to provide financial and administrative support services for all facets of state government. The business, finance, and managerial functions of state government are centralized here; the department prepares and executes the state budget, accounts for state revenues and expenditures, operates a central data processing center, plans and reviews construction and alteration of state buildings, and controls state-owned and leased property.

The Department of Finance and Administration contains ten divisions: Budget, Administration, Accounts, Office for Information Resources, Insurance Administration, Resource Development and Support, Real Property and Capital Projects Management, TennCare, Mental Retardation, and Social Services.

Executive Order 9 transferred the management and operations of Arlington Developmental Center and the West Tennessee Office of Community Services to the Department of Finance and Administration, effective February 7, 1996. In addition, Executive Order 10 transferred the management and operation of Arlington, Clover Bottom, Greene Valley, and Nat T. Winston Developmental Centers, and the Middle and East Tennessee Offices of Community Services to the Department of Finance and Administration, effective October 14, 1996. Included in this transfer was the Central Office Programmatic and Administrative Support within the Division of Mental Retardation Services.

Executive Order 21 was issued on July 29, 1999, to clarify the administrative responsibilities of the Department of Finance and Administration. It stated that the Department of Mental Health and Mental Retardation Administrative Services Division will remain part of the Department of Mental Health and Mental Retardation but will perform all administrative support functions and administer the major maintenance and equipment appropriation for the Division of Mental Retardation Services.

Executive Order 23 was issued on October 19, 1999, to transfer the TennCare program and its related functions and administrative support from the Department of Health to the Department of Finance and Administration.

An organization chart of the department is on the following page.

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## AUDIT SCOPE

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We have audited the Department of Finance and Administration for the period July 1, 1999, through June 30, 2000. Our audit scope included those areas material to the Tennessee Comprehensive Annual Financial Report for the year ended June 30, 2000, and the Tennessee Single Audit Report for the same period. These areas included the Medical Assistance Program (Medicaid/TennCare) and the statewide controls administered by the Department of Finance and Administration. In addition to those areas, our primary focus was on management's controls and compliance with policies, procedures, laws, and regulations in the areas of subrecipient monitoring, budgeting, real property and capital projects management, developmental center operations, and the financial integrity act. The audit was conducted in accordance with generally accepted government auditing standards.

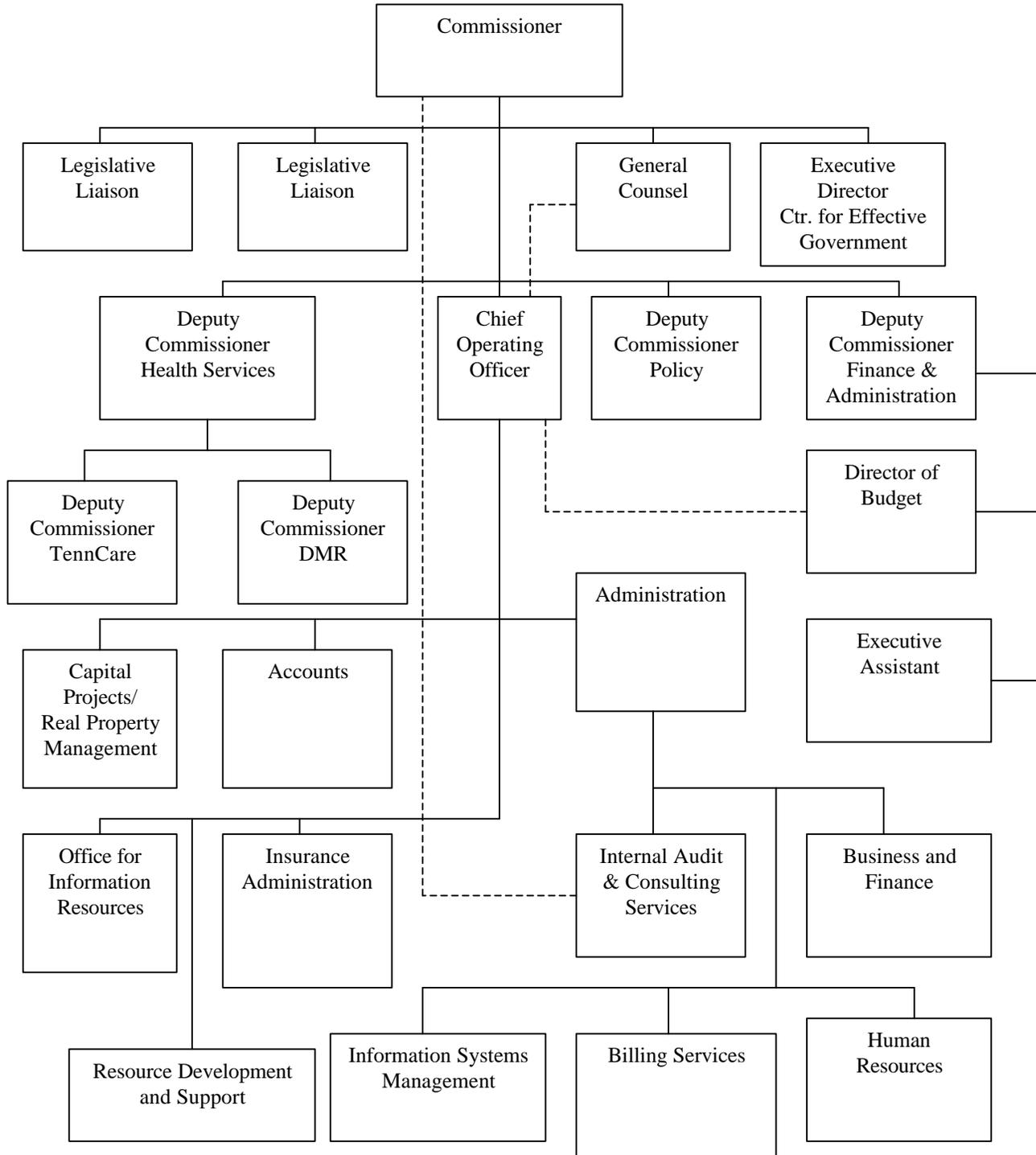
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## PRIOR AUDIT FINDINGS

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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 5, 2000. The follow-up report on findings related to the Medical Assistance Program (Medicaid/TennCare), previously reported as findings 1 through 31 in the year ended June 30, 1999, Department of Health audit report, was received October 16, 2000. The follow-up of these findings along with a follow-up of all prior Department of Finance and Administration audit findings was conducted as part of the current audit.

## DEPARTMENT OF FINANCE AND ADMINISTRATION



Note: Dashed lines indicate to whom a division reports for business matters if it is different from administrative matters.

## **RESOLVED AUDIT FINDINGS**

The current audit disclosed that the Department of Finance and Administration has corrected the following previous audit findings concerning

- TennCare's delegation of authority to the Division of Mental Retardation Services,
- pre-admission evaluation approvals,
- provider cost settlements, and
- lack of documentation or approval for the State of Tennessee Accounting and Reporting System (STARS) program changes.

## **REPEATED AUDIT FINDINGS**

The prior audit reports also contained findings concerning

- TennCare's numerous and serious administrative and programmatic deficiencies;
- the TennCare management information system's lack of flexibility and internal control;
- internal control over TennCare eligibility;
- unallowable payments to the Department of Children's Services;
- TennCare's payment rates to the Department of Children's Services;
- the written approval and clarification of grant requirements;
- monitoring of TennCare-related activities at the Department of Children's Services;
- TennCare's monitoring of the Medicaid Waiver for Home and Community Based Services;
- the Division of Mental Retardation Services' monitoring of the Medicaid Home and Community Based Services Waiver;
- claims not paid in accordance with the Home and Community Based Services Waiver;
- TennCare's cost allocation plan;
- the approval and review process of services for the Medicaid Home and Community Based Services Waiver;
- payments for incarcerated adults;
- recovery procedures for payments on behalf of deceased enrollees;
- Medicare cross-over claims processing;
- controls over access to the TennCare Management Information System;
- the administration and monitoring of contracts;
- TennCare's committing funds without approval;

- monitoring of the graduate medical schools;
- policies and procedures for accounts receivable;
- policies and procedures for accrued liabilities;
- controls over checks;
- compliance with TennCare’s Special Terms and Conditions;
- internal control over provider eligibility and enrollment;
- unnecessary utilization of care and services and suspected fraud;
- TennCare’s not complying with audit requirements for long-term care facilities;
- Automated Data Processing (ADP) risk analysis and system security review;
- revision of departmental rules;
- reconciliation of the Tennessee Insurance System (TIS) and STARS; and
- recordkeeping for Clover Bottom equipment.

These findings have not been resolved and are repeated in the applicable sections of this report.

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## **OBJECTIVES, METHODOLOGIES, AND CONCLUSIONS**

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### **AREAS RELATED TO TENNESSEE’S COMPREHENSIVE ANNUAL FINANCIAL REPORT AND SINGLE AUDIT REPORT**

Our audit of the Department of Finance and Administration is an integral part of our annual audit of the Comprehensive Annual Financial Report (CAFR). The objective of the audit of the CAFR is to render an opinion on the State of Tennessee’s general-purpose financial statements. As part of our audit of the CAFR, we are required to gain an understanding of the state’s internal control and determine whether the state complied with laws and regulations that have a material effect on the state’s general-purpose financial statements.

The Department of Finance and Administration is responsible for maintaining the state’s central accounting system and preparing the CAFR. The department, in conjunction with other state agencies, provides centralized statewide controls in the following areas:

- statewide accounting system,
- budgets and appropriations,
- cash receipts and disbursements,
- payroll transaction processing, and

- fixed asset records.

As part of our audit of the CAFR, we reviewed selected controls over these areas in the Department of Finance and Administration and other state agencies.

To address our statewide audit objectives, we interviewed key department employees; reviewed applicable policies and procedures; examined, on a test basis, evidence supporting the amounts and disclosures in the financial statements; performed analytical procedures, as appropriate; assessed the accounting principles used and significant estimates made by management; and evaluated the overall financial statement presentation. Our testing focused on the propriety of financial statement presentation, the adequacy of internal control, and compliance with applicable finance-related laws and regulations.

Our audit of the Department of Finance and Administration is also an integral part of the Tennessee Single Audit, which is conducted in accordance with the Single Audit Act of 1984, as amended by the Single Audit Act Amendments of 1996 and Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. The Single Audit Act requires us to determine whether

- the state complied with laws and regulations that may have a material effect on each major federal financial assistance program, and
- the state has effective internal control to provide reasonable assurance that it is managing major federal financial assistance programs in compliance with applicable laws and regulations.

We determined that on June 30, 2000, the Department of Finance and Administration had the Medical Assistance Program (Medicaid/TennCare) which was material to the CAFR and to the Single Audit Report.

To address the objectives of the CAFR and the Single Audit Report, as they pertain to the Medical Assistance Program we interviewed key department employees, reviewed applicable policies and procedures, and tested representative samples of transactions. For further discussion, see the applicable section (Medicaid/TennCare).

We have audited the general-purpose financial statements of the State of Tennessee for the year ended June 30, 2000, and have issued our report thereon dated November 29, 2000. The opinion on the financial statements is unqualified. The Tennessee Single Audit Report for the year ended June 30, 2000, will include our reports on the schedule of expenditures of federal awards and on internal control and compliance with laws and regulations. These reports include reportable conditions and material weaknesses resulting from this audit. These reports also include instances of noncompliance, some of which resulted in a qualified opinion on compliance with requirements of the federal Medicaid/TennCare program.

The audit of the department revealed the following findings in areas related to the CAFR.

- The Tennessee Insurance System (TIS) has significant problems which have caused TIS and the State of Tennessee Accounting and Reporting System (STARS) not to reconcile.
- The Division of Accounts' post-audit review process needs improvement.

## **Findings, Recommendations, and Management's Comments**

### **1. The Tennessee Insurance System has significant problems which have caused TIS and STARS not to reconcile**

#### **Finding**

As noted in the four prior audits, the Tennessee Insurance System (TIS) has not been designed, implemented, and maintained in a manner which allows it to function efficiently and effectively. As a result, the system is not producing the desired results, and changes are being made directly to the TIS database through the Application Development Facility (ADF). Because these changes are not being made to the insurance accounting on the State of Tennessee Accounting and Reporting System (STARS), TIS and STARS do not reconcile. Management responded to the prior audit finding by stating that it would be initiating a major reengineering project. The TIS upgrade project began in March 2000. The TIS Master Transaction Study will not begin until the upgrade project is complete in spring 2002. Management also stated that it has instituted a training program for agency insurance preparers, and has begun a review of the origins of ADFs. While steps are being taken, the problem still existed during the audit period.

The division is still using Application Development Facility (ADF), a software program, to manually adjust participants' accounts on TIS. These adjustments to participants' accounts are made directly in the TIS database rather than through transactions. The system's security must be overridden in order for an ADF change to be made. The division sends a request for the ADF change to the department's Information Systems Management (ISM) group, which in turn submits a request to the Office for Information Resources (OIR). OIR assigns one of its employees to make the ADF changes on the TIS database. As noted in the prior audit, overriding system security to make manual adjustments is a significant deficiency in the design and operation of the system.

The Division of Insurance Administration uses ADF as a "quick fix" to correct participant balances or errors attributable to unresolved system problems. Although division staff maintain paper documentation of the ADF changes, the system has no history or record of the changes because division staff simply overwrite previous information in the database. If the system had been designed and was functioning properly, use of ADF would not be necessary. As previously noted, making changes directly to a database instead of correcting errors through properly authorized and documented transactions circumvents system controls.

In addition, when the TIS database is corrected using ADF, STARS is not updated concurrently. As a result, the two systems do not agree, nor can they be completely reconciled. The auditors noted that unreconciled amounts between the daily net change in the TIS database and the cumulative accounting transactions passed from TIS to STARS daily during fiscal year 2000 ranged from (\$396,052.60) to \$46,287.82.

Departmental memorandums state that the TIS database is correct but the accounting information on STARS is incorrect. Although STARS has been corrected to the extent possible, there can be no assurance that all needed corrections have been made since not all ADF changes made to TIS were made on STARS and TIS does not maintain history records of all past transactions. We performed analytical reviews and other measures at year-end to ensure the insurance funds' financial statements presented in the state's Comprehensive Annual Financial Report were fairly stated. These additional procedures would not have been necessary had all TIS activity been properly reflected in STARS.

### **Recommendation**

To ensure that all TIS system problems are corrected as soon as possible, the Director of Insurance Administration should complete the TIS upgrade project that began in March 2000 and the TIS Master Transaction Study that is scheduled for fiscal year 2002. As the system problems are corrected, the use of ADF changes should be limited to rare instances. Until that time, STARS should be concurrently updated as ADF changes are made to TIS. In addition, the work group should continue to meet until all the problems causing the unreconciled amounts are resolved and TIS and STARS can be reconciled. As problems arise in the future, causes of the problems should be quickly identified and TIS should be corrected quickly through program changes or other appropriate means.

### **Management's Comment**

We concur. The issue of reconciliation between TIS and STARS has been the topic of considerable effort on the part of the Division for quite some time. Accounting transactions (mainly H and I batches) have been brought up to date, except for certain "problem" days, as of January 2001. This was accomplished with the temporary support of other divisions within F&A as well as the addition of two accounting positions to the accounting section within the Division of Insurance Administration. The accounting section is now composed of a staff of five accounting positions.

The TIS upgrade project began in March of 2000 and is designed to enhance the capabilities of the present system as well as improve its maintainability. Key areas that will be addressed with this two-year systems project include the following:

- Enhance existing functionality

- Add new functions
- Enable TIS to balance with STARS
- Improve interfaces with other systems
- Improve processing, and
- Improve reporting

The Division has devoted significant resources to the successful completion of this project. Additional resources have also been employed strictly to focus on TIS to STARS balancing. A TIS to STARS balancing work group meets regularly for the purpose of identifying problems that are causing the unreconciled amounts between TIS and STARS.

In addition to the TIS upgrade project, the Division recently implemented the TIS automated reconciliation project. The purpose of the automated reconciliation project is to automate existing manual processes that will allow the division, utilizing TIS, to reconcile daily and monthly transactions reported to STARS. This is a four-month project begun in February 2001.

In summary, the Division of Insurance Administration is committed to upgrade TIS, to the judicious use of ADF changes and subsequently to resolve the issue of TIS to STARS balancing.

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## **2. The Division of Accounts' post-audit review process needs improvement**

### **Finding**

The Division of Accounts reviews departmental expenditures through either the post-audit or pre-audit process before releasing batches of data in the State of Tennessee Accounting and Reporting System (STARS). For agencies in post-audit status, the division reviews the department's expenditures to determine whether the documents have been approved by authorized officials of the department and to ensure any corrections requested by the department are made. For agencies in pre-audit status, the division performs a more comprehensive review of the department's expenditures before they are processed.

Agencies may request to be placed in post-audit status by the Division of Accounts. The Post-Audit section of the division then performs a review of the department's internal control, completing an internal control questionnaire, as well as testing a sample of disbursements to determine if the department has properly processed and accounted for its transactions.

According to the Division of Accounts policy, for each agency on post-audit status, a detailed testing of disbursement vouchers will be conducted annually and a review of internal control will be conducted at least once every three years. Also, reports summarizing the results

and recommendations concerning continuation or discontinuation of post-audit status are to be issued in a timely manner.

For the year ended June 30, 2000, there were 15 agencies on post-audit status. However, the division completed only two post-audit internal control reports during the year. A review of prior reports issued revealed that the division has not completed an internal control review within the last three years for nine of the agencies on post-audit status. In addition, the division did not perform annual detailed testing on disbursement vouchers within the last year for nine agencies on post-audit status. Although recent disbursement voucher samples for the other six agencies have been tested, reports have not been completed and distributed to management for five of the agencies.

In the absence of post-audit reviews, the Division of Accounts has little assurance that internal control is in place and transactions for agencies on post-audit status are being properly processed. Without the timely completion of post-audit reports and proper follow-up on post-audit recommendations, known problems may not be corrected.

### **Recommendation**

The Division of Accounts should review the agencies on post-audit status within the time constraints stated in the Division of Accounts' policy to ensure that transactions for agencies on post-audit status are being properly processed and to ensure that the internal control for these agencies is in place and functioning as intended. In addition, management should prepare timely reports for all post-audit reviews performed.

### **Management's Comment**

We concur. Staff turnover and the resulting difficulty in finding qualified accountants to fill the vacancies, forced the Division for well over a year to reallocate many of the resources normally available to the post-audit review process to other more critical areas. This resulted in an inability to comply with its established policy regarding the timing of reviews and timeliness of reports. New staff has recently been hired. In addition, a schedule for the completion of the internal control reviews and disbursement testing to be conducted during the upcoming fiscal year has been developed in conformity with established policy. This schedule has been prioritized according to the dates and results of the last completed review of each of the post-audit status agencies.

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## **MEDICAL ASSISTANCE PROGRAM (MEDICAID/TENNCARE)**

The Medical Assistance Program (Medicaid/TennCare) is the largest federal program in the "Medicaid cluster" of grant programs. The State Medicaid Fraud Control Units and the State Survey and Certification of Health Care Providers and Suppliers grant programs are also included

in the Medicaid cluster. These two programs provide significant controls over the expenditures of Medicaid funds.

Our audit of the TennCare program focused primarily on the following areas:

- General Internal Control;
- Activities Allowed or Unallowed and Allowable Costs / Cost Principles;
- Cash Management;
- Eligibility;
- Matching, Level of Effort, Earmarking;
- Period of Availability of Federal Funds;
- Procurement and Suspension and Debarment;
- Program Income;
- Federal Reporting;
- Subrecipient Monitoring;
- Special Tests and Provisions;
- Schedule of Expenditures of Federal Awards;
- Financial (Accounts Receivable, Accrued Liabilities, Other Liabilities); and
- TennCare Management Information System General Controls.

The primary audit objectives, methodologies, and our conclusions for each area are stated below. For each area, auditors documented, tested, and assessed management's controls to ensure compliance with applicable laws, regulations, grants, contracts, and state accounting and reporting requirements. To determine the existence and effectiveness of management's controls, auditors administered planning and internal control questionnaires; reviewed policies, procedures, and grant requirements; prepared internal control memos, performed walk-throughs, and performed tests of controls; and assessed risk.

### **General Internal Control**

Our primary objectives for general controls were to obtain an understanding of, document, and assess management's general controls and to follow up on the prior audit finding concerning management's general controls, controls over checks, the administration and monitoring of contracts, and departmental rules. We interviewed key program employees; reviewed organization charts, descriptions of duties, and responsibilities for each division, and correspondence from the grantor; and considered the overall control environment of the TennCare program. We also reviewed the current departmental rules and interviewed key employees to determine the status of the discrepancies noted in the prior audit finding. We obtained an understanding of and documented TennCare's controls over checks and financial

change requests. We examined TennCare's contracts and obtained an understanding of TennCare's monitoring over these contracts.

The results of this area are as follows:

- we noted several deficiencies in management's general controls over the TennCare program, as described in finding 3;
- TennCare's controls over checks need improvement, as described in finding 30;
- controls over financial change requests need improvement, as described in finding 31;
- we detected weaknesses in the administration and monitoring of contracts as noted in finding 24;
- we also determined that TennCare still had not adequately complied with or revised its rules, as discussed in finding 38; and
- TennCare did not report an instance of fraud as required to the Comptroller of the Treasury as noted in finding 25.

### **Activities Allowed or Unallowed and Allowable Costs / Cost Principles**

The primary objectives of this area were to determine if grant funds were expended only for allowable activities and to follow up on prior-year audit findings.

To determine if grant funds were expended for allowable activities only, we performed computer-assisted audit techniques (CAATs) to test payments to the managed care organizations (MCOs) to determine if the correct capitation amount had been paid. An understanding was obtained of the procedures TennCare used to calculate payments to the behavioral health organizations (BHOs). We tested nonstatistical samples of Medicaid claims (e.g., nursing home claims) to determine if the claims were paid correctly and if claims were pursuant to the order of a physician. CAATs were used to search the payment data files for payments made on behalf of deceased enrollees and adult prisoners.

A nonstatistical sample of reimbursement claims paid to the Department of Children's Services (Children's Services) was tested. Supporting documentation for the claims was examined to determine if the charges were valid and allowable. The related case files at the community services agencies and the vendors were reviewed for evidence that the children in the sample had actually received the services for which TennCare had reimbursed Children's Services. CAATs were used to search payment data files that contained payments made by TennCare to Children's Services for payments made on behalf of incarcerated youth, therapeutic payments for individuals 21 and over, unallowable payments for leave days, and services that should be covered by the BHOs. We also used CAATs to identify payments made to Children's Services on behalf of children under three years of age receiving behavioral health services.

In addition, we determined TennCare's compliance with the Early Periodic Screening Diagnostic Treatment (EPSDT) consent decree, which required TennCare to implement procedures to ensure children in the custody of Children's Services had prescribed screenings. We performed analytical procedures on a listing of EPSDT screenings obtained from Children's Services and determined the percentage of children that had been given the prescribed screenings.

Supporting documentation for all significant expenditure items was obtained and examined. We performed reconciliations to determine if the amounts recorded in the State of Tennessee Accounting and Reporting System (STARS) agreed with the amount of checks issued and reported in federal reports. Significant supplemental funding pool payments were recalculated to test for compliance with the payment methodologies approved by the grantor.

For the Home and Community Based Services (HCBS) for the Mentally Retarded and Developmentally Disabled waiver, we reviewed the HCBS waiver and inquired about its operation. Key employees were interviewed at the Division of Mental Retardation Services (DMR) for information concerning the Division's responsibilities with the waiver. A nonstatistical sample of claims was selected to test expenditure allowability and claims processing and recording.

The results of this area were as follows:

- TennCare has not complied in all material respects with federal allowable cost requirements. As noted in finding 7, TennCare paid Children's Services over \$5 million for unallowable costs (i.e., payments for incarcerated youth, children under the age of three, therapeutic payments for individuals 21 years and older, leave days, and costs of therapeutic services inadequately documented). As noted in finding 8, TennCare paid Children's Services for services that are covered by and should be provided by the BHOs. As noted in finding 9, TennCare has not ensured that the Children's Services payment rates were reasonable. As noted in finding 10, TennCare has not obtained approval for increases in payment rates to Children's Services. As noted in finding 11, TennCare has not adequately monitored Children's Services to ensure the allowability of costs. As noted in finding 16, TennCare has not amended its cost allocation plan, which resulted in unallowable costs of over \$18 million. As noted in finding 18, TennCare incorrectly used federal funds to pay capitation payments to MCOs and BHOs for incarcerated adults. As noted in finding 19, TennCare does not retroactively recover all payments made on behalf of deceased enrollees. As noted in finding 21, controls over Medicare cross-over claims are weak and TennCare does not pay Medicare cross-over providers in accordance with its own rules. As noted in finding 12, TennCare paid Children's Services for case management services that were not adequately supported.
- As noted in finding 32, TennCare allowed providers to submit old claims and did not pay provider claims in a timely manner.
- TennCare's supporting documentation for significant expenditure items appeared reasonable.

- Testwork revealed that amounts recorded in STARS reconciled with the amounts of checks issued and reported in federal reports.
- Significant supplemental funding pool payments were in compliance with the payment methodologies approved by the grantor.
- Testwork indicated that TennCare is in compliance with the EPSDT consent decree.
- TennCare does not have adequate procedures in place to provide reasonable assurance that HCBS waiver funds were expended only for waiver allowable activities as noted in finding 17.
- TennCare and DMR did not have an effective formal monitoring process in place for the HCBS waiver program as noted in findings 13 and 14.
- TennCare committed state and federal TennCare funds before it had a contract with the Department of Children’s Services to coordinate services (see finding 26).

## **Cash Management**

Our primary objective for this area was to determine if management complied with the terms and conditions of the Cash Management Improvement Act Agreement between the state and the Secretary of the Treasury, United States Department of the Treasury (State-Treasury Agreement).

We tested nonstatistical samples of federal cash drawdown transactions for compliance with the State-Treasury cash management agreement. Based on the testwork performed, we determined that management had complied, in all material respects, with the State-Treasury cash management agreement.

## **Eligibility**

Our primary objectives were to determine whether controls over eligibility determinations and verifications / reverifications were adequate and if TennCare enrollees were eligible according to rules and regulations. Another objective of this area was to determine if recipients of Home and Community Based Services (HCBS) waiver services were eligible for services under the appropriate waiver.

We selected a nonstatistical sample of payments made on behalf of TennCare enrollees to determine if the individuals were eligible for TennCare on the dates of service for which the payment was made and the enrollees’ eligibility-related information had been verified or reverified accurately and in a timely manner. For Medicaid-eligible TennCare enrollees, we used information in the Automated Client Certification Eligibility Network for Tennessee (ACCENT) system and the TennCare Management Information System (TCMIS) to make this determination. For the uninsured and uninsurable TennCare enrollees, we obtained applications and other supporting documentation and used the TCMIS to make this determination.

We used computer-assisted audit techniques (CAATs) to verify whether the only payments made on behalf of “state-only” TennCare enrollees were payments to the behavioral health organizations (BHOs). (State-only enrollees are only eligible for mental health services and the cost of care is paid for with 100% state funds.) CAATs were also used to determine if these state-only enrollees’ income recorded in TCMIS exceeded the maximum amounts allowed to be eligible as a state-only enrollee. In addition, CAATs were used to search TennCare’s payment files for payments made for TennCare enrollees with invalid social security numbers. We also searched TennCare’s payment files for full-time state employees.

We performed an assessment of internal control involving eligibility of recipients and tested payment of claims for the HCBS waiver. A nonstatistical sample was selected to test recipient eligibility for the appropriate waiver.

Testwork revealed that internal control over eligibility was adequate for the Medicaid eligible enrollees and those enrollees were eligible according to TennCare’s rules and regulations except as noted in the Activities Allowed or Unallowed and Allowable Costs/Cost Principles section of this report. However, internal control over the eligibility of state-only enrollees was not adequate, and there were state-only enrollees that were not eligible according to the requirements. See finding 39 for further discussion. We also determined that internal control over eligibility for the uninsurable and uninsured population was not adequate and that TennCare had not complied, in all material respects, with federal eligibility requirements. Because so few uninsured and uninsurable enrollees in our sample had been verified or reverified timely, we could not determine if individuals were eligible as of the dates of service in our sample. In addition, CAATs revealed that TennCare made payments for TennCare enrollees with invalid social security numbers. See finding 5.

As noted in finding 20, TennCare made inappropriate payments on behalf of full-time state employees. We also determined that TennCare needs to develop written eligibility procedures that reflect the eligibility procedures actually used as discussed in finding 6. In addition, testwork revealed that there was not an adequate process in place for review and approval of documentation needed to support HCBS waiver recipient eligibility determinations as discussed in finding 17.

### **Matching, Level of Effort, Earmarking Period of Availability of Federal Funds**

The primary objectives of this area were

- to provide reasonable assurance that matching requirements were met using only allowable funds or costs which were properly calculated and valued, and
- to provide reasonable assurance that federal funds were used only during the authorized period of availability.

To provide reasonable assurance that matching requirements were met using only allowable funds or costs that were properly calculated and valued, we interviewed the key personnel responsible for this function in the Division of Budget and Finance and examined selected reports. We performed testwork to determine if administrative expenditures in the State Children's Health Insurance Plan (SCHIP) did not exceed the required limits.

We obtained and reviewed documentation from the grantor concerning the approved period of availability of federal funds and compared it to total federal program expenditures. A nonstatistical sample of transactions was tested to determine if the underlying obligations occurred during the period of availability.

Based upon the testwork performed, it appeared that TennCare was complying with matching requirements using only allowable funds or costs which were properly calculated and valued. In addition, federal funds were used only during the authorized period of availability.

### **Procurement and Suspension and Debarment**

The primary objective was to provide reasonable assurance that procurement of goods and services was made in compliance with the provisions of applicable regulations and guidelines, and that no subaward, contract, or agreement for purchase of goods or services was made with any debarred or suspended party.

We reviewed the OMB Circular A-133 *Compliance Supplement* for internal control and compliance requirements for procurement and suspension and debarment and the agency program requirements under the Medicaid cluster. In addition, key employees were interviewed and walk-throughs were performed regarding TennCare's procurement of goods and services and compliance with federal requirements. We reviewed all nongovernmental contracts for \$100,000 or more in effect during the year ended June 30, 2000, to determine if the contracts contained the required certifications concerning suspended or debarred parties and suspended or debarred principals. In addition, we selected a nonstatistical sample of purchases from TOPS (Tennessee On-line Purchasing System) to test for compliance with requirements contained in the OMB Circular A-133, *Compliance Supplement for Single Audits of State and Local Governments*. We also performed testwork to determine if material procurements of goods and services were made in compliance with the same policies and procedures used for the same or similar procurements from non-federal funds.

We determined that TennCare did not require all required contractors and providers to make necessary disclosures concerning suspension and debarment. See finding 22 for further information. Based on the testwork performed, however, it appeared that management had complied with other procurement requirements. Material procurements of goods and services were made in compliance with the same policies and procedures used for the same or similar procurements from non-federal funds.

## **Program Income**

Our objective was to provide reasonable assurance that program income was correctly earned, recorded, and used in accordance with the program requirements.

TennCare's program income consists of premiums paid by uninsured and uninsurable TennCare enrollees based on their income and family size. We used a nonstatistical sample of monthly capitation payments to determine if the premium amounts billed to the recipients for whom the payments were made were correct according to enrollee information in the TennCare Management Information System (TCMIS) and the premium calculation tables in the *Rules for the Bureau of TennCare*.

We also compared the total amount of premium revenue collected according to TCMIS reports and the amount recorded in the state's accounting records (STARS). In order to determine if the federal share of program income was used to reduce federal expenditures, as required, we recalculated the federal share for each quarter and reviewed the quarterly federal expenditure reports.

We determined that internal control over premiums was not adequate to provide reasonable assurance that program income was earned and recorded in accordance with program requirements, as discussed in finding 28. Based on the testwork performed, however, it appeared that premiums received were used in accordance with the program requirements.

## **Federal Reporting**

Our objective was to ensure that reports of federal awards submitted to the federal awarding agency included all activity of the reporting period, were supported by underlying accounting or performance records, and were submitted in accordance with program requirements.

We inquired of management about the requirements and procedures for preparing, reviewing, and submitting program financial and progress reports. We selectively tested the mathematical accuracy of the reports, reviewed supporting documentation for the information presented, and determined if the reports were prepared in accordance with grant guidelines and requirements.

Based on the testwork performed, it appeared that, in all material respects, reports of federal awards included all activity of the reporting period, were supported by underlying records, and were submitted in accordance with program requirements.

## **Subrecipient Monitoring**

The primary objective of this area was to determine whether subrecipients (graduate medical schools) were properly monitored to ensure compliance with federal award requirements.

We inquired of management about procedures for monitoring subrecipients, reviewed the requirements for payments to the state's four medical schools for graduate medical education, and tested the payments to determine if the amounts paid were correct. We tested TennCare's monitoring of the graduate medical schools for compliance with OMB Circular A-133. In addition, we reviewed Department of Finance and Administration policy 22 and determined TennCare's compliance with this policy.

TennCare has not properly monitored the graduate medical schools to ensure compliance with federal award requirements or OMB Circular A-133 as noted in finding 27. Testwork revealed that TennCare complied with the Department of Finance and Administration's policy 22.

## **Special Tests and Provisions**

Special Tests and Provisions (ST&P) consist of the following: Utilization Control and Program Integrity, Long-Term Care Facility Audits, Provider Eligibility and Provider Health and Safety Standards, and Managed Care. Each ST&P is discussed separately below.

### Utilization Control and Program Integrity

Our main objectives were to determine whether the state had established and implemented procedures to (1) safeguard against unnecessary utilization of care and services, including long-term care institutions; (2) identify suspected fraud cases; (3) investigate these cases; and (4) refer those cases with sufficient evidence of suspected fraud to law enforcement officials.

Key employees were interviewed about procedures related to utilization control and program integrity. We tested a nonstatistical sample of case files in the Program Integrity Unit to determine if the appropriate steps were taken to investigate suspected cases of fraud and, if appropriate, to refer them to law enforcement officials. We also interviewed the Special Agent In-Charge of the Medicaid Fraud Control Unit, which is part of the Tennessee Bureau of Investigation.

We noted that controls were not adequate to ensure compliance with federal requirements regarding unnecessary utilization of care and services and identification of suspected fraud. In addition to these control deficiencies, we determined that management had not complied with the *Code of Federal Regulations*, Title 42, Parts 455, 456, and 1002, which requires the state to have procedures to safeguard against unnecessary utilization of care and services. See finding 35 for more information about these matters. Based on the testwork performed, however, it appeared that noted cases of suspected fraud were properly investigated by the Program Integrity Unit, and that procedures existed to refer those cases with sufficient evidence to law enforcement officials.

### Long-Term Care Facility Audits

Our objective was to determine whether the state Medicaid agency performed long-term care facility audits as required.

Key personnel at the Bureau of TennCare and the Medicaid/TennCare section of the Comptroller's Office were interviewed about compliance with audit requirements, and related documents were reviewed. We reviewed a nonstatistical sample of long-term care facility cost reports to determine if the reports had been desk-reviewed in accordance with program requirements.

We determined that controls were not adequate to ensure compliance with federal and state requirements for long-term care facility audits, and that management had not complied with the audit requirements. See finding 36 for more information.

### Provider Eligibility and Provider Health and Safety Standards

Our objectives were

- to determine whether providers of medical services were licensed to participate in the Medicaid program in accordance with federal, state, and local laws and regulations, and whether the providers had made the required disclosures to the state; and
- to determine whether the state ensured that nursing facilities and intermediate care facilities for the mentally retarded that serve Medicaid patients met the prescribed health and safety standards.

Nonstatistical samples of payments to providers were tested to determine if the providers met the appropriate professional standards (e.g., were licensed in accordance with applicable laws and regulations) on the dates of service for which the payments had been made. The types of providers tested were Medicare cross-over providers, Department of Children's Services' providers, and providers for the Home and Community Based Services Waiver for the Developmentally Disabled and the Mentally Retarded program. We also reviewed the provider agreements to determine if they complied with federal regulations, including the disclosure requirements.

In addition, we tested a nonstatistical sample of payments to long-term care providers to determine whether the providers met the prescribed health and safety standards, and if TennCare's agreements with the facilities were in compliance with applicable laws and regulations on the dates of service for which the payments had been made.

We noted that internal control over provider eligibility and enrollment was not adequate to ensure compliance with federal regulations. Also, management did not comply with all regulations for provider eligibility; noncompliance with licensure and provider agreement requirements resulted in federal questioned costs. These matters are discussed further in finding 34. Our testwork did determine that all of the long-term care providers tested met the prescribed health and safety standards.

### Managed Care

Our objective was to determine whether the state operated its managed care program in compliance with the approved state plan waiver.

We reviewed the special terms and conditions (STCs) of the TennCare waiver and determined which ones were applicable for the year ended June 30, 2000. The STCs were discussed with the personnel responsible for compliance. Corroborating evidence, such as reports or other documentation, was reviewed to determine if management had complied with the STCs.

The audit revealed that controls were not adequate to ensure compliance with the STCs of the TennCare waiver, and that management had not complied with all applicable STCs. See finding 33 for more information concerning these matters.

### **Schedule of Expenditures of Federal Awards**

Our objective was to verify that the department's Schedule of Expenditures of Federal Awards was properly prepared and adequately supported. We verified the grant identification information on the Schedule of Expenditures of Federal Awards prepared by staff in the Division of Budget and Finance, and total reported disbursement amounts were traced to supporting documentation. Based on the testwork performed, we determined that, in all material respects, the Schedule of Expenditures of Federal Awards was properly prepared and adequately supported.

### **Financial**

Our primary objectives were

- to determine if subsidiary records of accounts receivable were properly maintained,
- to determine if the amounts recorded in the State of Tennessee Accounting and Reporting System (STARS) for accounts receivable were adequately supported, and
- to determine if accrued liabilities were adequately supported and properly recorded in STARS.

TennCare's accounts receivable were discussed with the personnel responsible for this function in the Division of Budget and Finance. In addition, reports and other documentation were reviewed to determine the receivable amounts. Significant receivables recorded in STARS were traced to supporting documentation. We compared current year accrued liabilities to prior year amounts and obtained explanations for significant variances. Significant individual amounts were tested for reasonableness and adequacy of support.

Although accrued liabilities appeared to be recorded in STARS correctly in all material respects, testwork revealed that not all accrued liabilities were adequately supported as noted in finding 29. Based upon the testwork performed, it appeared that the amounts recorded in STARS for accounts receivable were adequately supported and subsidiary records were properly maintained. Our testwork also indicated that

- TennCare has not established adequate overall policies and procedures for accounts receivable (finding 28),

- TennCare does not have adequate policies and procedures for accrued liabilities (finding 29), and
- TennCare committed accounting errors that resulted in a substantial adjustment to the state's financial statements.

### **TennCare Management Information System General Controls**

The primary objectives of this area were

- to determine if system security and system change procedures were adequate, and
- to determine whether the state Medicaid agency performed the required ADP risk analyses and system security reviews.

To accomplish these objectives, we documented the functions and responsibilities of the Division of Information Services, the information system contractor, and the Office for Information Resources in the Department of Finance and Administration with regard to the TennCare Management Information System (TCMIS). We documented system security and system change and work request procedures, reviewed related reports and manuals, and performed walk-throughs. The requirement for performing ADP risk analysis and system security reviews was discussed with the appropriate personnel.

We selected a nonstatistical sample of Resource Access Control Facility (RACF) user IDs and determined if the users' appropriate security forms were completed and on file with TennCare's security administrator, the level of access given agreed with the level of access requested, and the level of access given appeared reasonable given the employees' job responsibilities. We also tested logical security of TennCare's system to determine that usernames and passwords were required to obtain access to all screens. We also examined screens and determined if individuals with read-only access have the ability to change these screens.

Testwork revealed that system security needed improvement, as noted in finding 23. We determined that system change procedures were adequate. Although TennCare performed the system security reviews, they had not performed and documented the required ADP risk analysis requirements or submitted the required summary reports, as noted in finding 37. In addition, the TCMIS's lack of flexibility and internal control has been noted in finding 4.

### **Findings, Recommendations, and Management's Comments**

3. **Top management must address the TennCare program's numerous and serious administrative and programmatic deficiencies**

## Finding

Most of the findings in this report are the result of TennCare's numerous administrative and programmatic deficiencies. Well-publicized events concerning the ability of the program to continue in its present form have contributed to the perception that the program is in crisis. Management concurred with the prior-year audit finding and stated,

In addition to the major priorities of ensuring the integrity of the program, ensuring consistency in the process of the program with written policies and procedures and ensuring the existence of an emergency plan should a managed care organization fail, the following additional actions have now occurred or are in process: 1) A new Director of Operations has been hired, 2) Enhancements to the eligibility/reverification process are being implemented, 3) An RFP is in process to review current and future system needs, 4) Continuing to search for new director, as well as other critical vacancies in the Program, 5) New Medical Director and a Quality Improvement Director have been hired, 6) In the process of filling 95 new positions that were authorized by the legislature for FY2000.

However, written policies and procedures have not been created for all areas of the TennCare program.

As discussed in the "Objectives, Methodologies, and Conclusions" section of this report, the auditors are responsible for reporting on the department's internal control and management's compliance with laws and regulations material to the program. However, top management, not the auditors, is responsible for establishing an effective control environment, which is the foundation for all other components of internal control: risk assessment, control activities, information and communication, and monitoring. Under generally accepted auditing standards, control environment factors include assignment of authority and responsibility; commitment to competence; integrity and ethical values; management's philosophy and operating style; and organization structure.

Our evaluation of the control environment and the other components of internal control revealed several continuing overall, structural deficiencies that have caused or exacerbated many of the program's problems. These deficiencies are discussed below.

### TennCare Lacks Stable Leadership

The TennCare program has continued to lack stable leadership. Since the beginning of the program in January 1994, and through December 2000, the program has had five directors and two acting directors. In addition, during the same time, there has been significant turnover in the top positions of the program's various divisions, including the Division of Operations, the Division of Budget and Finance, the Division of Quality Improvement, the Division of Policy and Intergovernmental Relations, and the Division of Contract Development and Compliance. During the year ended June 30, 2000, the Director of TennCare, the Director of Operations, the Director of Long-Term Care, and an Assistant Commissioner for Health Related Services resigned.

### Inadequate System and Staff Resources

As discussed further in finding 4, the TennCare program still does not have an adequate information system. The program is still dependent upon a large and complex computer system, the TennCare Management Information System (TCMIS), that is outdated and inflexible.

According to management, the TennCare program is understaffed. The auditors also noted what appears to be a dramatic imbalance in the allocation of staff resources, which appears to reflect top management's priorities as well as the distribution of work. Although the Division of Programs is responsible for numerous programmatic functions, including the provision of special services to children and seriously mentally ill individuals, this division consists of only one employee. In contrast, during the year ended June 30, 2000, there were 37 positions in the Division of Information Services (I/S Division). While it is possible that all of the I/S positions are necessary, it appears that the Division of Programs may lack the resources it needs to adequately perform its duties and responsibilities.

In addition, when obtaining information on the rules and regulations for Medicare cross-over claims, the auditors learned that still no one has been assigned the responsibility for 1) being knowledgeable about the rules and regulations for these types of claims or 2) ensuring that these claims are being paid correctly. See finding 21 for more information about the processing and payment of these claims.

### Inadequate Written Operating Policies and Procedures

Despite its size and complexity, TennCare still does not have adequate written operating policies and procedures. As previously noted, the lack of written, comprehensive operating policies and procedures increases the risk that errors or inconsistencies may occur in the TennCare program.

As noted in finding 6, inadequate written policies and procedures are of particular concern for the eligibility function at TennCare. Although TennCare has several adverse court orders which make it more difficult for TennCare to follow its own rules and federal regulations, the Bureau has not developed written policies and procedures which dictate to all the divisions involved with the eligibility process the procedures that are to be used. During audit fieldwork, the auditors noted staff's hesitance to disenroll SSI (Supplemental Security Income) individuals from TennCare although there was significant evidence that the individuals' eligibility for the program would be questionable according to TennCare's rules as well as federal regulations, such as eligibility for incarcerated individuals. Written policies and procedures could assist staff in determining the correct course of action to take in circumstances when court orders conflict with TennCare rules. In many cases, when a conflict does exist, staff could perform additional procedures that would allow them to disenroll the individuals and still remain in compliance with court orders.

For example, TennCare could take action regarding enrollees affected by the *Daniel Clusters vs. Commissioner of Department of Health* case that prohibits the Bureau from disenrolling Supplemental Security Income (SSI) recipients who lose their SSI benefits without

making a new determination of TennCare eligibility independent of a determination of SSI by the Social Security Administration. When this situation occurs, to be in compliance with this court order, TennCare should make a new determination of eligibility independent of a determination of SSI by the Social Security Administration.

### Inadequate Monitoring

As previously noted, the Bureau of TennCare still does not have an on-site internal audit unit, and the Office of Audit and Investigations once again did not adequately monitor the internal operations of the Bureau. A strong and sizable internal audit presence is critically important, given the nature, size, and complexity of the program, and the number of internal control problems that exist.

In addition, as noted in the prior audit, in its August 9-12, 1999, site visit report, the Federal Health Care Financing Administration stated,

Although we have brought this to the attention of State officials on multiple occasions, we found that Tennessee has not developed a comprehensive plan for monitoring the TennCare program. Tennessee does have some activities in place for monitoring; however, Tennessee needs a plan that incorporates these activities and any other activities that the State may develop for long-term monitoring for the life of the project (i.e., TennCare). This plan should incorporate the monitoring of the TennCare Partners program.

### **Recommendation**

For the TennCare program to improve and succeed over the long term, the Director of TennCare and his staff must address the long existing problems within and external to the program's administrative structure.

The Director should also develop a plan to address the program's personnel requirements. The plan might include cross-training, employee development, emphasizing employee career-paths, staff reassignment, and workload redistribution. In addition, the Director should continue to pursue acquisition/development of a new TennCare information system.

The Director should ensure that written and comprehensive operating policies and procedures are developed for all areas of the TennCare program. The policies and procedures should be clearly communicated to all program employees, and responsibility for updating the policies and procedures, as well as distributing the updates, should be assigned to the appropriate staff.

Finally, as previously noted, the Director should develop and implement the comprehensive monitoring plan requested by the grantor. The Director should use the internal auditors to review and monitor the internal operations of the program, particularly the program's

extensive and complex automated processes. The internal auditors also could be used to help to implement the monitoring plan or to ensure that the plan is being implemented properly by others.

### **Management's Comment**

We concur. Top management has been working aggressively to address administrative and programmatic deficiencies in the TennCare Program. It must be recognized that major improvements in such a large and complex program cannot be accomplished in just a few months, and it must also be recognized that work on program improvements is made even more challenging by the constantly changing landscape of TennCare—health plans coming into and out of the program, court actions, provider concerns, etc. We believe the activities of the past year have helped us move forward in reaching our goal of a smoothly operating, well-integrated, effective and efficient program.

We did not have a TennCare Director at the time of the last audit. Our new Deputy Director, formerly Acting Director of the MassHealth Program in Massachusetts, has been on the job since June 2000. Our Chief of Operations, who is also Deputy Director of TennCare, has been on the job since February 2000. Both of them have initiated a number of changes to improve employee communications and workflow, to build teams for accomplishing various tasks, and to bring in consultants where necessary to assist in the many complex operations involved in administering and planning changes in the TennCare program.

We have a new TennCare Partners Program Operations Director, who has been on the job since August 2000 and who is moving rapidly to make improvements in that program. We now have a Manager of Personnel, which we have never had before at TennCare. A new Director of the Solutions Unit has recently been hired; she is a person with a vast wealth of experience in both state government and the day-to-day operations of a managed care plan. A staff reorganization is in the final planning stages, and recruiting is underway for additional positions that will head up both MCO operations and Member Services. Reorganization, function assignments and departmental personnel resource allocation is underway for the entire Bureau. Although we do not concur with the stated resource allocation discrepancies, there will be changes made in some operational areas based on operational needs, unit function and departmental statewide responsibilities.

Another significant organizational change that has occurred in the past year has been the establishment of the Office of Health Services, headed by the Deputy Commissioner. This office includes persons with expertise in legislation, budget and accounting, health policy, and children's services and has a wealth of expertise to offer to the TennCare staff. Audit and Investigation and the Program Integrity Unit with direct responsibility for TennCare are located in the Office of Health Services.

Our responses to the other findings contained in this section are provided below.

- a. Written policies and procedures. We have made good progress during the past year on this front. At the direction of the Deputy Director of TennCare, written policies and procedures have been developed for the following units: Administrative Appeals, TennCare Information Line, Provider Services, Legislative Response. In addition, we have begun the development of a TennCare Operational Protocol, which has been submitted to HCFA and which will address many of the items mentioned throughout this audit. We have also initiated a contract with a vendor to help us evaluate our system needs and plan for a new information system that will more adequately meet those needs.
- b. SSI terminations. The new eligibility redetermination process suggested would be a function of the Department of Human Services, which to date has stated that they lack the staff resources to conduct such a process. We could not initiate such an activity without submitting a new plan to the court and receiving court approval for that plan. Unfortunately, all of the other court actions with which TennCare is dealing have consumed all available legal and staff resources.
- c. Establishment of an on-site internal audit site. The Office of Audit and Investigations under the Department of Finance and Administration, Office of Health Services currently has a staff of 24 auditors. This office is responsible for performing internal audits of the Bureau of TennCare, the Division of Mental Retardation, the Department of Health and the Department of Mental Health and Developmental Disabilities. Audit and Investigations are currently taking an active role in performing audits of the Bureau's operations.
- d. Medicare crossover claims. A staff person has been identified in the Policy Unit to work with the Information Systems staff to oversee these concerns.
- e. TennCare Monitoring Plan. We are reviewing this plan and taking steps to determine whether there should be changes before we implement.

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4. **TennCare Management Information System lacks the necessary flexibility and internal control**

**Finding**

As noted in the prior two audits, management of the Bureau of TennCare has not adequately addressed critical information system internal control issues. In addition, the TennCare Management Information System (TCMIS) lacks the flexibility it needs to ensure that

the State of Tennessee can continue to run the state's \$4 billion federal/state health care reform program effectively and efficiently. Management concurred with the prior finding and indicated they would begin the process of identifying the requirements for the new system and perform strategic planning. Management, in its three-year information system plan submitted to the Office of Information and Resources in the Department of Finance and Administration, submitted a proposal for a TCMIS renovation. The project's objective is to analyze current TennCare operations and make recommendations of the most effective way to update or renovate the current TCMIS system. According to the plan, the implementation of a new TCMIS is to occur in 2002.

Because of the system's complexity, frequent modifications of the system, and because this system was developed in the 1970s for processing Medicaid claims, TennCare staff and Electronic Data Services (EDS) (the contractor hired to operate and maintain the TCMIS) primarily focus on the critical demands of processing payments to the managed care organizations, behavioral health organizations, and the state's nursing homes rather than developing and enhancing internal control of the system. This has contributed to a number of other findings in this report. These findings indicate that the TennCare Bureau

- has not ensured adequate system security controls related to access were in place (finding 23);
- has not made payments to certain providers in accordance with the rules (finding 21);
- has not strengthened system controls for Medicare cross-over claims (finding 21);
- made capitation payments for individuals who were not eligible for TennCare (findings 6, 7, 18, 19, and 20);
- incorrectly made payments to the Department of Children's Services for services that should have been provided by behavioral health organizations (finding 8);
- made payments to the Department of Children's Services for individuals over 21 years old (finding 7); and
- made payments to the Department of Children's Services for behavioral health services provided to children under the age of three (finding 8).

### **Recommendation**

The TennCare Bureau should address internal control issues and pursue the acquisition of a system designed for the managed care environment. Until a new system is acquired, the Bureau should continue to strengthen the system's controls to prevent or recover erroneous payments. The TennCare Bureau should follow the three-year information system plan and ensure that an updated system is implemented timely that more effectively supports TennCare's operations.

## **Management's Comment**

We concur in part. We have begun preparations for implementing a new TennCare Management Information System early in 2002. The new TCMIS will be a Medicaid HIPAA (Health Information Portability and Accountability Act) Compliant Concept Model.

A contractor has been chosen to assist with the new TCMIS strategic analysis and procurement process. The work has been organized into two phases:

### Phase I—Strategic Planning

Task 1—Conduct TCMIS Requirements Analysis

Task 2—Identify and Document TCMIS Alternatives

Task 3—Develop Cost/Benefit Analysis

Task 4—Recommend TCMIS Alternatives

Task 5—Develop Advance Planning Document (APD)

### Phase II—Procurement

Task 1—Develop New TCMIS Request for Proposal (RFP)

Task 2—Proposal Evaluation

Information about new TCMIS requirements will be collected through a process called Joint Application Design (JAD), which will bring together key staff persons in a structured, creative planning process. An initial meeting has already been held, with the more in-depth follow-up meetings scheduled for later in February 2001.

The work schedule calls for development of a new RFP by September 2001. This is a top project for the Bureau of TennCare, and completion of this project will address many of the issues identified throughout this audit.

Some of the issues stated in the finding are related to policy directed by management and not a limitation of TCMIS. Management comments related to each finding referenced are found with those findings.

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## **5. Internal control over TennCare eligibility is not adequate**

### **Finding**

The five prior audits of the Bureau of TennCare noted that in many cases, the eligibility of TennCare participants who are classified as uninsured or uninsurable had not been verified and/or reverified. Management concurred with the prior audit finding, stating that a task force was appointed to identify deficiencies, improve the reverification process, and address the audit finding. While changes were made toward the end of the audit period, problems still existed for the audit period.

For the uninsured and uninsurable population, which makes up approximately 41% of all TennCare enrollees, responsibility for initial eligibility determination is divided between the county health offices in the Department of Health and the eligibility unit in the Bureau of TennCare. For the Medicaid population, the Department of Human Services has the responsibility for eligibility determinations. The Department of Children's Services is responsible for eligibility determinations of children in state custody.

#### No Policies and Procedures Manual

Even though the program has been operating for over seven years, TennCare still did not have a written policies and procedures manual to ensure that TennCare recipients were appropriately and consistently determined to be eligible for TennCare. The county health offices, the TennCare Hotline, the Division of Information Services in the Bureau of TennCare, and the Eligibility Unit in TennCare all are involved in the eligibility process for the uninsured and uninsurable population. The different divisions have not been provided with a uniform written policies and procedures manual that would help to ensure appropriate and consistent eligibility criteria. See finding 6 for more details.

#### Inadequate Staff to Verify Information on Uninsurable Applications

The unit that reviews the uninsurable population is understaffed. The Bureau receives approximately 1,000 uninsurable applications weekly. During the audit period, there were two individuals who initially reviewed the applications to verify the information for completeness and accuracy. As a result of the unit being understaffed, not all the information on uninsurable applications (e.g., income, access to insurance, and social security numbers) is verified for accuracy. Not verifying information on these applications increases the risk that inaccurate information is used in determining eligibility.

#### Inadequate Monitoring of SSI Recipients

Testwork revealed that the Bureau of TennCare is not adequately monitoring SSI recipients. The *Rules of the Tennessee Department of Health*, Section 1200-13-12-.02 1 (c), states, "the Social Security Administration (SSA) determines eligibility for the Supplemental Security Income (SSI) program. In Tennessee, SSI recipients are automatically eligible for Medicaid. All SSI recipients are therefore TennCare eligible." The Bureau of TennCare has chosen not to select SSI recipients for the reverification process because according to management the Bureau is accountable only for eligibility and reverification of the waiver population. An SSI recipient is reverified by the Department of Human Services if the individual receives other benefits (e.g., food stamps and Families First). However, individuals who are receiving only SSI are not reverified by either the Department of Human Services or TennCare. The Bureau relies on referrals from the managed care organizations (MCOs), the Department of Health, the TennCare Hotline, or the Regional Mental Health Institute to monitor the SSI recipients. The Bureau has access to the Social Security Administration State On Line Query screen to monitor the SSI recipients. However, the Bureau does not proactively monitor SSI recipients who are not receiving other benefits.

### Improvement Needed for Reverification of Enrollees

TennCare's reverification project began in June 1998 and established face-to-face interviews for eligibility updates of enrollees. This project was intended to reverify the eligibility of one-twelfth (1/12) of the entire uninsured and uninsurable population each month. TennCare also relied heavily on updates to the TennCare Management Information System (TCMIS) for reverifying eligibility through data matches and information received from various sources. According to waiver requirements (Special Terms and Condition #24), the state must continue to assure that its eligibility determinations are accurate. As noted in the prior five audits, these reverification procedures, however, still did not adequately ensure that all TennCare participants were eligible. According to reports from TennCare management, TennCare mailed approximately 8,000 notices a month from July 1999 to March 2000. For the other three months, TennCare mailed approximately 100,000 reverification notices. These mailings totaled approximately 172,000 enrollees representing a small percentage of the over 500,000 uninsured and uninsurable enrollees.

Also, the Bureau does not verify information contained on a Medicaid extend application. "Medicaid extends" are individuals who are losing Medicaid eligibility but have eligibility for TennCare as an uninsured. The applications are entered on the TennCare Management Information System and processed without verification of information contained on the application. Medicaid extends are eligible for 12 months after the loss of Medicaid eligibility as an uninsured. However, not verifying Medicaid extend applications can result in inaccurate premium amounts based upon the unverified and possibly inaccurate income amounts reported by the recipient.

Testwork revealed that 5 of 60 recipients selected for review (8%) were not eligible on the date of service and 31 of 60 TennCare recipients (52%) that may or may not have been eligible on the dates of service had not had their eligibility information adequately verified or reverified within a year of the date of service. Seven of the 60 tested were added to the program within a year of the date of service, which required initial verification of the information on the application. Initial verification includes verifying the applicant's income, social security number, and access to insurance. Of the seven files requiring initial verification, five (71%) had not been verified properly. TennCare could not provide documentation that the enrollees' income and access to health insurance indicated on the application were verified.

The remaining 53 recipients were enrollees who were in the program for more than one year, which required reverification of the enrollees' information. Reverification includes obtaining current information about the enrollees' income and access to insurance. For 26 of 53 enrollees (49%), the enrollee's information had not been adequately reverified within a year prior to the date of service. Sixteen of the 26 enrollees (62%) had not been selected for reverification according to TCMIS. For those not selected, some applicants had been enrolled in the TennCare program as early as 1994. Also, testwork revealed that three of eight enrollees (38%) classified as uninsurable did not have a denial letter attached to verify their uninsurability.

The total amount of capitation improperly paid for the errors noted above was \$4,700, out of a total of \$7,550 tested. Federal questioned costs totaled \$2,966. The remaining \$1,734 was state matching funds. We believe likely questioned costs exceed \$10,000.

Adequate verification procedures are needed to ensure that only those eligible are enrolled in TennCare. According to Office of Management and Budget Circular A-133, payments are allowed only for individuals who are eligible for the TennCare/Medicaid program. For the year ended June 30, 2000, the Bureau paid capitation payments totaling approximately \$2.1 billion to MCOs and over \$355 million to behavioral health organizations for TennCare enrollees.

Annual reverification is also necessary to obtain current, accurate information about family size, income, Tennessee residency, and access to other insurance. This information is needed to determine whether participants previously considered eligible have become ineligible because of changes in their family or personal circumstances. Also, this information is used to determine the correct premium and deductible amounts paid by participants.

#### Pseudo Social Security Numbers Again Discovered

As in past years, when computer-assisted audit techniques were used to search the TennCare Management Information System (TCMIS), testwork revealed that 119 TennCare participants had “pseudo social security numbers,” that began with 8 or all zeros in one field. According to TennCare personnel, some applicants who do not have their social security cards and/or newborns who have not yet been issued social security numbers are assigned these “pseudo” numbers.

Testwork revealed that 73 of 119 individuals (61%) found with “pseudo” social security numbers had not had a correct social security number entered on TCMIS, although they were enrolled more than a year. Some of these TennCare participants had been enrolled in the Medicaid program as early as 1979. Also, while it is not always possible to obtain social security information for newborns (0-3 months), auditors noted that several individuals with pseudo social security numbers were over one year old. The total amount improperly paid for the errors noted above was \$38,449. Federal questioned costs totaled \$24,260. The remaining \$14,189 was state matching funds.

According to the *Code of Federal Regulations*, Title 42, Part 435, Section 910, the state agency must require, as a condition of eligibility, that those requesting services (including children) provide social security numbers. Additionally, Section 3(g) of the code states that the agency “must verify each social security number of each applicant and recipient with the Social Security Administration, as prescribed by the Commissioner, to ensure that each social security number furnished was issued to that individual, and to determine whether any others were issued.”

#### **Recommendation**

The Director of TennCare should promptly develop and implement adequate uniform procedures to ensure that the eligibility status of all TennCare recipients is determined properly,

consistently, and timely. The Director should oversee the development of a written policies and procedures manual and ensure that all divisions involved in the enrollment process of the uninsured and uninsurable population are provided with the manual to ensure that eligibility criteria are applied to the TennCare recipients consistently and accurately. The Director should ensure that adequate staff is assigned to verify information on uninsurable applications. Enrollees' information should be verified and reverified appropriately and in a timely manner, including SSIs that are not receiving other benefits. Social security numbers for all individuals should be obtained in a timely manner.

### **Management's Comment**

We concur in part, although we believe the findings need clarification. We must correct the misstatement that there are no written policies and procedures regarding eligibility. Eligibility policies and procedures have been developed and reviewed by the Office of General Counsel and the Attorney General's Office. These policies and procedures are being used by the Information Line; the Eligibility, Enrollment, and Reverification Unit; and the Administrative Appeals Unit. A companion document is being developed for health departments.

Our responses to other findings in this section are as follows:

1. Staffing concerns. In order to resolve these issues, we are organizing a new Member Services Unit which will handle all member communications, as well as oversight of eligibility, enrollment, reverification, and administrative appeals. This will be addressed in the Bureau reorganization covered in Management responses to the previous findings.
2. SSI recipients. The State is prohibited by court order from disenrolling persons who have been enrolled in TennCare as SSI recipients at any time since November 1987, unless these persons die or move out of state and indicate a wish to be transferred to the Medicaid program in their new state. These individuals are carried on the TennCare rolls as Medicaid eligibles, which means that they have no copayment obligations. Until such time as the State can terminate the TennCare eligibility of former SSI enrollees, we believe it makes more sense to focus our reverification efforts on those enrollees who could actually be disenrolled from the program.
3. Accuracy of eligibility determinations. In response to the criticism that TennCare accepts self-declaration of income in many instances, subject to reverification, it is important to recognize that this was a policy decision made early in the program. It was considered important to avoid any delays in provision of services to eligible individuals, and the plan was to perform more detailed checks on the information they provided after they were enrolled. We have been interested to note that in recent years other states, in implementing their Child Health Insurance (CHIP) Programs, have also adopted this policy. We believe that the accuracy of eligibility

determinations will be improved with our new Member Services Unit and proposed rules and policies already discussed.

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

### **Auditor's Comment**

Based upon subsequent discussions with management, the policies and procedures described in management's response were completed on September 26, 2000, after the end of the audit period. We will review these policies and procedures as a part of our next audit of the department.

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6. **TennCare should develop written procedures to reflect the eligibility procedures used**

### **Finding**

The Bureau of TennCare has not developed written policies and procedures that reflect the eligibility procedures that are currently in place. The Bureau has several adverse court orders, which hinder TennCare from adhering to the previously established TennCare Rules and from adhering to federal regulations. Although TennCare has changed its informal policies and procedures in response to court orders, the Bureau has not developed written procedures to reflect the policies and procedures used. A written policy and procedure manual is necessary to ensure that eligibility criteria is consistently and appropriately applied.

Testwork revealed that the court ruling of *Rosen vs. the Commissioner of Health* prohibits the Bureau from disenrolling or terminating individuals from the TennCare program "unless and until they have first been afforded notice and an opportunity for a hearing, in compliance with 42 CFR Part 431, Subpart E." The temporary restraining order, starting May 2000, against TennCare is a result of the Rosen Case. TennCare has unwritten procedures in place which are intended to ensure that TennCare is in compliance with this court order. One of the unwritten procedures is to not disenroll individuals who have moved out of Tennessee unless the enrollee requests disenrollment in writing. However, one of the technical requirements of TennCare eligibility listed in the *Rules of the Department of Health*, 1200-13-12-.02(3)(b)(2), states that the non-Medicaid-eligible applicant "must be a resident of the State of Tennessee." The *Rules of the Tennessee Department of Human Services*, 1240-3-3-.02(6), states that to be a Medicaid-eligible enrollee, "an individual must be a resident of the State of Tennessee, as defined by federal regulations at 42 CFR 435.403." Executive Order No. 23 transferred the TennCare program from the Department of Health to the Department of Finance and Administration with an effective date of October 19, 1999. Although TennCare is now a part of the Department of Finance and

Administration, the rules are still applicable per *Tennessee Code Annotated 4-5-226(b)(2)*. Due to the recent transfer and the administrative details required to change the rules, TennCare's rules have not been moved under the Department of Finance and Administration as of November 2000. Therefore, throughout the audit report, TennCare rules will be cited as *Rules of the Tennessee Department of Health*. According to TennCare's Deputy Director, TennCare considers enrollees in the military, enrollees temporarily working out of the state, and other enrollees who may plan to return to Tennessee at a future date as state residents. However, TennCare has not developed a written definition or a policy concerning who would be classified as a resident of the State of Tennessee.

Using computer-assisted audit techniques to search the TennCare recipient file located on the TennCare Management Information System (TCMIS), we found over 24,000 enrollees who have a non-Tennessee address. Some of the enrollees have addresses in other countries. Although the Bureau is attempting to comply with the court rulings, it has not developed written procedures to clearly define residency requirements and thus has not limited federal participation to residents of the State of Tennessee. The total amount paid on behalf of these enrollees was \$59,918,812. While some portion of the over 24,000 enrollees may be appropriately considered residents of Tennessee, the absence of written policies makes that determination very difficult. Therefore, \$37,807,272 is considered federal questioned costs. The remaining \$22,111,540 is state matching funds.

In addition, we found over 145,000 enrollees who have P.O. boxes listed as their address. Auditor inquiry revealed that TennCare does not prohibit enrollees from submitting a P.O. box address when enrolling in the program. Allowing enrollees to use P.O. box addresses makes it very difficult to ensure compliance with the rules cited earlier that require residency in the State of Tennessee. Management stated that in certain cases TennCare felt that P.O. box addresses were necessary such as in cases of domestic violence or homeless individuals. However, testwork revealed that TennCare has not established a written policy that describes the instances where the use of P.O. boxes would be allowable. Furthermore, TennCare has not developed a way of identifying these individuals who would be in these categories. The amount paid on behalf of these individuals was over \$442 million.

Another court order is the *Daniel Clusters vs. Commissioner of Department of Health* case that prohibits the Bureau from disenrolling Supplemental Security Income (SSI) recipients who lose their SSI benefits without making a new determination of TennCare eligibility independent of a determination of SSI by the Social Security Administration. The *Rules of the Tennessee Department of Health*, 1200-13-12-.02 1(c), states that all SSI-eligible enrollees are eligible for Medicaid. To attempt to comply with this court ruling, TennCare has chosen not to disenroll SSI enrollees that have lost their SSI benefits unless the individual dies or requests disenrollment in writing. See finding 5 for more details. However, to properly determine eligibility, TennCare must redetermine eligibility for the individuals determined to no longer be SSI-eligible.

### Recommendation

The Director of TennCare should ensure that the Bureau develops written policies and procedures to reflect the eligibility procedures that are used. These policies and procedures should also include a definition of who is a resident of the State of Tennessee and situations where use of a P.O. box would be allowable. The Director should ensure that enrollees who are on TennCare because of a court order can be identified to assist the Bureau in monitoring for compliance with federal regulations and court orders. The Director of TennCare should make it a priority to ensure long-term compliance with rules and regulations through effective and comprehensive policies and procedures as well as controls that ensure compliance with rules and regulations.

### Management's Comment

We concur in part. The Division of Member Services, which includes the Information Line, the Eligibility, Enrollment and Reverification Unit, and the Administrative Appeals Unit have developed policy and procedures that outline eligibility criteria. These policies and procedures have been developed and reviewed by the Office of General Counsel and the Attorney General's office. Work has started on policy and procedure manuals for the local Health Departments.

Definition of Tennessee residency is a part of the on-going lawsuit negotiation. Once resolved, the definition will be used by the Bureau.

Reverification determination processes and procedures are being re-evaluated; application and reverification procedures will mirror each other. These changes will take twelve to eighteen months to complete.

### Auditor's Comment

Based upon subsequent discussions with management, the policies and procedures described in management's response were completed on September 26, 2000, after the end of the audit period. We will review these policies and procedures as a part of our next audit of the department.

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7. **Because communication between TennCare and Children's Services has been inadequate, TennCare incorrectly reimbursed the Department of Children's Services for services that were unallowable, inadequately documented, or not performed, resulting in federal questioned costs of \$4,357,292**

## Finding

As noted in the prior audit, TennCare has paid the Department of Children's Services (Children's Services) for services that were unallowable, inadequately documented, or not performed. In accordance with its agreement with TennCare, Children's Services contracts separately with various practitioners and entities (service providers) to provide Medicaid services not covered by the managed care organizations (MCOs) and the behavioral health organizations (BHOs) that are also under contract with TennCare. Children's Services pays these service providers for Medicaid services (enhanced behavioral health services) and non-Medicaid services (housing, meals, and education) directly. Children's Services then should bill TennCare for the reimbursement of only the Medicaid services. During the year ended June 30, 2000, TennCare paid approximately \$103 million in fee-for-service reimbursement claims to Children's Services.

TennCare has not adequately defined and communicated the specific Medicaid/TennCare services it is requesting from Children's Services. Management concurred with the prior audit finding and stated that TennCare would continue to work with DCS to determine the cause and resolution necessary to resolve problems addressed with this program. However, TennCare has still not completely determined the cause of the numerous problems addressed with this program.

In a letter of correspondence from the U.S. Department of Health and Human Services (HHS) to the Commissioner of the Department of Finance and Administration (F&A) regarding the Single Audit of the State of Tennessee for the period July 1, 1998, through June 30, 1999, HHS stated:

This is a material instance of noncompliance and a material weakness. We recommend procedures be implemented to ensure Federal funds are not used to pay for 1) health care costs of children who are in youth development or detention centers, . . . on runaway status, . . . or individuals over 21 years of age, (2) behavioral health services for children under the age of three, and (3) unsupported medical treatment.

In addition, TennCare has not communicated the specific laws and regulations that Children's Services must follow. Testwork revealed the following deficiencies:

### Payments for Incarcerated Youth

As noted in the prior three audits, TennCare has not identified incarcerated youth enrolled in the program and has paid for the health care costs of youth in the state's youth development centers and detention centers. Under federal regulations (*Code of Federal Regulations*, Title 42, Part 435, Sections 1008 and 1009), delinquent children who are placed in correctional facilities operated primarily to detain children who have been found delinquent are considered to be inmates of a public institution and thus are not eligible for Medicaid (TennCare) benefits.

Although TennCare's management has entered into a Memorandum of Understanding (MOU) with F&A Division of Resource Development and Support (RDS) to examine this area,

TennCare still does not have adequate controls and procedures in place to prevent these types of payments.

Using computer-assisted audit techniques (CAATs), a search by the auditors of TennCare's paid claims records revealed that TennCare made payments totaling \$2,309,625 for the year ended June 30, 2000, for juveniles in the youth development centers and detention centers. Of this amount, \$1,310,492 was paid to MCOs; \$185,862 was paid to BHOs; and \$813,271, to Children's Services. Federal questioned costs totaled \$1,340,041. An additional \$783,722 was state matching funds, and as explained below, the \$185,862 paid to the BHOs is not questioned.

BHOs are not to be reimbursed for costs associated with incarcerated youth. The total payments to the two BHOs are based on a predetermined budget for mental health services approved by the Health Care Financing Administration (HCFA). These payments are allocated between the BHOs based on the number of eligible clients. Eligibility includes not being incarcerated. When a BHO has included ineligible clients in its population of TennCare-eligible clients, the portion of the money budgeted for that BHO should be reduced to that extent and awarded to the other BHO. The total amount paid to the BHOs is not affected. Thus, the total amount paid to the BHOs is not a questioned cost in this audit.

Although the total amount paid to the BHOs is not affected, future funding might be affected. When ineligible individuals are included in the population, the population is skewed and could affect assumptions made when determining the amount of the global budget paid to the BHOs in the future.

The payments to the MCOs were monthly capitation payments—payments to managed care organizations to cover TennCare enrollees in their plans. Since the Bureau was not aware of the ineligible status of the children in the youth development and detention centers, TennCare incorrectly made capitation payments to the MCOs on their behalf.

#### Payments for Children on Leave Status

TennCare has paid for enhanced behavioral health services for children who are in the state's custody but are on runaway status or placed in a medical hospital. No services were performed for these children because they have run away from the service providers or have been placed in a medical hospital. According to Office of Management and Budget (OMB) Circular A-133, to be allowable, Medicaid costs for services must be for an allowable service that was actually provided. *Code of Federal Regulations*, Title 42, Part 1003, Section 102, prohibits billing for services not rendered.

It is the responsibility of Children's Services to notify TennCare when children run away from service providers or are hospitalized in a medical hospital. Testwork revealed that Children's Services does not notify TennCare when children are on runaway status or are placed in a medical hospital. The Children's Services' provider policy manual allows service providers to bill Children's Services for up to 10 days for children on runaway status, but Children's Services cannot bill TennCare for those days. The Children's Services' provider policy manual also allows

service providers to bill Children's Services for seven days if the provider plans to take the child back after hospitalization. If the provider has written approval from the Children's Services Regional Administrator, the provider may bill for up to 21 days while the child is in the hospital, but Children's Services cannot bill TennCare for any hospital leave days. Since the Bureau still has no routine procedures, such as data matching, to check for such an eventuality, it was again unaware Children's Services was reimbursed for particular treatment costs that were not incurred by the service providers. However, based on the prior finding, TennCare should have been aware of the possibility of such costs and should have taken appropriate action to identify such situations.

Using CAATs, we performed a data match comparing TennCare's payment data to runaway records from Tennessee Kids Information Delivery System (TNKIDS). The results of the data match indicated that TennCare had improperly paid \$827,010 for the year ended June 30, 2000, to Children's Services for children on runaway status. Federal questioned costs totaled \$521,823. The remaining \$305,187 was state matching funds.

In addition, using CAATs, we performed a data match comparing TennCare's payment data to medical records from the MCOs. The results of the data match indicated that TennCare had improperly paid \$1,999,313 for the year ended June 30, 2000, to Children's Services for children while they were in hospitals. Federal questioned costs totaled \$1,261,517. The remaining \$737,796 was state matching funds.

#### Payments for Individuals 21 and Over

As noted in the prior audit, TennCare still does not have procedures to identify the TennCare-eligible individuals who have reached the age of 21; therefore, TennCare did not stop payments to Children's Services for Medicaid services provided to these individuals who had reached the age of 21. In accordance with the TennCare waiver, Children's Services should bill and receive reimbursement from TennCare only for Medicaid services provided to recipients in its care who are under 21 years of age.

TennCare contracts with Children's Services to determine the eligibility of children under its care and should notify TennCare when an individual reaches the age of 21. However, Children's Services does not notify TennCare when an individual reaches the age of 21. Since the Bureau still has no routine procedures to check for such an eventuality, it once again was unaware that Children's Services billed for recipients who were 21 years and older. However, TennCare could have known that Children's Services has billed TennCare for children 21 years and older by using system edits that compare the date of birth to the dates of service. When the recipient is 21 years or older, the recipient may receive TennCare services through the MCOs, BHOs, or other departments, but not through Children's Services.

Using CAATs, a search of TennCare's paid claims records revealed that TennCare improperly paid a total of \$206,124 for the year ended June 30, 2000, for individuals 21 and over. Federal questioned costs totaled \$130,059. The remaining \$76,065 was state matching funds.

### Payments for Services Provided to Children Under Three Years

Despite HHS' recommendation discussed above, TennCare failed to take corrective action and again paid Children's Services for behavioral health services provided to children under the age of three. Using CAATs, a search of TennCare's paid claims records revealed that TennCare improperly paid a total of \$1,746,512 for the year ended June 30, 2000, for children under the age of three. Federal questioned costs totaled \$1,102,006. The remaining \$644,506 was state matching funds.

### Payments to Children's Services for Claims That Were Not Adequately Supported

As noted in the prior audit, vendors were still unable to provide documentation indicating the child received therapeutic treatment. For six of 60 claims tested (10%), TennCare inappropriately reimbursed Children's Services for billings when there was inadequate evidence that the child received the service. OMB Circular A-87 requires all costs to be adequately documented.

A total of \$2,925 was paid for these services. Federal questioned costs totaled \$1,846. The remaining \$1,079 was state matching funds. We believe that likely federal questioned costs associated with this condition could exceed \$10,000.

A review of our CAATs associated with custody (see finding 8), runaways, incarcerated youth, individuals over 20, vendor billings, children under the age of three, children who were placed in medical hospitals, children who received alcohol and drug treatment (see finding 8), and children in the Hometies program (see finding 8) revealed that our results sometimes duplicated questioned costs. We estimate the amount of duplicated questioned costs to be approximately \$750,000. The estimated federal amount of the duplicated questioned costs is approximately \$473,194. The state matching funds are estimated to be approximately \$276,806.

In total, \$5,595,157 was improperly paid to Children's Services; \$1,310,492, to the MCOs; and \$185,862, to the BHOs. As discussed earlier, the amounts paid to the BHOs will not be questioned. A total of \$4,357,292 of federal questioned costs is associated with the conditions discussed in this finding. The remaining \$2,548,357 was state matching funds.

### **Recommendation**

The Director of TennCare should recognize the probability of such improper payments continuing in the absence of effective controls. He should ensure that at least computer-assisted monitoring techniques are developed by the Bureau to prevent or detect payments for incarcerated youth, children on runaway status, individuals 21 and older, children placed in medical hospitals, and children under the age of three. The Director of TennCare should ensure that Children's Services bills only for recipients who receive services and are eligible to receive services. Management should also consider whether any action is necessary regarding the monthly allocation of funds between the BHOs. An accurate population of eligible BHO clients should be determined for purposes of future monitoring. In addition, the Director of TennCare

should immediately follow up with HCFA to comply with HHS's recommendation. The Director of TennCare should also ensure that Children's Services is immediately notified of all relevant laws and regulations. He should seek assistance from the Governor in assigning responsibility for ensuring that these improper payments are detected and prevented. Also, the Director of TennCare should ensure that TennCare's management communicates effectively with Children's Services to ensure timely resolution of the numerous problems noted.

### **Management's Comment**

We concur in part, and we believe portions of the findings need clarification.

1. Definition of services. It is not accurate to say that "TennCare has not adequately defined and communicated the specific Medicaid/TennCare services it is requesting from Children's Services." The current interdepartmental agreement between TennCare and DCS lists the services precisely and includes attachments that describe each one in detail. The attachments are the same as those used in the BHO contract to define covered services. (The services which TennCare contracts with DCS to provide are identical to services otherwise covered by the BHO.) TennCare has specifically identified to DCS which costs are allowable and which are not.
2. Payments for incarcerated youth. We will request that F&A Office of Program Accountability Review (PAR) strengthen its efforts to better identify these payments.
3. Payments for children on leave status. TennCare has instructed DCS not to bill TennCare for services not provided to children on leave status. TennCare is developing a DCS Policies and Procedures Manual and will confirm this understanding in that manual. In addition, TennCare will request that F&A PAR strengthen its efforts to assure that inappropriate payments are better detected in the future.
4. Payments for individuals 21 and over. The individuals 21 and over who are being served by DCS are generally individuals with mental retardation who are waiting for an adult placement. TennCare is aware that this situation exists and we do not believe it is inappropriate to provide services to these persons. We have met with DCS and the Division of Mental Retardation Services to discuss ways in which these individuals can be moved into the adult mental retardation service system more quickly, but the fact remains that the State is responsible for them and should be able to use TennCare dollars to contribute to the cost of their care.
5. Payments for services provided to children under three years. We disagreed last year with the opinion of the auditors that DCS should not be paid for behavioral health services provided to children under 3, and we disagree again this year. The

belief that children under 3 cannot benefit from mental health services is not supported by any clinical research of which we are aware. Mental health treatment for young children is certainly different from that provided to older individuals. It tends to focus on milieu therapy (which is the primary service DCS is providing) rather than formal counseling sessions, but it is still very important. Federal EPSDT law requires that any Medicaid coverable service be made available to any eligible child under the age of 21 when such a service is medically necessary. To arbitrarily deny a Medicaid coverable service to children simply because they are in a particular age group is, we believe, discriminatory and in violation of federal Medicaid law.

6. Payments to DCS for claims that were not adequately supported. TennCare will request that F&A PAR include procedures in their reviews to detect payments that may not be adequately supported. In addition to the above efforts, TennCare is considering performing retrospective reviews and cost settlements at year-end to determine any over-billings by DCS. This is intended as a temporary measure until such time as any system changes can be made.

### **Auditor's Comment**

#### Definition of Services

As stated in finding 26, TennCare operated for a majority of the fiscal year without a contract with the Department of Children's Services. Thus, for a majority of the fiscal year, there was no authoritative guidance describing the services to be provided.

#### Payments for Individuals 21 and Over

We agree that it seems that the state should be able to use TennCare dollars to provide services to individuals 21 and over. However, the current TennCare waiver does not permit the Department of Children's Services to bill and receive reimbursement from TennCare for services provided to recipients in its care who are 21 or older. As stated in the finding, the U.S. Department of Health and Human Services indicated in its response to the prior audit finding that payments for individuals 21 and over should not be made in the current manner. If TennCare wishes to continue paying Children's Services for the individuals, an amendment to the TennCare waiver should be obtained.

#### Payments for Services Provided to Children Under Three Years

Management fully concurred with this finding in last year's audit report. HHS has also confirmed that TennCare should not pay for behavioral health services for children under the age of three. As stated in the finding, HHS has requested that TennCare implement procedures to ensure federal funds are not used to pay for behavioral health services for children under the age of three. Management has not produced clinical research that would indicate that children under three could benefit from mental health services. Since management disagrees with this ruling from the grantor, we recommend that management contact the grantor for further clarification.

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8. **TennCare incorrectly reimbursed the Department of Children’s Services over \$13 million for services that are covered by and should be provided by the behavioral health organizations**

**Finding**

As noted in the prior audit, TennCare has incorrectly reimbursed the Department of Children’s Services (Children’s Services) for services that are covered by and should be provided by the behavioral health organizations (BHOs). When TennCare began (January 1, 1994), TennCare contracted with Children’s Services to provide all behavioral treatment for children in state custody or at risk of state custody. On July 1, 1996, TennCare contracted with the BHOs to provide some behavioral health treatment for children in state custody or at risk of state custody. However, the TennCare waiver was not amended to define the responsibilities of Children’s Services.

Management concurred with the prior audit finding and stated that “TennCare would review the services provided by the BHOs in relation to those services provided by Children’s Services and would work with Children’s Services to ensure their knowledge of those services that can be billed to TennCare and those that must be billed to the BHOs.” In addition, management stated that TennCare would “address monitoring techniques that may be available to help detect or prevent unauthorized payments for children in state custody or at risk of coming to state custody.” Although TennCare management concurred with the prior audit finding, TennCare still has not ensured that Children’s Services was aware of those services that were covered by the BHOs. This is evidenced by the contract between TennCare and Children’s Services, which does not sufficiently describe the services that Children’s Services should provide and which services should be provided by the BHOs. In addition, TennCare has not implemented any monitoring techniques to detect or prevent unauthorized payments for children not in state custody because TennCare has chosen to rely solely upon Children’s Services to bill TennCare only for children in state custody.

In accordance with its agreement with TennCare, Children’s Services contracts separately with various practitioners and entities (service providers) to provide Medicaid services not covered by the BHOs that are also under contract with TennCare. Children’s Services pays these service providers for Medicaid services (enhanced behavioral health services) and non-Medicaid services (housing, meals, and education) directly. Children’s Services then should bill TennCare for the reimbursement of only the Medicaid services. During the year ended June 30, 2000, TennCare paid approximately \$103 million in fee-for-service reimbursement claims to Children’s Services.

TennCare contracts with the BHOs to provide the basic and enhanced behavioral health services for children not in state custody as well as basic behavioral health services for children in state custody. TennCare has also contracted with the BHOs to provide all services to prevent children from entering state custody (Hometies) for children at risk of state custody. In addition,

TennCare has contracted with the BHOs to provide the first \$30,000 worth of alcohol and drug treatment for children in state custody. All behavioral services for children not in state custody should be provided through the TennCare BHOs. Enhanced behavioral health services for children in state custody should be provided by Children’s Services. In a letter of correspondence from the U.S. Department of Health and Human Services (HHS) to the Commissioner of the Department of Finance and Administration regarding the Single Audit of the State of Tennessee for the period July 1, 1998, through June 30, 1999, HHS stated:

We recommend procedures be implemented to ensure federal funds are not used to pay for health care cost of children who are . . . not in state custody . . . or in the Hometies Program.

Since TennCare still does not have procedures to identify services covered by the BHOs for children not in state custody or at risk of state custody as noted in the table below and discussed in subsequent paragraphs, TennCare has again paid both the BHOs and Children’s Services for children not in state custody.

	Federal Share	State Share	Total
Hometies Services	\$460,055	\$269,062	\$729,117
Continuum Services	3,269,726	1,912,295	5,182,021
Other Services	2,216,599	1,296,376	3,512,975
Total Costs	\$5,946,380	\$3,477,733	\$9,424,113

TennCare has made payments to Children’s Services for enhanced behavioral health services for children not in state custody. Using computer-assisted audit techniques (CAATs), auditors performed a data match comparing payment data on the Bureau of TennCare’s system to custody records from Tennessee Kids Information Delivery System (TNKIDS). The results of the data match indicated that TennCare had improperly paid \$9,424,113 for the year ended June 30, 2000, for children who were not in the state’s custody. A portion of these improper amounts (see below for further discussion) was paid for services to prevent children who have never been in state custody from entering state custody, also known as the Hometies Program in Children’s Services, which is covered by the BHOs. Of the \$9,424,113 paid, \$5,182,021 was paid for services to prevent children from reentering state custody (continuum) who had been in state custody. TennCare has contracted with the BHOs, who are paid a monthly fixed capitation rate to provide all services to prevent children from entering state custody. TennCare has also contracted with Children’s Services on a fee-for-service basis, for continuum services. Through this contract arrangement, TennCare has been paying for the same services twice. Federal questioned costs, excluding \$460,055, which is included in the Hometies amount questioned below, totaled \$5,486,325. An additional \$3,208,671 of state matching funds was related to the federal questioned costs.

TennCare has again made payments to Children’s Services for Hometies services provided to children at risk of state custody. TennCare improperly paid Children’s Services \$729,117 for the year ended June 30, 2000, for services covered by the BHOs. Federal questioned costs totaled \$460,055. An additional \$269,062 of state matching funds was related to the federal

questioned costs. Although Children's Services again improperly billed TennCare for Hometies services, Children's Services requested in a memo to TennCare dated June 20, 2000, that the amount that was improperly paid be offset against future payments. As of November 28, 2000, the funds have not been recovered.

TennCare has incorrectly made payments to Children's Services for alcohol and drug treatment provided to children in state custody by Children's Services. However, the BHOs are contractually responsible for the first \$30,000 of such expenditures. Neither TennCare nor Children's Services has a mechanism for identifying children who have already received \$30,000 of these services provided by the BHOs. Thus, TennCare improperly paid Children's Services \$3,722,966 for the year ended June 30, 2000, for services covered by the BHOs. Federal questioned cost totaled \$2,349,099. The remaining \$1,373,867 was state matching funds.

In addition, testwork revealed that different service providers that were on contract with Children's Services would be paid by the BHOs and Children's Services for the same dates of service for the same child. Using CAATs, auditors performed a data match comparing payment data on the Bureau of TennCare's system to the payment data from the BHOs. The results of the data match indicated that Children's Services had paid approximately \$3.6 million to providers for the same dates of service for which the BHOs had paid other providers. The data match also identified numerous payments where the same service providers were paid twice for the same services. The service providers received payments from the BHOs and also from Children's Services. The listing of duplicated payments was provided to management to determine how this could occur. Management could provide the auditors with an explanation for some of these payments. However, a TennCare Director indicated that some of these payments could be provider fraud.

Because TennCare once again did not adequately define the services in the contract with Children's Services that are to be provided by Children's Services, TennCare has again effectively paid for these services twice and has misused federal and state funds.

A review of our CAATs associated with custody, runaways (see finding 7), incarcerated youth (see finding 7), individuals 21 and older (see finding 7), vendor billings (see finding 7), children under the age of three (see finding 7), children who were placed in medical hospitals (see finding 7), children who received alcohol and drug treatment, and children in the Hometies program revealed that our results sometimes duplicated questioned costs. We estimate the amount of duplicated questioned costs to be approximately \$750,000. The estimated federal amount of duplicated questioned costs is approximately \$473,194. The state matching funds are estimated to be approximately \$276,806.

In total, as a result of the conditions described in this finding, \$13,147,080 was improperly paid to Children's Services. A total of \$8,295,479 of federal questioned costs is associated with the conditions discussed in this finding. The remaining \$4,851,601 was state matching funds.

## **Recommendation**

The Director of TennCare should immediately revise the contract with Children's Services to clarify the services for which the BHOs are responsible and the services for which Children's Services is responsible. All agreements regarding Children's Services' responsibilities to provide behavioral health services should be documented, included in the contract between TennCare and Children's Services, and reflected in the contracts with the BHOs. TennCare should develop and implement controls to prevent payments to Children's Services for alcohol and drug treatment services for children that have not had \$30,000 of these services already provided. In addition, the Director of TennCare should ensure that monitoring techniques are implemented to detect and prevent unauthorized payments for children in state custody or at risk of being in state custody. Controls should be developed and implemented to ensure the BHOs and Children's Services pay only for services for which they are responsible. In addition, controls to prevent paying the same providers twice should be developed and implemented. Also, the Director of TennCare should immediately follow up with the Health Care Financing Administration to comply with HHS's recommendation.

## **Management's Comment**

We concur in part. We continue to work with DCS and the BHOs to clarify coverage of benefit issues between the two. Although the audit finding states "the contract . . . does not sufficiently describe the services that Children's Services should provide," the current interdepartmental agreement between TennCare and DCS lists the services precisely and includes attachments that describe each one in detail. The attachments are the same as those used in the BHO contract to define covered services. TennCare has specifically identified to DCS which costs are allowable and which are not. We have clarified issues surrounding Hometies services with DCS and they have assured us that procedures will be implemented to ensure that these services are not billed to TennCare.

TennCare has contracted with F&A PAR to monitor the contract with DCS. However, we recognize that monitoring of this contract and services billed to us need continued examination and improvement. We will continue to review the monitoring and claims processing procedures to improve detection of unallowable services.

## **Auditor's Comment**

As stated in finding 26, TennCare operated for a majority of the fiscal year without a contract with the Department of Children's Services. Thus, for a majority of the fiscal year, there was no authoritative guidance describing the services to be provided. Hopefully the new contract will help to clarify the scope of services for which the Department of Children's Services is responsible. However, even with a clearer understanding between the Department of Children's Services and TennCare, incorrect reimbursements can occur if there are inadequate procedures to identify inappropriate billings by the Department of Children's Services for services covered by the BHOs.

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9. **TennCare should exercise its responsibility to ensure the Department of Children's Services' new payment rates are reasonable and have been approved by the Health Care Financing Administration (The old rates set by the Department of Children's Services were not based on an understandable methodology)**

**Finding**

As noted in two previous years' audit findings, with which management concurred, TennCare has not ensured the Department of Children's Services (Children's Services), has established federally approved Medicaid treatment rates for services provided for children in state custody. TennCare has relied on Children's Services to determine the Medicaid treatment rates paid to the Medicaid service providers for children in the state's custody. Children's Services pays the Medicaid service providers for all Medicaid (treatment) and non-Medicaid services (housing, meals, and education) directly, then bills TennCare for the reimbursement of Medicaid services.

In a letter of correspondence from the U.S. Department of Health and Human Services (HHS) to the Commissioner of the Tennessee Department of Finance and Administration regarding the Single Audit of the State of Tennessee for the period July 1, 1998, through June 30, 1999, HHS stated:

This is a material weakness and a repeat finding. We recommend procedures be strengthened to ensure costs charged to the Federal program are based on actual medical treatment costs.

Management of Children's Services could not provide information as to how the treatment portion of services was determined. A study has been performed by Children's Services, and TennCare submitted the results to the Health Care Financing Administration (HCFA) on September 22, 2000. However as of October 19, 2000, TennCare has not obtained approval from the HCFA for the proposed rates and as a result has not implemented the new rates. Because the old rates are not based on an understandable methodology to determine the true treatment costs incurred by the Medicaid service providers, Children's Services may be over- or underbilling TennCare for costs associated with the treatment. In addition, TennCare may be reimbursing Children's Services for non-Medicaid services. Because actual treatment costs could not be determined and differentiated from unallowable costs, auditors could not determine the amounts of possible overbillings and unallowable costs paid by the federal government. Since management at Children's Services could not explain the current methodology, it is unlikely the current rates meet Medicaid principles.

## Recommendation

The Director of TennCare should seek a response from HCFA regarding the rates developed by Children's Services. When approved, the Director of TennCare should ensure that Children's Services implements the federally approved rates that have been developed to comply with Medicaid principles for treatment costs associated with children in state custody.

## Management's Comment

We concur. The Bureau will again request a response for HCFA. However, we cannot dictate the response time of HCFA. When approved, we will work with Children's Services to ensure the rates are implemented.

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### 10. TennCare continues to pay adjusted rates that may not be appropriate without written approval and clarification of grant requirements

#### Finding

As noted in the prior four audits, modifications to TennCare's grant requirements are often necessary because TennCare is a relatively new approach to Medicaid for both the state and the Health Care Financing Administration (HCFA). However, the intent of some requirements becomes unclear with the changes. The payment rates for certain psychiatric services are one such case. Although management has concurred for four consecutive years with the prior findings and stated in the prior two findings that they contacted HCFA officials and they still are awaiting response, no evidence of this contact has been provided.

When TennCare began, mental health services were not immediately moved into a managed care setting as were other health services. As a result, the state requested permission from HCFA to continue to pay for some mental health services on a fee-for-service basis. The November 18, 1994, approval letter from HCFA states:

For both the Children's Plan [Department of Children's Services] and the SPMI [severely and persistently mentally ill], retroactive payments to January 1, 1994, will be permitted on a fee-for-service (FFS) basis, subject to the State's processing these claims through the State Medicaid Management Information System that was in place prior to January 1, 1994, at the previously existing rates. [emphasis added]

Without seeking guidance from HCFA, TennCare interpreted this waiver as allowing the state to continue to adjust for inflation the SPMI and the Department of Children's Services (Children's Services) rates for psychiatric hospitals and community mental health centers as it had

done under Medicaid. During the year ended June 30, 1995, TennCare also adjusted these rates to cover additional costs, such as capitalization of fixed assets and property taxes, and enhanced the rates by a Medicaid “disproportionate share factor” to help cover hospital charity costs. Prior to TennCare, these costs and the disproportionate share factor were not a part of the rates.

On July 1, 1996, TennCare implemented the TennCare Partners Program to provide mental health services in a managed care setting and discontinued fee-for-service payments for SPMI. However, Children’s Services continues to pay the higher adjusted rates on a fee-for-service basis. Since TennCare is using the higher adjusted rates, then both the state and the federal government are paying more than has been approved by the waiver.

Although management agreed that all policies and programs and resulting payments should comply with grant requirements, management has not obtained documentation from HCFA regarding its position on the adjusted rates. The Fiscal Director of TennCare stated during this and previous audits that HCFA had verbally approved the adjusted rates. As of June 23, 2000, TennCare has not received the approval letter from HCFA. However, in a letter of correspondence from the Department of Health and Human Services (HHS) to the Commissioner of the Department of Finance and Administration regarding the Single Audit of the State of Tennessee for the period July 1, 1998, through June 30, 1999, HHS stated:

This is a material weakness and a repeat finding. We recommend procedures be strengthened to ensure 1) rates are set in accordance with the Federal agreement and 2) unallowable payments are identified and returned.

### **Recommendation**

As stated for the past two years, the Director of TennCare should immediately follow up with HCFA to comply with HHS’s recommendation or obtain formal written approval for the adjusted rates. The Director of TennCare should also ensure that all policies or programs and resulting payments comply with grant requirements. If these requirements are unclear or if a substantial change is made, TennCare should seek written approval from the grantor before implementing the change.

### **Management’s Comment**

We concur. We will again request a response from HCFA.

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**11. TennCare has not adequately monitored TennCare-related activities at the Department of Children's Services**

**Finding**

As noted in the prior three audits, TennCare has still not adequately monitored the Department of Children's Services (Children's Services). TennCare again entered into a Memorandum of Understanding (MOU) with the Department of Finance and Administration (F&A) to monitor several aspects of Children's Services' operations for the year ended June 30, 2000. Management concurred with the prior audit findings and stated that TennCare would enhance the scope of services required in the monitoring plan with F&A for the year ended June 30, 2000. Also, management stated that TennCare would work with F&A monitoring staff to ensure their knowledge of allowable and unallowable services. Although TennCare's management has made changes to the scope of service, it appears that TennCare has still not completely enhanced the scope of service in the MOU. In addition, TennCare again did not ensure that F&A had a sufficient understanding of all the allowable and unallowable services. For example, information should have been communicated regarding services that are to be covered by the behavioral health organizations (BHOs) instead of Children's Services (finding 8). Also, TennCare did not include monitoring of case management services provided by DCS for children (see finding 12).

In accordance with the agreement between Children's Services and TennCare, Children's Services contracts separately with various practitioners and service providers to provide health care benefits not provided by the managed care organizations (MCOs) and the behavioral health organizations (BHOs) under contract with TennCare. Children's Services pays these providers and bills TennCare for reimbursement. For the year ended June 30, 2000, TennCare paid approximately \$103 million to Children's Services in fee-for-service reimbursement claims.

TennCare's monitoring through an MOU with F&A includes efforts to ensure that

- only services allowable under the grant are billed;
- the amounts billed are correct and allowable;
- the expenditures are valid and properly supported; and
- only eligible, licensed, or certified providers are providing the services.

F&A again did not follow the MOU's requirements related to monitoring of the following critical areas:

- F&A again did not test the accuracy of Children's Services' billing rates (finding 9).
- F&A again did not test the providers to ensure that all provider enrollment qualifications were met.

- Although the MOU was signed on November 15, 1999, F&A submitted only one monitoring report during the year ended June 30, 2000. The MOU requires that F&A “report the results of monitoring at least quarterly to the Director of the Bureau of TennCare.” The one monitoring report sent to TennCare was dated May 11, 2000.
- Although F&A was aware of some unallowable costs, TennCare did not ensure that F&A was aware of all possible unallowable costs associated with Children’s Services’ payments for noncustodial children and with services that were covered by the BHOs for children in state custody (finding 8). Since TennCare again has not informed F&A of all possible unallowable costs, F&A’s monitoring is still less effective.

### **Recommendation**

The Director of TennCare should ensure that F&A properly performs its responsibilities under the monitoring agreement. TennCare should consider all critical areas of compliance, especially related to Children’s Services’ billings for ineligible services or children. These areas and the applicable compliance requirements should be appropriately included in the monitoring agreement with the Department of Finance and Administration.

### **Management’s Comment**

We concur. This year TennCare appointed a DCS liaison whose specific responsibility is facilitating communication and coordinating activities between DCS and TennCare. She has met with F&A monitoring staff to clarify issues and to discuss reports. She also meets regularly with DCS to discuss billing codes, billing practices, coverage of services, etc. TennCare will continue to work with F&A to strengthen its monitoring of DCS.

**12. TennCare did not ensure that case management services provided by the Department of Children’s Services were adequately documented**

### **Finding**

TennCare did not ensure that case management services provided by the Department of Children’s Services (Children’s Services) were adequately documented. TennCare has contracted with Children’s Services to provide case management services that are outlined in the State Plan. In accordance with the State Plan, the provider is required to establish a written policy that governs the case management duties. Children’s Services Policy 9.1 requires that a child’s case file have case notes. The case notes should consist of

- . . . chronological information concerning each contact with the child/family or other individuals. Appropriate documentation shall include the following:

narratives, monthly recordings, collaterals, case notes/progress notes, dictation, contacts or case documentation on child and family.

In addition, Children's Services' policy also requires that the files contain placement authorizations. Testwork revealed that 17 of 60 case management files reviewed (28%) did not contain monthly case notes, nor did they contain placement authorizations. Apparently TennCare has not monitored or required the Department of Finance and Administration (F&A) Division of Resource Development and Support (RDS) to monitor case management services provided by Children's Services to ensure that case management is adequately documented. See finding 11 for more information concerning monitoring. Complete records are essential if case managers are to appropriately assess and monitor the progress of children. Also, Office of Management and Budget (OMB) Circular A-87 requires all costs to be adequately documented. In addition, complete records also help ensure that TennCare-eligible enrollees are actually receiving services that have been billed to TennCare.

### **Recommendation**

The Director of TennCare should ensure that Children's Services is properly documenting its case management services. Complete and accurate case notes documenting the progress of the child as described in the Children's Services policies should be prepared in a reasonable time and maintained in the child's case file. In addition, all placement authorizations should be prepared and maintained in the child's case file. Adequate monitoring should be performed to ensure that all case management services billed to TennCare are adequately documented.

### **Management's Comment**

We concur. While the Bureau of TennCare concurs on this finding for the audit period ending June 30, 2000, we have made several changes during the current fiscal year to address some, if not all, of these issues. A TennCare/DCS Liaison position was created to assist in the communications between TennCare and DCS and also to assist in the coordination of processes. The Liaison has addressed case management as follows:

- Ongoing weekly meetings are still being held with DCS regarding certain types of services, such as case management, and the documentation of these services in the child's record at the DCS office.
- Meetings have been held with DCS regarding their billing codes and billing practices and specifically addressed the allowable and non-allowable billings from DCS to TennCare.
- Ongoing meetings were being held with DCS regarding their 2001 Contract, which is currently being drafted. The drafted Contract will include specific definitions and details regarding DCS' documentation requirements and on-site monitoring of these records, as well as billing procedures with regards to case management.

- Procedures are being drafted to outline on-site reviews of DCS' documentation of case management services to children in state custody. This will be in addition to the monitoring currently being conducted by F&A Fiscal Monitors' staff.
- Met with TennCare fiscal staff and the F&A monitoring staff to identify specifically those services which are allowable under DCS' Contract and to identify specifically the documentation that should be noted in the child's chart regarding case management.
- Quarterly meetings are held with F&A monitoring staff to discuss the reports received from the review of DCS.

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**13. TennCare's monitoring of the Medicaid Waiver for Home and Community Based Services for the Mentally Retarded has not been adequate**

**Finding**

As noted in the prior audit, the TennCare Bureau's monitoring of the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled under Section 1915(c) of the Social Security Act (HCBS waiver) is still inadequate to provide the federally required assurances of health and welfare and of financial accountability. Management concurred with the prior audit finding and stated,

Efforts will be made to ensure timely submission of the HCFA [Health Care Financing Administration] 372 Reports and the timely submission of monitoring reports as required in the inter-agency agreement. TennCare will update policies and procedures for monitoring the HCBS Waiver and will evaluate staffing resources in this area or other monitoring options that may be available.

Nevertheless, HCFA 372 Reports and monitoring reports were not submitted timely. Policies and procedures for monitoring the waiver were not updated, and although an additional Long-Term Care staff nurse was temporarily assigned, no permanent change has been made concerning the monitoring staff.

TennCare has not developed a formal monitoring plan (including the necessary policies and procedures) to ensure that all the required areas are adequately monitored and that other procedures are performed to provide the required federal assurances. TennCare has not reported the required assurances in a timely manner and has not adequately documented the support for the health, welfare, and financial accountability section of the report. Furthermore, TennCare has not performed adequate monitoring of the Division of Mental Retardation Services (DMR), which oversees the program for TennCare. DMR is contractually required to monitor the HCBS waiver's Medicaid service providers. (See finding 14 for information concerning DMR's monitoring activities.) Management could not explain why the formal monitoring plan was not

developed, required reports were not submitted timely, and TennCare did not perform adequate monitoring of DMR.

Section 1915(c)(2)(A) of the Social Security Act requires that

necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services.

The HCBS waiver which has been in effect since the 1980s requires TennCare to have a formal plan of monitoring in place to ensure the health and welfare of individuals in the waiver. The waiver further requires that all problems identified by the monitoring process will be addressed by TennCare in an appropriate and timely manner, consistent with the severity and nature of deficiencies. The HCBS waiver also requires TennCare to provide assurances of financial accountability for funds expended for home and community based services provided under the State Medicaid Plan. The monitoring plan must include filing the required federal reports.

TennCare still does not appear to have adequate personnel to perform the monitoring needed to support the federally required assurances. Although an additional monitor was temporarily assigned, the TennCare Bureau had only one permanent monitor for the approximately 4,500 recipients of waiver services, 379 service providers, and DMR during the year ended June 30, 2000. The one monitor was a registered nurse. No fiscal personnel were on staff to perform fiscal monitoring for assurance of financial accountability.

Section 1915(c)(2)(E) of the Social Security Act requires the state to provide the Secretary of the U.S. Department of Health and Human Services (HHS) with an annual report, the HCFA 372 report, on the impact of the HCBS waiver on the type and amount of medical assistance provided under the state plan and on the health and welfare of the recipients, including TennCare's assurances of health and welfare and of financial accountability under the waiver.

For the year ended June 30, 1999, TennCare once again did not submit the HCFA 372 Report within 181 days after the last day of the waiver period as required by the HCFA *State Medicaid Manual*, Section 2700.6 E., Submittal Procedures for Due Date. The Home and Community Based Services waiver HCFA 372 reports that should have been submitted in January 2000 were not submitted until September 2000 for the Shelby County waiver and were not submitted until November 2000 for the mentally retarded and developmentally disabled waiver. The report for the ADAPT waiver (Davidson, Hamilton, and Knox counties) that should have been submitted in May 2000 was not submitted until November 2000. The respective HCFA 372 (S) reports for fiscal year 1998 were submitted at the same time the HCFA 372 reports were submitted and were more than 181 days late. In addition, TennCare once again could not provide adequate documentation to support the health and welfare information in the HCFA 372 report. Without adequate documentation of the work performed in the monitoring process, once again it could not be determined if monitoring was adequate to support health and welfare assurances, and

since no fiscal monitoring was performed, there was no support for financial accountability assurances in the report.

Furthermore, TennCare has not performed adequate monitoring of the waiver. While TennCare has no formal monitoring policies and procedures, TennCare does have monitoring responsibilities for the HCBS waiver in its contract with DMR. The contract specifically includes the following responsibilities for TennCare:

1. TennCare is to review a random sample of Preadmission Evaluations prepared by DMR during the annual state assessment period. TennCare did review a random sample of four Preadmission Evaluations.
2. TennCare is to monitor the plan of care for persons receiving waiver services by reviewing a sample of the plans of care for recipients in the program during the state assessment. Testwork revealed that the TennCare monitoring staff did monitor plans of care during the annual state assessment period.
3. TennCare is required to monitor DMR's policies for implementation and coordination of the waiver services approved by HHS. However, TennCare has not monitored DMR's implementation and coordination of the waiver services. In addition, TennCare had no role in the approval process of the Operations Manual for Community Providers, which is the policy manual used by DMR.
4. Per the contract, TennCare is to provide quality assurance monitoring to evaluate performance of the DMR. However, TennCare has not performed adequate quality assurance monitoring of DMR.
5. TennCare is to perform periodic audits of client records to validate the findings of the DMR Quality Enhancement review, and report the results to DMR with action required or needed to rectify deficiencies in a timely manner. This report is an annual statewide assessment of DMR's overall performance in the waiver. TennCare does not have guidelines to use when performing periodic audits of client records. Furthermore, TennCare has not provided DMR with timely statewide assessment reports. The statewide assessment reports performed for years ended June 30, 1999, and June 30, 1998, have not been submitted to DMR as of December 11, 2000.
6. TennCare is to assure the health and welfare of the individuals served in the waiver, through monitoring of quality control procedures described in the Medicaid Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled. TennCare does not have adequate documentation to indicate this was performed.

Only two of the six responsibilities have been fulfilled. Contractual requirements do not include specific responsibility for assurances of financial accountability. As a result, TennCare

cannot support the required federal assurances for health and welfare and for financial accountability. Also, TennCare's inadequate monitoring increases the risk that federal requirements are not met.

### **Recommendation**

The Director of TennCare should develop waiver monitoring policies and procedures to ensure that a formal monitoring plan exists to provide the required health and welfare and financial accountability assurances to HCFA. The Director should ensure that the HCFA 372 reports and contractually required reports are submitted in a timely manner. The Director should monitor the process to ensure adequate assurances of health and welfare and of financial accountability are made to HCFA. The Director should ensure that an adequate number of appropriately trained staff is available to perform monitoring.

### **Management's Comment**

We concur. The Division of Long Term Care has proposed a Long Term Care Quality Monitoring Unit to develop more formalized Quality Monitoring policies, procedures, and tools and to ensure adequate staff for collection of field data. Some work has been done in regard to drafting policies and procedures for this unit; however, staff resources have not been sufficient to complete this process, particularly in light of the staff resources that have been required to complete complaint investigations requested by HCFA during the past year.

Staff positions for this unit have been included as improvements in the TennCare budget. Additional positions have been assigned to the Division of Long Term Care that will eventually be moved into the Quality Monitoring Unit. In the interim, while we await the legislature's approval for the management positions for this unit, staff are being hired and temporarily assigned to other management staff within the Division of Long Term Care. A Public Health Nurse Consultant 2 with survey experience has been recently hired and is in training to assume the role of Quality Coordinator for MR waiver programs. After she is trained on collection of data in the field, she will intensively work toward development of survey tools and quality monitoring policies. A fiscal staff person has been assigned to work with the Division of Long Term Care to provide advice on fiscal monitoring procedures.

Policies are being drafted to address timely requests of 372 reports from EDS, review of initial 372 reports, and timely submission of the completed report to HCFA. LTC Waiver staff have worked extensively with IS and EDS staff in the past year to ensure that 372 reports accurately reflect service utilization and costs of waiver programs. We concur that the reports were late; however, the time devoted to fine tuning the 372 report process should result in more timely completion and submission of 372 reports in the future.

A random sample of PAEs reviewed by DMRS was reviewed for the 98/99 and 99/00 State Assessment and will be included in the reports for these audits. Because of staffing issues, Quality Monitoring staff have not been able to complete the reports as of yet; however, the 98/99

report is in final draft and the 99/00 report is in initial draft stage. With new staff positions added, the Division of LTC is on track to have all outstanding reports completed by the end of the current fiscal year and will be able to complete reports timely from this point forward. The TennCare DMRS contract will be revised to exclude the responsibility for reviewing a random sample of PAEs as DMRS no longer reviews PAEs. As of June 2000, the PAE review function for MR waiver programs was assumed by the Division of LTC.

A sample of Waiver enrollees' plans of care were reviewed in the 98/99 and 99/00 State Assessments and the results will be included in the state assessment reports.

The Division of LTC will work with DMRS to establish formal policies for review of waiver policies and provider bulletins and to make necessary revisions to contracts and provider agreements. While we concur that the TennCare staff had little input in the development of the current DMRS Operations Manual, TennCare Waiver and Quality Monitoring staff have reviewed portions of the current manual that are under revision. Additional sections of the Operations Manual will be reviewed as they are completed. Waiver and Quality Monitoring staff are providing input to DMRS staff regarding problematic issues and requested changes during the review process.

**Timeframe for completion:** It will take at least 1-2 years to get all requested positions filled and individuals trained in the Quality Monitoring Unit. It will take 6 months to a year to develop all policies and survey tools needed for this unit.

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**14. TennCare should ensure that the Division of Mental Retardation Services provides adequate monitoring of the Medicaid Home and Community Based Services**

**Finding**

As noted in the prior audit, the TennCare Bureau did not ensure that the Division of Mental Retardation Services (DMR) complied with its contract monitoring requirements for the Medicaid Home and Community Based Services (HCBS) for the Mentally Retarded and Developmentally Disabled waiver. The contract between the TennCare Bureau and DMR requires DMR to give assurance that necessary safeguards will be taken to protect the health and welfare of the recipients of home and community based services and assurance of financial accountability for funds expended for home and community based services. Management concurred with the prior-year finding and stated, "TennCare will work with DMR to ensure compliance with the interagency agreement and will provide adequate monitoring policies and procedures to ensure all federal requirements are met." However, DMR did not comply with the interagency agreement and monitoring was not adequate. Furthermore, DMR had no monitoring policies and procedures. Management could not explain to the auditors why there was not adequate monitoring and why the interagency agreement was inadequate.

Testwork revealed that DMR is adequately monitoring to ensure that the traditional long-term care providers have the necessary safeguards in place to protect the health and welfare of waiver recipients. However, testwork revealed that DMR has still not adequately monitored the waiver's alternative providers. Alternative providers are home health agencies and individual providers such as dentists, behavioral therapists, nutritionists, and physical therapists.

In addition, DMR is still not providing necessary assurance of financial accountability for funds expended for all providers. Furthermore, DMR's current monitoring policies have not been revised to include the monitoring process for the alternative providers and do not include the fiscal monitoring process for the financial accountability assurances.

DMR relies on programmatic personnel at the regional offices to perform monitoring for health and welfare assurances of the traditional long-term care providers. No fiscal monitors were on staff during the year ended June 30, 2000. The contract between the TennCare Bureau and DMR requires DMR to provide assurance of the financial accountability for the funds expended for home and community-based services, which includes the collection of patient liability and the protection of the client's personal funds. In the absence of fiscal monitors, DMR programmatic monitors have performed some fiscal monitoring of the waiver recipients' personal funds. However, on a statewide basis, fiscal monitoring is not effective for financial accountability since there is no fiscal monitoring of the vendor's billing records or collection of patient liability. Programmatic staff may not be adequately trained to perform fiscal monitoring.

### **Recommendation**

The Director of TennCare and the Deputy Commissioner over DMR should ensure that DMR complies with contractual requirements for assurances of health and welfare and of financial accountability of funds expended for home and community based services, including the collection of patient liability and the protection of the clients' personal funds. TennCare should also provide DMR with adequate monitoring policies and procedures to ensure that all federal requirements are met.

### **Management's Comment**

We concur. Based on recommendations from the prior audit, DMRS developed monitoring procedures and instruments for use with home health and other alternative providers. These procedures were implemented on July 1, 2000 and those providers are currently being monitored.

During the audited period, DMRS relied on programmatic personnel and one fiscal monitor at the regional offices to perform fiscal monitoring including monitoring of vendor's billing records and waiver recipients' personal funds. As of July 1, 2000, responsibility for fiscal monitoring was transferred to the Department of Finance and Administration, Program Accountability Review (PAR) unit. The PAR unit is staffed by qualified personnel who conduct

thorough fiscal monitoring of provider agencies and the results are communicated to the regional office where action can be taken on the findings when warranted.

**Timeframe for completion:** The remedies described above have been implemented, but it will take at least a year to evaluate their effectiveness.

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15. **Claims for services provided to the mentally retarded and developmentally disabled have not been paid in accordance with the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled**

**Finding**

As noted in the prior audit, TennCare has allowed other state departments to contract with and to pay Medicaid providers in violation of the terms of the Medicaid Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (HCBS waiver). The *Code of Federal Regulations*, Title 42, Part 431, Section 10(e)(3), allows other state and local agencies or offices to perform services for the Medicaid agency. As a result, TennCare, formerly with the Department of Health (TDH) and now with the Department of Finance and Administration (F&A), has contracted with the Division of Mental Retardation Services (DMR), formerly with the Tennessee Department of Mental Health and Mental Retardation (TDMH/MR) and now with the Department of Finance and Administration (F&A), to oversee the HCBS waiver program. Management concurred with the prior finding and stated,

We will work with HCFA [the Health Care Financing Administration] to ensure that our waiver procedures are in compliance with all federal requirements for the waiver and will work with DMR to ensure their compliance with all waiver requirements. Any procedures necessary to ensure maximum federal participation will be pursued. Provisions will be implemented that allow the provider voluntary reassignment of their service payment to a government agency, i.e., DMR, with the ability to cancel the arrangement should he choose to receive direct payment from the Medicaid agency.

However, management did not implement any of their proposed actions. Management could not explain why they did not implement any of their proposed actions.

The contract between TennCare and DMR states,

The Contractor (TDMH/MR) should not assign this Contract or enter into a subcontract for any of the services performed under this Contract without obtaining the prior written approval of the State (TDH). . . . TDMH/MR must submit complete copies of all subcontracts to TDH. Copies of subcontracts and

amendments to subcontracts executed during the term of this contract must be submitted prior to the execution of such subcontract or amendments.

DMR (the Contractor) does not obtain written approval from TennCare before entering into contracts with providers, nor does it submit copies of the provider contracts to TennCare before they are executed.

Section 1902(a)(27) of the Social Security Act and the HCBS waiver also require TennCare to contract directly with the providers. However, TennCare has allowed DMR to contract directly with the Medicaid providers. Furthermore, TennCare has inappropriately paid DMR as a Medicaid provider. DMR in turn has treated the actual Medicaid service providers as DMR vendors. According to Medicaid principles, as described in the Provider Reimbursement Manual, Part I, Section 2402.1, DMR is not a Medicaid provider because it does not perform actual Medicaid services.

Although TennCare can use other state departments to perform services, Sections 1905(a) and 1902(a)(32) of the Social Security Act and the HCBS waiver require TennCare to make direct payments to providers of services covered by the waiver. In addition, the waiver agreement requires provider claims to be processed on an approved Medicaid Management Information System and provider payments to be issued by TennCare. However, TennCare has allowed DMR to process claims on its own system and make payments through the State of Tennessee Accounting and Reporting System (STARS) to providers. As a result, the state contributed funds for the waiver services without receiving federal financial participation. For example, DMR paid providers for services that could not be charged to the federal grantor because they were not allowable under the waiver regulations. Auditor inquiry revealed a situation where DMR provided services for an individual; however, TennCare appropriately denied payment for the services because a Preadmission Evaluation had not been properly completed by DMR.

DMR has paid waiver claims outside the prescribed waiver arrangement. The waiver is designed to afford eligible individuals access to home and community based services as authorized by Section 1915(c) of the Social Security Act. Typically, any claims submitted by providers for services performed for waiver recipients would be processed in accordance with all applicable federal regulations and waiver requirements, and the state would receive the federal match funded at the appropriate federal financial participation rate.

The current billing and payment process is as follows:

1. Medicaid service providers perform services for waiver recipients.
2. Providers bill DMR for services.
3. DMR pays providers based on rates established by DMR but not the rates in the waiver. TennCare has incorrectly allowed DMR to use the Community Services Tracking System and STARS to pay the providers.
4. DMR bills TennCare (as if DMR were a provider) based on the waiver rates.

5. TennCare pays DMR (as if DMR were a provider) the TennCare rates using the TennCare Management Information System (TCMIS) system.

Because TennCare has not ensured that DMR complied with the waiver and federal regulations, TennCare paid DMR more than DMR had paid the providers in 51 of 58 claims examined. TennCare paid DMR less than DMR paid the providers on the other 7 claims. These differences are included in the questioned costs in finding 17.

The HCBS waiver requirements prohibit services for recipients when they are absent from their homes. In addition, the HCBS waiver does not permit recipient leave days because care is home based and not performed in a residential facility. TennCare forwarded DMR a transmittal letter from HCFA of HHS dated October 31, 1994, stating that leave days could not be paid for by the HCBS waiver.

However, DMR implemented a system that would, in essence, permit patient leave days. For example, providers performing services for 300 days are paid the same amount as providers performing services for 365 days. DMR's procedure manual, the *Operations Manual for Community Providers*, chapter 6, states:

Providers earn funding only for services provided. However, a generous allowance for leave is accommodated in the rate schedule for adult day and residential services.

The DMR payment system has no controls to prevent payment for unperformed services, and TennCare has no controls to detect DMR's billing for unallowable leave days and unperformed services.

Per Office of Management and Budget (OMB) Circular A-133, for costs to be allowable Medicaid costs, claims must be for allowable services rendered that are supported by records or other evidence indicating the services were provided and consistent with a recipient's plan of care for HCBS waiver services. In addition, 42 CFR 1003.102, states that penalties or assessments may be imposed by the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) if an item or service was not provided as claimed. Furthermore, the Federal Register (FR), August 10, 1995, Volume 60, Pages 40847-40851: Notices, *OIG Special Fraud Alerts*, states that claiming unperformed or excessive services is fraud and may be prosecuted by the OIG.

Testwork revealed that DMR used a payment and rate methodology that allowed providers to be paid for days (leave days) in which waiver recipients were not receiving services. For example, the current payment methodology used by DMR pays providers for a maximum of 25 days of service even if the provider has billed for 31 days; then the provider could bank the 6 days. If, in a future month, the provider's service falls below 25 days, the provider could use the 6 banked days to enable the provider to receive payment for 25 days. In 12 of 60 claims tested (20%), DMR paid Medicaid service providers for fewer units (hours or days) than TennCare paid DMR.

In addition, by not paying providers directly as required, federal reimbursement has been delayed longer than if TennCare had paid providers directly in accordance with federal regulations.

### **Recommendation**

The Director of TennCare should take immediate action to comply with all federal requirements, including those in the waiver, to ensure that all federal financial participation claimed is allowable. The Director must also inform DMR of all federal requirements, including those in the waiver, and ensure that DMR complies with all requirements. The Director should ensure that TennCare pays providers in accordance with the waiver and only for allowable services that are actually performed. TennCare should process claims on the approved Medicaid (TennCare) Management Information System and pay providers directly. DMR provider billings to TennCare should reflect only the actual level of services performed. The Director of TennCare should ensure that staff performs fiscal monitoring of providers to ensure that payments are for services actually provided.

### **Management's Comment**

We concur. The TennCare Division of LTC will continue to work with DMRS to implement policies that ensure TennCare review and approval of subcontracts. A new provider agreement has been developed that allows both TennCare and DMRS to sign an agreement with each provider of waiver services. With the current fiscal agent, there is concern that the TCMIS system is not adequate to process provider claims for services directly. During the request for proposal and contract process with interested new fiscal agents, the possibility for direct provider payment and voluntary reassignment of provider payment to DMRS will be explored.

DMRS continues to pursue federal financial participation to the greatest extent allowable. The Division also receives state appropriations for the purpose of funding certain services that are not covered by the current waiver.

The approved rates listed in the waiver document are estimated rates as required by HCFA in order to complete the waiver budget. Historically, rates reimbursed to MR waiver service providers have been negotiated and HCFA is aware of this rate reimbursement procedure. However, HCFA has been contacted regarding the need for clarification of reimbursing providers at negotiated rates rather than using the approved waiver rates. TennCare is awaiting a response to this issue from HCFA.

Although DMRS did not concur with the prior year finding concerning payment of leave days, the methodology for payment of residential services was changed to ensure that payment is made only for those days during which waiver recipients received direct services. The alternative method was implemented July 1, 2000. Fiscal monitors with the office of Program Accountability

Review (PAR), Department of Finance and Administration, currently review vendor billing records to ensure that payments are made only for services actually performed. All traditional provider agencies are monitored annually.

**Timeframe for completion:** It could take at least 3 years to implement a new system that will accommodate direct payment of waiver providers.

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**16. The TennCare Bureau’s failure to establish a cost allocation plan resulted in federal questioned costs of \$18,320,757**

**Finding**

As noted in the prior audit, TennCare is required to have a Medicaid cost allocation plan to provide for the recovery of administrative costs associated with the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (HCBS/MR) program. Management concurred with the prior audit finding and stated, “The Bureau is currently in the process of developing a cost allocation plan to be submitted for approval as determined necessary.” However, according to TennCare’s Chief Financial Officer, no cost allocation plan was developed and submitted for approval. Management could not explain why an approved cost allocation plan had not been obtained. Currently the Department of Finance and Administration’s Division of Mental Retardation Services (DMR) has the responsibility for day-to-day management of the HCBS/MR waiver program. Our audit revealed that the Bureau of TennCare has allowed DMR to receive indirect costs for the supervision of the HCBS/MR program without an approved cost allocation plan. According to TennCare’s records for the year ended June 30, 2000, the indirect costs totaled \$29,035,631, of which \$18,320,757 is federal questioned costs and \$10,714,874 is state funded costs.

Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments, Attachment D, Public Assistance Cost Allocation Plans*, requires an approved cost allocation plan for all direct and indirect administrative costs for public assistance programs. Without an appropriately amended and approved plan, the TennCare Bureau is not eligible to recover these costs from the federal grantor.

**Recommendation**

The TennCare Director should immediately develop and submit a cost allocation plan in accordance with OMB Circular A-87.

## Management's Comment

We concur. A letter was submitted to HCFA in spring of 2000 requesting approval of a cost allocation method for the MR/DD waiver. HCFA responded that the letter should be submitted to the Department of Health and Human Services (HHS). The letter to HHS was submitted in June of 2000. They in turn sent the letter to HCFA financial experts for review. Consequently, we have not received approval from HCFA to proceed with the cost allocation plan.

**Timeframe for completion:** Unknown. HCFA has indicated that they will not be able to begin reviewing the request until February.

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17. **TennCare has not ensured that adequate processes are in place for approval of the recipient and for the review and payment of services under the Medicaid Home and Community Based Services Waiver**

### Finding

As noted in the prior audit, TennCare has not ensured the Division of Mental Retardation Services (DMR) appropriately reviews and authorizes allowable services for recipients of the Medicaid Home and Community Based Services Waiver (HCBS waiver). In addition, DMR has not adequately documented the review and approval of services on the individual's Service Plan. Also, services were provided to recipients without proper preadmission evaluations, and unallowable claims were paid. Management concurred with the prior audit finding and stated,

The current service authorization process will be reviewed by TennCare staff and if determined appropriate, an amendment to the HCBS Waiver will be submitted to HCFA to clarify the process that will be used to provide documentation of services authorized and approved for waiver participants.

However, TennCare has not amended the HCBS waiver to clarify the process that will be used to provide documentation of services authorized and approved for waiver participants.

Section 13 of the HCBS waiver states that services under the waiver will be furnished pursuant to an approved plan of care. Documentation of approval of the plan of care is performed on the Service Plan based on appendix E of the HCBS/MR waiver document. DMR's *Operation Manual for Community Providers*, chapter two, requires Service Plans to be authorized before entry into DMR's Community Services Tracking System as approved, and chapter one requires a preadmission evaluation to be properly completed for each recipient. In addition, Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, states that costs must be documented.

A sample of 60 individual support plans (ISP) representing claims totaling \$61,645 were tested. Thirteen of these (22%) were determined to be improper. Problems with the ISPs included that the ISPs were not signed and dated by those in attendance; there was no ISP signature sheet; or the ISP was missing. None of the 60 ISPs indicated that a formal review was performed as required by chapter two of the *Operations Manual for Community Providers*.

We tested the recipients of the waiver to determine whether they were eligible for the services rendered. A properly approved and completed preadmission evaluation (PAE) serves as documentation of waiver eligibility. Examination of 60 PAEs revealed that 18 (30%) were improper. Problems with the PAEs included

- the recipient's preadmission evaluation (PAE) was not supported by a physical examination and/or psychological evaluation as required by chapter one of the *Operations Manual for Community Providers*;
- the physician's signature and an approval signature were not obtained within 30 days as required by the waiver; and
- there was no indication that the recipient was mentally retarded prior to age 18 as required by chapter one of the *Operations Manual for Community Providers*.

Also, 13 of the recipients files were missing one or both of the following:

- a completed PAE, or
- a Form 2362, Notice of Disposition or Change Form, used to calculate a recipient's patient liability.

Testwork also revealed that all 60 of the claims were paid based on inappropriate rates. Fifty-eight of the claims were improper because the rates in the Division of Mental Retardation's Community Services Tracking System did not agree with the waiver-approved rates in the TennCare Management Information System (TCMIS) (See finding 15 for more details.) The other two payments were made directly to the service provider; however, the rates used for these two payments were not waiver-approved rates. Adjusted rates were used to pay the service provider which were supposed to more closely resemble actual expenditures; however, the rates were not HCFA approved. In addition, 15 of these 60 vendor records did not properly support actual performance of services billed. Service plans required by the *Operations Manual for Community Providers* are used to list authorized services. Cost plans required by the *Operations Manual for Community Providers* list which services will be provided, the frequency of the service, and the cost of the services. Testwork revealed that 88% of service plans tested (53 of 60) and 90% of cost plans (54 of 60) were either not approved, not approved timely, or were missing. The service plans sampled had 55% that were not approved, 23% that were missing, and 10% that were not approved timely. Of the cost plans sampled, 83% were not approved timely, 3% were not approved, 2% had a conflicting date, and 2% were missing.

For 49 of 60 claims paid (82%), the periods covered by the service plans and the cost plans did not agree or there was not a service plan or cost plan. By having the periods covered

not agree, there is a risk that services on an approved cost plan would not be listed on an approved service plan for the dates of service and vice versa.

The total of improperly documented claims in the sample was \$60,552. Federal questioned costs totaled \$38,207. The remaining \$22,345 was state matching funds. The total population for the HCBS waiver claims was \$191,304,282.

Since TennCare has not ensured that adequate processes are in place for approval of the recipient and for the review and payment of services under the Medicaid Home and Community Based Services Waiver, Medicaid providers of HCBS waiver services have been paid for inadequately documented services.

### **Recommendation**

The Deputy Commissioner over DMR should ensure that approval and review of services under the HCBS waiver are adequately documented. The Director of TennCare should ensure that the eligibility criteria for all individuals are documented on the PAE. Claims without adequate documentation should be denied. Cost plan and service plan dates should be in agreement. A formal review should be performed for all ISPs. TennCare should pay all claims in accordance with waiver-approved rates.

### **Management's Comment**

We concur. Based on recommendations from the prior audit, DMRS modified its Service Plan review and authorization process. DMRS Regional Directors now ensure that approval of services is adequately documented on each individual's service plan. Every service plan is reviewed, approved and signed. The revised process was implemented in the summer of 2000. On site reviews in each Region during October by DMRS central office staff indicated 100% compliance for Service Plans received since June, 2000. Cost plan and service plan date consistency has likewise improved with the revised process. During the past year, a workgroup focusing on Individual Support Coordinator issues developed a process for reviewing all Individual Support Plans (ISPs). The Director of each ISC Agency must review and approve each ISP before it is sent to the Regional Office. During the annual Quality Assurance survey conducted by DMRS, a 10% sample of ISPs is drawn to validate the accuracy of the Director's review. The revised process will be implemented by the second quarter of 2001.

TennCare Quality Monitoring staff reviewed for appropriate care plans and service plan authorization during the 98/99 and 99/00 State Assessments. As previously discussed, the reports are being drafted. The TennCare Division of LTC will include monitoring for appropriate plans of care and service plan authorizations in developing the survey tool and policies for quality monitoring during the State Assessment.

The PAEs reviewed were done during the period of time DMRS was performing PAE review for the MR Waiver. As of June 2000, the TennCare Division of LTC assumed the PAE review responsibility for MR Waiver applicants. A draft policy has been written to address the review of PAEs for those applying for TennCare reimbursed programs for the mentally retarded. The need for a psychological evaluation is addressed on page 4 of the draft policy. The history and physical and initial plan of care requirement is addressed on page 6 of the draft policy. Physician's signature is addressed on page 7 of the draft policy. The nursing staff assigned to review ICF/ MR PAEs have been instructed to review the psychological evaluation and assure that a diagnosis of mental retardation prior to the age of 18 is documented.

**Timeframe for completion:** Remedies have been implemented. It will take 6 months to a year to evaluate effectiveness.

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**18. TennCare paid capitation payments and fee-for-service payments on behalf of incarcerated enrollees, resulting in federal questioned costs of \$5,710,336**

**Finding**

As noted in the prior audit, TennCare still has not ensured that adequate controls are in place to prevent capitation payments to managed care organizations and behavioral health organizations and for fee-for-service claims when enrollees become incarcerated. In addition, TennCare still does not have a process to retroactively recover all capitation payments from the managed care organizations (MCOs) when enrollees are incarcerated. Management concurred with the prior finding and stated that TennCare would continue to review and monitor its procedures for identifying incarcerated adults and determine which capitation payments can legally be recovered. However, TennCare has not made changes to the MCO contracts that would allow such a recovery and has not changed the procedures for identifying incarcerated enrollees. Also, management stated that if capitation payments cannot be recovered to the time of incarceration, the state will determine if state dollars should be used to fund the unrecovered dollars. However, the federal Medicaid program has not been reimbursed for the unrecovered dollars.

The capitation payments are made to the MCOs and behavioral health organizations (BHOs) on behalf of TennCare enrollees to cover medical and mental health services. These payments are generated electronically each month by the TennCare Management Information System (TCMIS) based upon the recipient eligibility information contained in the system. If the eligibility information in TCMIS is not updated timely, then erroneous payments will be made. The fee-for-service claims are for payments that were made to providers for services or medical equipment provided to TennCare enrollees.

TennCare personnel stated that data received from the Tennessee Department of Correction is often incomplete and/or inaccurate. Prisoners are often not willing to give complete

and/or accurate information regarding their identity (name, social security number, date of birth, etc.). These problems can often cause delays in identifying prisoners and stopping benefits.

Using computer-assisted audit techniques, a search of TennCare's paid claims tapes revealed that TennCare made payments totaling \$9,950,293 from July 1, 1999, through June 30, 2000, for approximately 7,600 adult inmates in state prisons. Of this amount, \$8,959,494 was paid to MCOs, \$90,525 was paid for fee-for-service claims, and \$900,274 was paid to BHOs. Of these amounts, \$5,710,336 is federal questioned costs. An additional \$3,339,683 of state matching funds was related to the federal questioned costs. As explained below, the \$900,274 paid to the BHOs is not questioned costs.

BHOs are not to be reimbursed for costs associated with incarcerated adults. However, the total payments to the two BHOs are based on a predetermined budget for mental health services approved by the Health Care Financing Administration (HCFA). These payments are allocated between the BHOs based on the number of eligible clients. Eligibility includes not being incarcerated. When a BHO has included ineligible clients in its population of TennCare-eligible clients, the portion of the money budgeted for that BHO should be reduced to that extent and awarded to the other BHO. The total amount paid to the BHOs is not affected. Thus, the total amount paid to the BHOs is not a questioned cost in this audit.

Although the total amount paid to the BHOs is not affected, future funding might be affected. When ineligible individuals are included in the population, then the population is skewed and could affect assumptions made when determining the amount of the global budget paid to the BHOs in the future.

Under federal regulations 42 CFR 435.1008 and 1009, the state, not the federal government, is responsible for the health care costs of adult inmates.

In a letter of correspondence from the U.S. Department of Health and Human Services (HHS) to the Commissioner of the Department of Finance and Administration regarding the Single Audit of the State of Tennessee for the period July 1, 1998, through June 30, 1999, HHS stated:

We recommend 1) procedures be implemented to ensure capitation payments are not made [for] enrollees who become incarcerated and 2) the questioned cost be returned.

Based on discussions with TennCare's Director of Information Services, management's current policies still do not always prevent capitation payments from being made when enrollees are incarcerated and do not allow for recovery of capitation payments made for incarcerated adults. The policies include

- Management's policy decision not to disenroll any SSI (Supplemental Security Income) enrollees, until notification of death or proof that the individual has elected Medicaid coverage in another state. Testwork revealed that many of the individuals

noted in fact were not classified as SSI enrollees in TennCare's system. (See finding 6 for more details.) This situation was communicated to management during the last audit, but management has failed to address it.

- The inclusion of Section 2-7(c) of TennCare's contracts with the MCOs that prevents TennCare from making disenrollments retroactively "except for situations involving enrollment obtained by fraudulent applications or death." For example, if a person was incarcerated in June 1999 and TennCare was notified in September 1999, TennCare would only recover capitation payments made beginning September 1999, rather than going back to the exact date of incarceration in June.
- In May 2000, TennCare was placed under a temporary restraining order that prohibits TennCare from terminating or interrupting TennCare coverage for uninsured or uninsurable enrollees unless the enrollee has been afforded notice and an opportunity for a hearing in compliance with 42 CFR 431 E. In light of this order, TennCare does not rely upon its reverification process as a basis to terminate an individual. (See finding 6 for more information.)

In addition to TennCare's policy, current MCO contract language prevents total recovery of all capitation payments made to them in error. Current contract language with the MCOs allows TennCare to recover payments retroactively only in cases of an enrollee's death or if there has been fraudulent enrollment committed by the enrollee. The contracts, however, do allow for retroactive rate adjustments for up to one year.

Management's current policies do not include a data match to prevent or detect fee-for-service claims that were used to pay for incarcerated adults. The fee-for-service claims are paid based on the eligibility reported on TCMIS. If the eligibility information in TCMIS is not updated timely, then erroneous fee-for-service payments will be made.

### **Recommendation**

Under the leadership of the Director of TennCare, management should determine which payments, made on behalf of incarcerated adults, can legally be recovered and take the necessary steps to recover all such payments. The Director of TennCare should ensure that the methodology used to detect incarcerated adults and to prevent or recover future capitation payments for adult inmates ensures compliance with federal regulations. Also, the methodology used should include procedures to prevent or recover fee-for-service payments made to providers for adult inmates. In addition, the Director of TennCare should immediately follow up with HCFA to comply with HHS's recommendation. Management should also consider whether any action is necessary regarding the monthly allocation of funds between the BHOs.

TennCare should consider changes in the MCO contract language that would clearly allow full recovery of capitation payments for ineligible enrollees. If this is not practical, TennCare should develop a mechanism to identify these payments and use state dollars only to pay for incarcerated enrollees.

## Management's Comment

We concur in part. With respect to the auditors' judgment that the current MCO contract language should be changed relative to retroactive recoupments for capitation payments made in error, it is important to note that the current contract has been in existence for over 7 years and has received detailed scrutiny from all relevant agencies of the State, as well as federal government. We certainly believe there can be differences of opinion about the best way to pay for services in a managed care model. However, we believe the TennCare program should make the final decision on such matters and should follow the procedures outlined in the contract until there is a determination made that these procedures need to be changed.

TennCare relies on the Department of Correction to provide information as to who is and who is not incarcerated. We are working with the Department of Correction and the Program Integrity Unit of the Department of Finance and Administration, Office of Health Services to improve information sharing among our respective agencies. New reports and edits are being developed.

## Auditor's Comment

We agree that it is a management decision as to whether the MCO contracts should be amended to allow for retroactive recovery of payments for incarcerated adults. While it would appear that the state would not want to pay capitation payments to MCOs that would be incurring no expenses for incarcerated enrollees, there could be other reasons why the state would want to make these payments. However, as stated in the finding, these incarcerated adults are not eligible for the TennCare program according to the federal regulations. As a result, TennCare should not use federal funds, as they have, to pay for the health care costs of these individuals.

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**19. TennCare did not recover over \$800,000 of capitation payments and fee-for-service claims paid to managed care organizations and providers for deceased individuals**

## Finding

As noted in the prior two audits, TennCare has not ensured that adequate controls are in place to recover capitation payments made to the managed care organizations (MCOs) when an enrollee becomes deceased. In addition, TennCare has not ensured that adequate controls are in place to recover fee-for-service payments that are made to providers when an enrollee becomes deceased. Although management concurred with the prior finding and stated that procedures would be established to allow recoveries for capitation payments that exceed the 12-month reconciliation for identified deceased enrollees, no procedures were implemented to allow such a recovery.

Using computer-assisted audit techniques (CAATs), a search of TennCare's paid claims tapes and eligibility history file revealed that TennCare made payments totaling \$842,090 from July 1, 1999, through June 30, 2000, for which the date of death loaded on the TennCare Management Information System (TCMIS) was before the dates of service. Of this amount, \$581,700 was paid to MCOs and \$260,390 was paid for fee-for-service claims. Of the \$842,090 in payments, \$531,338 is federal questioned costs and the additional \$310,752 is state matching funds.

The fee-for-service payments are for services or medical equipment provided to TennCare enrollees. The fee-for-service claims are paid or denied based on recipient eligibility information listed on TCMIS. Based on discussions with management, the fee-for-service payments occurred because the date-of-death notification occurred after the date of the payment. For example, if an individual were to die on January 1, 2000, and TennCare paid for the use of durable medical equipment after the date of death but before it received a date-of-death notification, TennCare would be required to recover this payment. Although exception reports are produced that alert management of these payments, discussions with management revealed that the reports produced by the system do not include all the payments. According to Information Services staff, the recoveries for fee-for-service claims are performed manually, not automatically by the system. Not using TCMIS to automatically recover these payments increases the risk that payments might not be recovered. In addition, management stated that if more than a year were to pass before one of these payments were to be identified, then a recovery would never be made. Management could not explain why fee-for-service recoveries were not made automatically by the system or made retroactively past a year.

The capitation payments are made to the MCOs on behalf of TennCare enrollees to cover medical services. These capitation payments are generated electronically each month by TCMIS based upon the recipient eligibility information contained in the system. Fee-for-service claims are paid or denied based on recipient eligibility information contained in the system as well. If the eligibility information in TCMIS is not updated timely, then erroneous capitation and fee-for-service payments will be made. According to TennCare staff, often there can be delays in obtaining information about deceased individuals. Thus, it is important to retroactively recover payments when there is a delay in the death notification. However, the TCMIS is currently set up to recover payments retroactively to only 12 months before the date-of-death notification. Although TennCare does not always receive notification of date of death in a timely manner, timely reverification of eligibility would allow TennCare to detect a change in an individual's eligibility status. However, TennCare has not reverified the eligibility of enrollees timely (see finding 5 for more details).

When it takes over a year to detect an enrollee's death, TennCare does not recover all of the previous capitation payments or fee-for-service payments made for deceased individuals.

Testwork on recovery of payments after the date of death also revealed that TennCare had not recovered payments from the MCOs. We performed a data match between TennCare's paid claims tapes and information of the Office of Vital Records in the Department of Health. We

found \$3,287,906 in payments made on behalf of deceased individuals based on the Office of Vital Records. We selected a sample of 60 of these transactions to verify that these payments had been recovered. For 39 of 60 MCO capitation payments tested (65%), TennCare had not recovered the payment to the MCOs as of September 28, 2000. These individuals were deceased prior to the dates of service, and TennCare has not recovered the payments made on behalf of these individuals.

A total of \$8,546 was paid for these individuals. Federal questioned costs totaled \$5,392. The remaining \$3,154 was state matching funds. We believe that likely federal questioned costs associated with this condition could exceed \$10,000.

### **Recommendation**

The Director of TennCare and TennCare management should develop and implement effective controls to recover payments for individuals when the date-of-death notification occurs after the date of payment. In addition, the Director of TennCare should ensure that all capitation and fee-for-service payments made on behalf of deceased recipients are recovered back to the date of death.

### **Management's Comment**

We partially concur. We will review procedures over recovery of fee-for-service claims paid on behalf of deceased enrollees. We do not concur with the finding related to capitation payments. We will review the process of identifying deceased enrollees to minimize delays. However, some delays are inevitable. We believe the contract with the MCOs does not permit retroactive recovery of capitation payments for enrollees greater than twelve months. We will request an opinion from the Attorney General's office on this matter.

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**20. TennCare made payments on behalf of full-time state employees, resulting in federal questioned costs of \$367,476**

### **Finding**

TennCare paid over \$500,000 in capitation payments on behalf of full-time state employees who are classified as uninsured or uninsurable in the TennCare Management Information System (TCMIS). These payments were made because TennCare has not used controls to prevent or recover payments on behalf of state employees.

According to *Rules of the Tennessee Department of Health* 1200-13-12.02 (3)(b)(5), to be eligible for TennCare as an uninsured or uninsurable, an applicant "must not be eligible for participation in an employer sponsored health insurance plan, either directly or indirectly through

a family member.” Also, rule 1200-13-12-.02 (5)(b)(1) states that TennCare shall cease when “the enrollee becomes eligible for participation in an employer sponsored health plan, either directly or indirectly through a family member.” Management at TennCare has chosen not to use controls to prevent these payments because of the temporary restraining order that was in effect for part of the year ended June 30, 2000. However, the restraining order does allow the removal of enrollees who request to be disenrolled from TennCare. (See finding 6 for more information regarding the restraining order.) However, in not using controls to prevent payments, TennCare cannot ensure that it is following its own rules.

Using computer-assisted audit techniques to search TennCare’s paid claim records, testwork revealed that 852 uninsured and uninsurable TennCare participants were also full-time employees that were eligible for insurance through their employment with the State of Tennessee on the date of service. The auditors submitted the listing of the employees found to management of the Bureau of TennCare and requested management to show the auditors rules that would make these enrollees eligible. However, no such documentation was provided.

The total amount of capitation payments paid for the errors noted above was \$582,394. Federal questioned costs totaled \$367,476. The remaining \$214,918 was state matching funds.

### **Recommendation**

The Director of TennCare should ensure that procedures are developed and implemented to ensure that full-time employees of the State of Tennessee are removed from the TennCare rolls. The temporary restraining order does allow the removal of enrollees who request to be disenrolled from TennCare. The Director of TennCare should work with other state agencies to encourage employees to request removal from TennCare rolls.

### **Management’s Comment**

We concur. TennCare currently is operating under a temporary restraining order that does not allow us to terminate any uninsured/uninsurable member for any reason other than a voluntary termination per the member’s request or by death. We have worked diligently with the Department of Insurance with this endeavor. There have been many State employees who have wanted to terminate their coverage with TennCare in order to enroll in the State Insurance plan. All State employees must sign up for the State insurance within the first 30 days of their employment or they are not eligible for the State insurance. These employees would have to meet a qualifying event under HIPAA in order to enroll in the State insurance. It is the opinion of the Department of Insurance that voluntary terminations are not considered a qualifying event under HIPAA. Therefore, those State employees who voluntarily terminate their coverage with TennCare are still not being offered coverage under the State Insurance plan. We continue to work with the Department of Insurance in discussing and resolving this issue.

## Auditor's Comment

Further analysis of the listing of state employees that TennCare made payments for revealed that over 86% of the individuals identified in this finding had insurance through their employment with the state. Thus, it would appear for this group of individuals that obtaining a voluntary request for termination from TennCare would be easy because they already have insurance through their employment.

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### **21. TennCare continues to disregard its own rules regarding overpayments to providers and needs to improve processing of Medicare cross-over claims**

#### **Finding**

As noted in the four prior audits, TennCare has not complied with departmental rules, resulting in overpayments to providers caring for enrollees who are both TennCare and Medicare recipients. Management concurred with the prior finding and in February 2000 stated that TennCare staff will continue to review payment procedures that are not in accordance with departmental rules and will modify, as determined appropriate, the rules or the procedures to bring payment methods into compliance with departmental rules. According to the Chief Financial Officer, as of September 2000, TennCare is still researching the rules and has not determined whether or not it is more appropriate to change the rules or the computer system. This is the third year that management has given this same response. Furthermore, as noted in the prior three audits, TennCare has not corrected control weaknesses in processing the Medicare cross-over claims (claims paid partially by both Medicare and Medicaid). Management concurred with the prior finding and stated that it would implement procedures to ensure that the claims pricing and payment subsystem is routinely tested. However, no changes to procedures have been implemented to ensure that the claims pricing and payment subsystem is routinely tested nor have any other changes been made to correct the computer system control weaknesses in processing Medicare cross-over claims.

Medicare recipients are required to pay coinsurance and a deductible to the provider for services received. If the patient is also eligible for Medicaid, Medicare bills TennCare instead of the patient for the coinsurance and deductible. According to the *Rules of the Tennessee Department of Health*, Chapter 1200-13-1.05, the total amount paid by all parties (Medicare, patient, and TennCare) cannot exceed the fee limitations set by TennCare. This rule seems appropriate. Therefore, it appears that the systems rather than the rule should be changed. However, TennCare's computer system always pays the entire deductible or coinsurance billed for outpatient hospitalization services, regardless of how much Medicare or the patient paid or any limitations set by TennCare. In addition, the TennCare Management Information System (TCMIS) does not always ensure that claims from ambulance services, anesthesiologists, clinical psychologists, clinics/groups, and claims for durable medical equipment (DME) from other out-of-state providers comply with this rule. The total amount of all expenditures for professional and

institutional cross-over claims during the year ended June 30, 2000, was approximately \$73 million.

Testwork revealed that for 14 of 25 Medicare professional cross-over claims tested (56%) payments exceeded the maximum allowable. The 25 claims totaled \$439.95, and \$252.56, or 57%, was unallowable. TennCare's payments of \$252.56 exceeded the maximum amount allowed according to the Medicaid Fee Schedule and the rule stated above. Federal questioned costs totaled \$159.36. The remaining \$93.20 consisted of state matching funds. During the year ended June 30, 2000, TennCare paid \$46,706,907.05 for Medicare professional cross-over claims. We believe likely questioned costs associated with this condition exceed \$10,000.

In addition, the following control weaknesses were noted:

- Although professional cross-over claims from psychologists and social workers have been Medicaid-eligible since the late 1980s, these claims are to be denied if the recipients have other insurance (third-party resources). OMB Circular A-133 requires that "states must have a system to identify medical services that are the legal obligation of third parties." However, TCMIS has not been updated to detect third-party resources on these cross-over claims. Testwork on samples of claims with third-party resources revealed that 16 of 25 social workers' claims (64%), 20 of 25 clinical psychologists' claims (80%), and 20 of 25 other out-of-state provider claims (80%) were paid that should have been denied or reduced due to the availability of third-party resources. Auditor testwork also revealed claims from other out-of-state providers (i.e., durable medical equipment [DME] suppliers) were not being denied or reduced when third-party resources were available. Because insurance plan benefits differ, we could not determine the amount of questioned costs associated with this condition.
- TennCare's policies and procedures manual for pricing cross-over claims is not adequate. Our review of the pricing manual revealed that it does not contain sufficient detail to allow a relatively inexperienced individual to price cross-over claims.
- Despite the complex nature of claims processing, Bureau staff do not routinely perform manual pricing tests to determine if the system is paying claims correctly for institutional cross-over claims. Bureau staff indicated that they perform pricing tests on professional cross-over claims. However, documentation to support the assertion that such claims have been manually priced was not maintained by the Bureau.
- Auditor inquiry revealed that staff at the TennCare Bureau did not have sufficient knowledge of the rules and regulations pertaining to TennCare's financial obligation and responsibility for Medicare cross-over claims to develop effective policies and procedures. In addition, no staff at the TennCare Bureau were assigned responsibility to monitor changes in laws and regulations regarding Medicare cross-over claims.
- Auditor inquiry revealed that system documentation was inadequate to determine why error code 181, "Invalid Coinsurance Amount," occurs on both professional and institutional cross-over claims. Although TennCare Bureau staff override this error

code and manually price the claim, staff were not knowledgeable as to why the error codes occur.

### **Recommendation**

The Director of TennCare should thoughtfully review these long-standing conditions and determine why staff have not carried out actions which have been promised in prior responses to these findings. He should decide what action is necessary to ensure compliance with its own rules and then make the necessary changes to the TCMIS to bring the method of payment into compliance with departmental rules. The Director of TennCare should ensure that TCMIS has been updated to detect third-party resources on cross-over claims and should ensure that TennCare's policies and procedures regarding cross-over claims are adequate. Management and staff should keep abreast of new and changing program requirements and should ensure that the Bureau's policies, procedures, and computer systems are updated timely to reflect new developments. Also, the Director of TennCare should ensure that the claims pricing and payment subsystem of TCMIS is routinely tested and that documentation of the testing of these claims is maintained. The Director of TennCare should ensure that the staff responsible for overriding error codes are aware of why the errors occur and that the system documentation for the codes is adequate.

### **Management's Comment**

We concur for the audit period in question, although we have taken steps in recent months to improve these processes. In late November a rule was drafted which stated that the total amount paid by a combination of Medicaid as deductible and coinsurance shall not exceed the amount Medicaid otherwise would have paid for the covered service, or, where there is no Medicaid fee schedule, reasonable billed charges. This proposed rule will be presented at a hearing on April 16, 2001. We will review the third party liability issues surrounding cross-over claims noted in this finding.

A Policy staff person has been identified as the person responsible for monitoring changes in Medicare laws that may impact TennCare, including payment of crossover claims. With respect to adequate system documentation, we will address this issue during the course of the Information Systems overhaul described elsewhere in this document.

The Provider Relations Unit's policy and procedure manual is now complete. It includes instructions for pricing and/or the reimbursement methodologies used to calculate TennCare's payment amount for crossover claims. In addition, the Provider Relations Unit is now ordering CPX-50s from the Medicaid fiscal agent to manually price a sample of claims set to pay on the provider's weekly remittance advice. This review allows staff to verify that TennCare's payment amounts are correct.

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**22. TennCare did not require contractors and providers to make necessary disclosures concerning suspension and debarment**

**Finding**

The Bureau of TennCare did not require all providers of goods and services with contracts with TennCare equal to or in excess of \$100,000 and all others involved in nonprocurement transactions to certify that their organization and its principals are not suspended or debarred from a government program. Testwork revealed that 4 of 21 contracts with nongovernmental entities (19%) did not include the suspension and debarment certification. In addition, the Division of Mental Retardation within the Department of Finance and Administration did not require providers to certify that their organization and its principals are not suspended or debarred.

According to the Office of Management and Budget “A-133 Compliance Supplement,” which references the *Code of Federal Regulations*, Title 45, Part 76,

Non-Federal entities are prohibited from contracting with or making subawards under covered transactions to parties that are suspended or debarred or whose principals are suspended or debarred. Covered transactions include procurement contracts for goods or services equal to or in excess of \$100,000 and all nonprocurement transactions. . . . Contractors receiving individual awards for \$100,000 or more and all subrecipients must certify that the organization and its principals are not suspended or debarred.

Because the Bureau does not always require contractors and providers to certify that their organization and its principals are not suspended or debarred, the Bureau would not know if it had contracted with suspended or debarred parties.

**Recommendation**

The Director of TennCare should require all providers of goods and services with contracts with TennCare equal to or in excess of \$100,000 and all others involved in nonprocurement transactions to certify that their organization and its principals are not suspended or debarred from a government program. In addition, the Director of TennCare should ensure that the Division of Mental Retardation requires its providers to certify that they have not been suspended or debarred.

**Management’s Comment**

We concur. The Bureau will ensure that contractors provide certifications related to suspension and debarment. We will work with the Division of Mental Retardation on compliance with this area.

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**23. Controls over access to the TennCare Management Information System need improvement**

**Finding**

As noted in the prior two audits, one of the most important responsibilities, if not the most important, for the official in charge of an information system is security. The Director of TennCare is responsible for, but did not ensure that, adequate TennCare Management Information System (TCMIS) access controls were in place during the audit period. As a result, deficiencies in controls were noted during system security testwork.

In a letter of correspondence from the U.S. Department of Health and Human Services (HHS) to the Commissioner of the Department of Finance and Administration regarding the Single Audit of the State of Tennessee for the period July 1, 1998, through June 30, 1999, HHS stated:

This is a material instance of noncompliance and a repeat finding. We recommend procedures be strengthened to ensure access to the TennCare Management Information System is safeguarded.

The TCMIS contains extensive recipient, provider, and payment data files; processes a high volume of transactions; and generates numerous types of reports. Who has access, and the type of access permitted, is critical to the integrity and performance of the TennCare program. Good security controls provide that access to data and transaction screens be limited to a “need-to-know, need-to-do” basis. When system access is not properly controlled, there is a greater risk that individuals may make unauthorized changes to the TCMIS or inappropriately obtain confidential information, such as recipient social security and Medicaid identification numbers, income, and medical information. Audit testwork revealed the following discrepancies.

**Justification Forms Not Obtained for Existing Users**

Access to TCMIS is controlled by Resource Access Control Facility (RACF) software. The purpose of RACF is to prohibit unauthorized access to confidential information and system transactions. The TennCare security administrator in the Division of Information Services is responsible for implementing RACF, as well as other, system security procedures.

The security administrator assigns a “username” (“RACF User ID”) and establishes at least one “user group” for all TennCare Bureau and TCMIS contractor users. User groups are a primary method by which RACF controls access. Each member of a user group can access a set of TCMIS transaction screens.

On July 12, 1999, TennCare started requiring standardized justification forms to be filled out by all new users to TennCare’s system. TennCare required new users to justify their reasons for access to TennCare’s system. Although management concurred with the prior finding, the

security administrator has not required existing users prior to July 12, 1999, to fill out Justification for TennCare Access Forms documenting the type and level of access requested as well as reasons why access was required. Although it was recommended in the prior audit finding, TennCare's security administrator stated that forms had not been obtained for all existing users because she was not instructed to obtain these forms. As a result, testwork revealed that 52 of 60 users tested (87%) did not have Justification for TennCare Access Forms properly filled out and completed. Of the 52 users, TennCare did not obtain justification forms for 50 of the users. Not requiring existing users to sign Justification for TennCare Access Forms makes it more difficult to monitor and control user access. For example, it is not possible to compare the type and level of access needed and requested with the type and level of access given.

#### Unnecessary Access to TCMIS

User access testwork revealed as it did in the prior audits, that all users in the default group (a group automatically assigned to all Department of Health and TennCare RACF users) had the ability to update at least two screens. This could be accomplished by typing over the "function" field and replacing INQ (inquiry) with CHG (change). Then the user could make changes to the screens and press a particular function key to update. Management sent a work request to the contractor, EDS, on August 11, 1999, to explore the problem. Management concurred with the prior audit finding and stated that Information Services is currently in system testing with the facilities manager contractor to correct function deficiency which allows inappropriate access. However, as of September 18, 2000, the EDS had not completed the work.

#### Security Administration Not Centralized

Testwork also revealed that the security administrator for the Department of Health, who is separate from TennCare's security administrator, has the ability to give users access to TCMIS. Management concurred with the prior audit finding and stated that only the TennCare security administrator can now authorize access to the TCMIS. However, management's assertion to the auditors in response to the prior audit finding was incorrect. An examination of usage logs revealed that there were at least five occasions where the Department of Health administrator acted before consulting TennCare.

Furthermore, if users' RACF user names expire, the TennCare security administrator can reinstate the access of users given by the Department of Health security administrator, and vice versa. When access to TCMIS is decentralized, it is more difficult to monitor and control. Auditors discussed this issue with the statewide RACF system security administrator in the Office of Information Resources. The administrator stated that this access could easily be removed, but that they just need an e-mail request from management from the Bureau of TennCare to remove this access.

In addition, the Department of Health default group to which the Department of Health's security administrator can add people has access to 89 TCMIS screens. Thus, the Department of Health security administrator has the ability to add users to TCMIS transactions without notifying TennCare's security administrator.

## **Recommendation**

The Director of TennCare should ensure that the standardized authorization forms are obtained for all current and future users that have access to TCMIS. Access levels for all screens should be reviewed to guarantee that only authorized users have the ability to make changes. Responsibility for TCMIS security should be centralized under the TennCare security administrator. In addition, Director of TennCare should ensure that information given to auditors is correct. A request should be sent to the statewide RACF security administrator to request that the Department of Health Security Administrator's ability to add and change users on TCMIS be removed. TCMIS transactions in the Department of Health default group should be removed.

## **Management's Comment**

We partially concur with these audit findings.

1. TennCare Information Systems will continue coordinating efforts to ensure that proper access forms are obtained for all TennCare and other users who require interaction with the TennCare system. Since standard forms were developed, TennCare has required all new users and supervisors to complete the standard forms. The TennCare Information Systems security administrator has been working with all existing users of the system since last year's audit findings to obtain completed forms from users and supervisors.
2. Access levels for all screens are authorized to users and supervisors based upon security level access requested by business user group supervisors. TennCare Information Systems has initiated systems maintenance requests to the TennCare facilities manager concerning identified access issues.
3. Centralization of TCMIS security under TennCare Information Systems' security administrator was implemented as of November 3, 2000.
4. On November 3, 2000, TennCare sent a request to the statewide RACF security administrator requesting that the Department of Health Security Administrator's ability to add and change users on the TCMIS be removed. TCMIS transactions in the Department of Health default group were removed at that time.

## **Auditor's Comment**

It is not clear from management's comment with which part(s) of the finding they do not concur. It should be noted that the actions taken by management as described in their comments had not occurred at the time of audit fieldwork. We will follow up in the next audit to verify that the actions listed by management have been taken.

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**24. TennCare should ensure adequate contracts and effective monitoring of contracts**

**Finding**

As noted in the previous audit, the Bureau of TennCare needs to ensure adequate contracts and effective monitoring of contracts. Management responded to the portion of the prior-year finding related to the lack of an interdepartmental contract with the Department of Commerce and Insurance by stating that one would be developed; however, an interdepartmental contract has not been established as of October 26, 2000, because, according to TennCare staff, they have not had time. In accordance with the TennCare Waiver, the Department of Commerce and Insurance, TennCare Examiners Division, is responsible for conducting examinations of managed care organizations (MCOs) and behavioral health organizations (BHOs) that contract with the Bureau of TennCare. Commerce and Insurance conducts these examinations of MCOs and BHOs to ensure financial viability and compliance with statutory and contractual provisions, and rules and regulations. The scope of services provided by Commerce and Insurance includes financial review, complaint negotiation, claims process monitoring, and assessments of financial position. Although Commerce and Insurance is performing these services, which are completely funded by the TennCare program, testwork revealed that the Bureau of TennCare has not initiated an interdepartmental contract with the Department of Commerce and Insurance.

The Bureau of TennCare also has a cooperative agreement with the Department of Human Services (DHS) for the determination of Medicaid eligibility. This agreement has not been revised or amended since October 1969, when the original agreement started. The TennCare program was implemented in January 1994 after the state obtained a waiver from the federal Health Care Financing Administration, which allowed the state to replace its basic Medicaid program (Medical Assistance Program) with a managed care system. Since the agreement has not been revised or amended since 1969, the unique features of the TennCare program are not included in the agreement. Furthermore, the cooperative agreement does not provide sufficient detail to ensure that all parties are fully informed of the relevant scope of services and related responsibilities. The agreement states that the Department of Public Welfare (currently known as the Department of Human Services) assumed responsibility for “the determination of eligibility” for Medicaid recipients. However, the agreement does not provide details concerning which policies, standards, or methods should be used to make the eligibility determinations. In response to this portion of the prior-year finding, management stated that they would update interagency agreements between state agencies to reflect the needs of the current program. However, this has not been done because, according to TennCare staff, they have not had time.

Testwork also revealed that the Bureau’s controls over the monitoring of contracts is inadequate. Although management responded to the prior-year finding by indicating that TennCare would review contracts that have not been monitored and determine the most appropriate monitoring efforts, the Bureau has not implemented written policies and procedures to monitor the Bureau’s contracts. This was due in large part because TennCare did not assign responsibility for monitoring these contracts until October 2000. In addition to the Commerce

and Insurance arrangement, the Bureau contracts with other entities, including state departments, to assist with the TennCare program. As noted in other findings, the Bureau does not have effective monitoring procedures to ensure contract compliance. Examples of these contracts and agreements include the following:

- an agreement with the Department of Commerce and Insurance to conduct examinations of the MCOs and BHOs to ensure financial viability and compliance with statutory and contractual obligations;
- a contract with the Comptroller of the Treasury, Medicaid/TennCare Division, to establish reimbursable cost rates for the Tennessee Medicaid Title XIX and the TennCare Waiver Programs;
- a contract with First Mental Health Incorporated to provide external reviews to monitor quality assurance;
- a contract with the Department of Children's Services to provide non-medical treatment and case management services;
- a contract with the Department of Human Services to provide Medicaid eligibility determinations;
- a contract with the Department of Health's Office of Health Licensure and Regulation to certify healthcare facilities;
- a contract with the University of Tennessee-Memphis and Erlanger Medical Center / T.C. Thompson Children's Hospital in Chattanooga to conduct a high-risk regional perinatal program; and
- a contract with East Tennessee State University in Johnson City, Meharry Medical College in Nashville, University of Tennessee-Memphis, and Vanderbilt University in Nashville to provide graduate medical education.

Without effective monitoring procedures, the Bureau cannot ensure that compliance requirements of the contract are met.

### **Recommendation**

The Bureau of TennCare should establish an interdepartmental contract with the Department of Commerce and Insurance to formally document the existing agreement between the two departments. The Director of TennCare should revise the cooperative agreement with DHS to ensure that all parties are fully informed of the scope of services and specific responsibilities. In addition, this agreement should be revised to reflect the TennCare program and the rules that govern the program. The Director of TennCare should also develop and implement written policies and procedures to monitor contracts.

## Management's Comment

We concur. Each contract has been assigned to a specific individual within the Bureau. This will be a priority in the coming year.

We concur. TennCare executed a NEW contract with Health Services Advisory Group (HSAG) to provide external reviews and to monitor quality and contractual standards for MCOs and BHOs. This contract is now in force. Site visits to all the MCOs are being planned.

While the Bureau of TennCare concurs on this finding for the audit period ending June 30, 2000, we have during the current fiscal year identified a specific staff member to work with TennCare staff, DCS, and F&A Monitors with regards to monitoring DCS' compliance with their current Contract and in addition, will be drafting DCS' 2001 Contract.

The Bureau will review the agreement with DHS and initiate an agreement with Commerce and Insurance. It is not anticipated that these will be completed before the end of FY 2001.

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### 25. As required by law, fraud should be reported to the Comptroller of the Treasury

#### Finding

TennCare did not report an instance of fraud to the Comptroller of the Treasury as required by law. During the audit, it was determined that on July 9, 1999, the Office of Audit and Investigations with the Department of Health had received information that a TennCare clerk with the Bradley County Health Department had committed fraud and forgery in submitting several TennCare applications for herself; her husband, who was in jail at the time; and a friend. The TennCare application review process rejected the husband's application because TennCare staff determined that he was in jail at the time and thus not eligible. However, the applications for the clerk and her friend were accepted because the clerk had falsified the related supporting documentation for those applications. Her falsified documentation included forged signatures. To conceal her actions, the clerk did not record the applications for TennCare on the TennCare enrollment log maintained at the Bradley County Health Department.

The state paid capitation fees to a TennCare managed care organization (MCO) on behalf of the clerk and her friend totaling \$1,662 before their ineligible status was discovered. This matter was properly referred for prosecution, which is still pending. However, the department failed to promptly notify the Comptroller of the Treasury. Section 8-19-501, *Tennessee Code Annotated*, states:

It is the duty of any official of any agency of the state having knowledge of shortages of moneys of the state, or unauthorized removal of state property,

occasioned either by malfeasance or misfeasance in office of any state employee, to report the same immediately to the comptroller of the treasury.

The purpose of the statutory requirement to notify the Comptroller is to ensure a thorough investigation and an appropriate resolution in the best interest of the state.

### **Recommendation**

The Director of TennCare should ensure that all instances or suspected instances of fraud are immediately reported to the Comptroller of the Treasury.

### **Management's Comment**

We concur. On July 9, 1999, the fraud incident was reported at a local Health Office. Audit and Investigations did not have in place a formal system of reporting instances of employee misconduct. Effective September 2000, the Office of Audit and Investigations began logging and reporting all suspected employee misconduct resulting in a loss of state resources. Further, written procedures have been developed and implemented for reporting suspected employee misconduct in collaboration with fiscal officials within the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation and the Bureau of TennCare.

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## **26. TennCare committed funds without approval**

### **Finding**

As noted in the prior audit, the Bureau of TennCare began making payments to the Department of Children's Services before it had a contract with the Department of Children's Services to provide services. A contract should serve as the legal instrument governing the activities of TennCare as they relate to the Department of Children's Services and would specify the scope of services, grant terms, payment terms, and other conditions. Management concurred with the prior finding and stated that they were working with the Department of Children's Services to get a signed contract and would make every attempt to have contracts signed prior to services being delivered. A contract between the Department of Finance and Administration, Bureau of TennCare, and the Department of Children's Services was not executed for the period July 1, 1999, through June 30, 2000, until May 24, 2000. TennCare paid the Department of Children's Services over \$102 million for the period July 1, 1999, through June 30, 2000. Not having an executed contract in place at the beginning of the fiscal year can lead to confusion between the parties regarding the scope of services, grant terms, payment terms, and other conditions.

## **Recommendation**

The Deputy Commissioner for the Department of Finance and Administration, Office of Health Related Services, should ensure that a contract between the Department of Finance and Administration, Bureau of TennCare, and the Department of Children's Services is in place at the start of each fiscal year before services are provided.

## **Management's Comment**

We concur. We will make every effort to have the interdepartmental agreement with DCS signed before implementation.

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### **27. TennCare has not ensured adequate monitoring of the graduate medical schools**

#### **Finding**

As noted in the previous two audits, TennCare has not monitored the graduate medical schools to ensure that requirements related to graduate medical education (GME) payments are met, nor has TennCare advised the graduate medical schools of the audit requirements of subrecipients. Management concurred with the previous year's audit finding and stated that the Bureau would advise the subrecipients of the audit requirements for subrecipients of federal funds. However, the Bureau did not advise the medical schools of the audit requirements as required by Office of Management and Budget (OMB) Circular A-133. Management also stated that the medical schools were included in the contract-monitoring plan submitted to the Department of Finance and Administration (F&A) in accordance with Policy 22. The current year's GME contracts were included in the interdepartmental agreement with F&A's Division of Resource Development and Support (RDS) to perform the contract monitoring. Although RDS has performed some monitoring duties for the year ended June 30, 1999, it has not begun monitoring the medical schools for the year ending June 30, 2000.

GME payments are made to the state's four graduate medical schools: (1) the University of Tennessee at Memphis, (2) Vanderbilt University, (3) Meharry Medical College, and (4) East Tennessee State University. The GME payments consist of two components: a primary care allocation component and a resident stipend component. The amount of each school's primary care component is awarded to residents in family practice, internal medicine, pediatrics, or obstetrics during the year of residency, for which the school ensures that the dollars follow the students to their training sites. Under the stipend component, the residents agree to serve TennCare enrollees in a "Health Resource Shortage Area" of Tennessee. During the year ended June 30, 2000, GME expenditures were approximately \$46 million.

The activities of RDS do not supplant the primary responsibilities of the agencies the division is serving. It is still the primary responsibility of the Bureau to ensure compliance with applicable rules. If the division is not effective in its monitoring, the Bureau must take other steps to meet these responsibilities.

The contract between TennCare and RDS does not require RDS to perform all the procedures needed to ensure adequate monitoring of the medical schools. Some examples of the deficiencies in the contract between TennCare and RDS include the following:

- The lists of residents used to determine the primary care component are inaccurate. The lists of residents are used to calculate the payments to the medical schools. By not verifying the lists of residents, TennCare cannot ensure that it is paying the schools the correct amount.
- The graduate medical schools have taken appropriate action to correct federal noncompliance audit findings. Neither TennCare nor F&A has received audit reports from the graduate medical schools; therefore, they cannot determine if the schools have taken the necessary action to correct audit findings as required by OMB Circular A-133.
- The students stay in the stipend program for the required number of years and serve the stipulated population. If TennCare does not ensure that the students serve the required amount of time, then the medical schools and the students could receive funds to which they are not entitled.

OMB Circular A-133 requires TennCare to monitor subrecipients' activities to provide reasonable assurance that the subrecipients administer federal awards in compliance with federal requirements. OMB Circular A-133 also requires TennCare to ensure that required audits are performed and that subrecipients take prompt corrective action on any findings.

The department cannot determine subrecipients' compliance with applicable regulations if appropriate monitoring procedures are not performed and required audits are not obtained. Furthermore, funds could be used for objectives not associated with the grant, and subrecipient errors and irregularities could occur and not be detected.

### **Recommendation**

The Director of TennCare should immediately advise the graduate medical schools of the audit requirements for subrecipients of federal funds and determine why this step was not taken as was indicated in the prior audit. TennCare should adequately inform RDS of all the areas that are required to be monitored and require RDS to perform these monitoring duties in addition to the monitoring duties stated in the interdepartmental agreement and insist on evidence that the monitoring was performed timely and adequately. All monitoring should be sufficiently documented, and deficiencies should be promptly reported to the graduate medical schools. TennCare should also require the schools to submit corrective action plans.

## Management's Comment

We concur in part. Monitoring reviews of the four graduate medical schools for the fiscal year ending June 30, 1999 were performed by Finance and Administration, Division of Resource Development and Support, Office of Program Accountability Review (PAR) during the year ended June 30, 2000 and reports were issued shortly thereafter. During the current fiscal year, PAR has performed one review and will complete the three remaining reviews by the end of the year. While a timeframe for the completion of these monitoring reviews is not mandated, we consider their timeframes for completion of reviews reasonable.

Currently there are nine individuals participating in the stipend program, three of which are still enrolled in medical school. During the fall of 2000, TennCare contacted each of the active providers by letter and requested pertinent information regarding their practice to ensure each was complying with the terms of the stipend program. However, consideration will be given as to whether additional review is needed by PAR and, if deemed appropriate, the contract will be amended.

Although TennCare does receive the Single Audit Report for the State of Tennessee, which includes audit findings for the University of Tennessee and East Tennessee State University, two of the four GME contractors, we will review the GME and PAR contracts and revise where necessary to ensure compliance with A-133 requirements. In addition, corrective action plans will be requested as appropriate from the GME contractors.

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### 28. **TennCare needs to improve policies and procedures for accounts receivable**

#### Finding

As noted in the two prior audits, TennCare has not established adequate overall policies and procedures for accounts receivable. Management concurred with the prior-year finding and stated, "Policies and procedures are being developed to include monitoring, collecting, writing off, and recording in STARS the TennCare accounts receivable. . . ." Management also stated that they would "work with other state agencies to document the establishment of accounts receivable at year end." However, testwork for the third straight year revealed a continued inadequacy of policies and procedures.

Accounts receivable policies and procedures that were developed in response to the prior audit consisted of brief general statements of the methods of calculating the amounts to be included in the State of Tennessee Accounting and Reporting System (STARS). There were no written procedures for monitoring, collecting, or writing off any of TennCare's receivables.

Management stated that the organization's policies and procedures were the same as those described in *Rules of the Department of Finance and Administration*, and therefore they did not

need additional policies and procedures. However, as noted below, they did not follow *Rules of the Department of Finance and Administration*, Division of Accounts, Chapter 0620-1-9, entitled “Policies and Procedures Governing the Write-Off of Accounts Receivable.” Furthermore, these rules are very general and do not tell how gross and net receivable amounts are determined as well as how to determine the amounts to be reported.

TennCare’s failure to comply with *Rules of the Department of Finance and Administration*, Division of Accounts, Chapter 0620-1-9, is demonstrated in the area of cost settlement accounts receivable. In accounting for these receivables, the Bureau still failed to comply with the requirement for the establishment of an “Allowance for Estimated Uncollectibles where appropriate,” since there was no allowance for estimated uncollectibles. In addition, the rule that “a certain length of time must pass before an account is considered uncollectible” was violated. The average age of “active” cost settlement accounts receivable was approximately four years, according to TennCare’s records. Furthermore, testwork and discussions with TennCare fiscal staff revealed that there was no “minimum age” rule regarding consideration of accounts for write-off.

TennCare also violated provisions of Chapter 0620-1-9 in the area of premium accounts receivable. An allowance for uncollectible accounts was not established. A \$15 million audit adjustment was made for the State of Tennessee Comprehensive Annual Financial Report to reflect the uncollectible accounts that were not recorded on STARS. In addition, TennCare violated the chapter in the area of drug rebate receivables, since an aging of the accounts was not performed.

Testwork again revealed several discrepancies in the controls over enrollee premiums receivable. Premiums are collected from enrollees who are classified as uninsured and uninsurable. These enrollees are required to pay premiums in order to receive health services under the program. TennCare is responsible for maintaining the enrollee’s premium account and for determining the applicable monthly premium amount based on an enrollee’s income and family size. Testwork revealed that TennCare still has the following inadequate controls to ensure the accuracy of premium reporting:

- The TennCare Bureau prepares a cumulative premium report each month to track the total premiums billed to enrollees, the total amount remitted by enrollees, the total amount due from enrollees, and the total premium statements mailed to enrollees for each month. Management uses this report to develop premium estimates for financial reporting purposes. Our review of this cumulative report revealed several inconsistencies that jeopardize the reliability of this report. The report provided to the auditors during this audit period contained differences from the report used in the prior audit. For example, the amount of premiums billed for the month of January 1994 was different on the two reports. Although the amount should not have changed, the report auditors received in 2000 showed January 1994 billings as \$485,444.08, and the 1999 report showed January 1994 billings as \$485,645.03. Such an inconsistency, while immaterial, shows that the report is unreliable. Management indicated that this difference was the result of computer programming errors.

- In addition, the column that summarizes total due from enrollees reported balances when, in fact, management had written off these receivable balances. Management indicated that this difference was the result of computer programming errors.
- There are no written procedures for the comparison of a list of deposits prepared by the fiscal agent Electronic Data Systems (EDS) with STARS transactions listings. Not having written procedures results in a review that is not consistently documented.
- TennCare management does not perform analytical procedures on projected enrollee premium income on a month-to-month basis. By not performing such an analysis, TennCare cannot ensure that all individuals who are required to pay premiums are actually billed and that all premiums billed are accurate. For example, TennCare does not compare enrollment to the total amount billed.
- Testwork revealed that TennCare was not properly verifying and reverifying eligibility for the purpose of premiums (see finding 5 for more information). Therefore, proper premiums may not be charged to enrollees.

### **Recommendation**

The Director of TennCare should ensure that policies and procedures for overall accounts receivable and premium functions are completed and implemented. In addition, the Director of TennCare should strengthen controls over premiums for the uninsured and uninsurable enrollees. Controls should include accurate premium reporting, analytical review, and proper write-off of uncollectible premiums receivable. Furthermore, TennCare's management should establish an estimate for uncollectible accounts where appropriate, establish a specific length of time that must pass before an account is deemed uncollectible, and perform an aging for all accounts receivable.

### **Management's Comment**

We concur. Policies and procedures are being developed to include monitoring, collecting, writing off and recording in STARS the TennCare accounts receivable, which includes premium collections. TennCare staff will work with other agencies to document the establishment of accounts receivable at year end. TennCare will review the current controls and procedures relative to premium reporting.

## **29. Policies and procedures for accrued liabilities still need improvement**

### **Finding**

As noted in the prior two audits, TennCare's policies and procedures for accrued liabilities were not adequate. Due to these inadequacies, numerous deficiencies in TennCare's accrued

liability records were noted. Management concurred with the prior finding and stated that these policies and procedures were “being developed.” In addition, they stated that they would “work with other state agencies to document the establishment of accrued liabilities at year end,” and that they would “net accounts receivable and accrued liabilities only when deemed necessary.” Testwork revealed that policies and procedures for accrued liabilities remain inadequate. Furthermore, improper netting of cost settlement accounts receivable and accrued liabilities was again discovered, along with other problems which could have been prevented by the development and implementation of proper policies and procedures for accrued liabilities.

Testwork revealed that, as during the period following the first finding in this area in 1998, no work had been performed by TennCare management regarding the development of formal written policies and procedures for accrued liabilities. Management produced documents describing in general, on one page, the procedures used at year-end to compile the accrued liabilities amounts. However, there are no policies regarding the netting of accrued liabilities and accounts receivable or other questioned practices as discussed below. These procedures for accrued liabilities were inadequate and allowed improper accruals. All of these matters had been discussed with management in detail over the past two audits, so the issues should be clear. Specifically, testwork revealed the following:

- For the year ended June 30, 2000, the accrued liabilities for Long-Term Care – General, HCBS Waiver – Senior, and Skilled Nursing Facilities were improperly calculated by simply subtracting actual expenditure amounts from budget amounts, and then adding remaining amounts from prior-year under- and overaccruals to obtain current-year accrued liabilities. TennCare personnel followed the procedure prescribed by management for the calculation; however, as previously discussed with management, this practice does not meet the definition of the accounting term “liability.”
- Accrued liabilities for Long-Term Care Mental Retardation (Private) were overstated by approximately \$5.4 million because, according to management’s orally communicated instructions, the liability was to be stated as the sum of checks written on June 29, 2000, and physically released to providers after July 1, 2000, for services to be performed in July of the same calendar year. Properly written policies and procedures for accrued liabilities would have prevented this improper accrual.
- Improper netting of accounts receivable and accrued liabilities was repeated in the year ended June 30, 2000. TennCare again miscalculated the managed care organization (MCO) capitation accrued liability as the sum of MCO New Claims and MCO Withholding. The sum of the two amounts, in some cases, was a negative number, indicating that the MCO owed money to TennCare at the end of the fiscal year. When the sums were added, resulting in the amount called the MCO capitation accrued liability for fiscal year 2000, an improper netting of accounts receivable and accrued liabilities was the result. In this manner, TennCare understated accrued liabilities by approximately \$1.1 million. As in the cases discussed above, and as previously stated to management, properly written and implemented policies and procedures regarding accrued liabilities could have prevented this error.

Proper accounting policies and procedures ensure compliance with generally accepted accounting principles and that the financial information used for decision-making and state and federal reporting is accurate.

### **Recommendation**

As previously stated in the prior two audits, the Director of TennCare should ensure that policies and procedures for accrued liabilities are written and implemented and should ensure that the Fiscal Director obtains accurate and sufficiently detailed supporting documentation for amounts that will be recorded in the State of Tennessee Accounting and Reporting System. In addition, the Fiscal Director should ensure that liabilities accrued by his office are carefully prepared and reviewed to ensure compliance with generally accepted accounting principles.

The Fiscal Director also should ensure that receivables and payables (liabilities) are accounted for separately and consistently. Amounts should be netted on an individual provider or account basis only.

### **Management's Comment**

We concur. Policies and procedures are being developed to ensure accrued liabilities are adequately documented before recording in STARS. TennCare staff will work with other state agencies to document the establishment of accrued liabilities at year-end.

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## **30. Controls over checks should be strengthened**

### **Finding**

As noted in the prior audit, the TennCare Bureau needs to improve controls over manual and system checks. For the year ended June 30, 2000, these checks totaled over \$3.9 billion.

Management concurred with the prior audit finding and stated that they would monitor the fiscal agent to ensure adequate segregation of duties. However, based on conversations with management, this monitoring was not performed. Testwork revealed that the segregation of duties is still not adequate and the controls are still weak. Electronic Data Systems (EDS), the fiscal agent, is responsible for preparing the checks. However, EDS has not established adequate controls over checks. The following deficiencies were noted:

- Physical security over the manual and system check stock is compromised because the room key and the key logs are not kept together. The key could be obtained without anyone signing the log. The *Tennessee MIS Financial Procedure Manual*, Section K (Check Storage and Check Logs), states that the log and key to the vaults are to be kept together at all times.

- EDS does not record receipt of blank system checks for accountability. The *Tennessee MIS Financial Procedure Manual*, Section K (Inventory and Control of Checks), part D, states that a “blank stock check log” is to be used “to establish control for blank check stock received from the vendor. A clerk and witness will store blank checks received from the vendor in the vault and complete the Blank Stock Check Log.” Not recording the receipt of blank system checks makes it more difficult to conduct physical check inventories and to monitor and investigate checks.
- Systems check logs were not reconciled to the TennCare Management Information System (TCMIS) to ensure that all checks were accounted for properly.
- Although EDS employees indicated that they perform an inventory of checks, such inventories are not documented. *The Tennessee MIS Financial Procedure Manual*, Section K (Inventory and Control of Checks), “Maintaining Check Stock,” states that “an inventory of all checks will be maintained.”
- EDS does not reconcile the manual check log to checks that are completed to ensure that all checks are accounted for. There is a possibility that a manual check could be completed that does not show up on the check log. Without reconciliations, the unlogged check could go unnoticed for an extended period of time.
- Testwork revealed that because of a system error, a manual check was issued without being entered into the Basic Accounting Reconciliation System (BARS), causing the check not to be included on the TCMIS check register report. When this occurs, there is a possibility that an unauthorized manual check could be issued without detection.
- The individual who manages the checks and the key logs has the potential to control the whole manual check process. This person is responsible for the strong box, which includes the rubber stamp and partially completed checks.

These weaknesses in controls over checks could permit an individual to gain access to checks without detection. In addition, a lack of appropriate segregation of duties could permit an individual to control the whole check process and issue a check for unauthorized purposes.

The only compensating control used was a reconciliation of checks issued and cleared each month. This reconciliation involves records from the Department of the Treasury (Treasury), the Department of Finance and Administration’s Division of Accounts, and TennCare. This reconciliation ensures that TennCare’s and Treasury’s records of checks issued and cleared correspond to the State of Tennessee Accounting and Reporting System (STARS).

Effective internal controls require that physical security and accountability over checks be maintained and that no one person have the ability to control the entire check-issuance process.

## Recommendation

The Director of TennCare should determine why the monitoring of the fiscal agent promised in the last audit was not performed. He should also ensure that the fiscal agent has adequate controls over access to manual and system checks. EDS should keep the keys to the vaults together with the vault key logs, and system check logs should be reconciled to TCMIS. The Director of TennCare should ensure that inventories of checks are performed and the results of the inventory are documented. Check logs should be reconciled to checks issued to ensure accountability. Manual check logs should always be used to record the receipt and issuance of manual checks, and controls should be strengthened to prevent checks being issued without being entered into BARS. The Director of TennCare should also ensure that there is adequate segregation of duties to prevent someone from controlling the entire check process.

## Management's Comment

We concur. The Bureau has requested a review of controls over manual checks be performed by Internal Audit and will continue monitoring implementation of these recommendations.

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### 31. Controls over financial change requests should be strengthened

#### Finding

The TennCare Bureau needs to improve controls and policies over financial change requests (FCRs). FCRs are used by the Bureau to make adjustments or corrections to payments made to providers. Electronic Data Systems (EDS), the fiscal agent, is responsible for keying FCRs into the TennCare Management Information System (TCMIS). However, TennCare has not established adequate controls for FCRs. The following deficiencies were noted:

- There are no procedures to ensure that all FCRs are entered into TCMIS properly. Per discussions with TennCare personnel, any TennCare employee is able to initiate an FCR, and it is the initiator's responsibility to make sure that the FCR has been keyed in correctly by EDS personnel. There is a risk that the initiator may not follow up on the FCR, which may result in an FCR being entered improperly or not entered at all.
- TennCare does not reconcile FCR forms with what has been entered into the system. Without a reconciliation, there is a possibility that an adjustment has been entered into the system incorrectly or entered for unauthorized purposes. The *Tennessee MIS Financial Procedures Manual*, Section D, "Review and Log Requests," states that the fiscal agent must log each FCR received onto a "Financial Control Sheet" by each FCR category. These amounts should be totaled, and then after all documents are

entered, an audit trail should be printed to determine that the amounts are equal to the “Financial Control Sheet.”

These weaknesses in controls over FCRs could permit an individual to enter a change into TCMIS for unauthorized purposes. In addition, these weaknesses in controls could allow incorrect changes to be keyed into TCMIS without detection.

### **Recommendation**

The Director of TennCare should assign responsibility for ensuring that all FCRs have been entered into TCMIS properly and correctly. Also, the Director of TennCare should ensure that FCRs and information entered into the TCMIS system are reconciled to ensure that all changes keyed into TCMIS are supported by an FCR.

### **Management’s Comment**

We concur. The Bureau will review controls and procedures over FCRs and implement changes as needed.

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**32. TennCare allowed providers to submit old claims and did not pay provider claims in a timely manner**

### **Finding**

The Bureau of TennCare allowed providers to submit claims later than 12 months from the date of service and did not pay all Medicaid Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Waiver (HCBS-MR waiver), Department of Children’s Services (Children’s Services), and long-term care provider claims within 24 months of the date of service. In addition, the Bureau did not pay Medicare cross-over provider claims within 6 months after receiving notice of the disposition of the Medicare claim.

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

- (1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service. . . . (4) The agency must pay all claims [received] within 12 months of the date of receipt. . . . (ii) If a claim for payment under Medicare has been filed in a timely manner, the agency may pay a Medicaid

claim relating to the same services within 6 months after the agency or the provider receives notice of the disposition of the Medicare claim.

The Bureau of TennCare pays long-term care and Medicare cross-over providers directly. The Division of Mental Retardation (DMR) within the Department of Finance and Administration pays providers under the HCBS-MR waiver. Children's Services providers are paid directly by Children's Services. After paying their providers, DMR and Children's Services submit their provider claims to the Bureau for reimbursement. Review of support for paid claims revealed that the Bureau accepted claims that were submitted later than 12 months after the date of service. Computer-assisted auditing techniques revealed that the Bureau paid \$21,617,055.49 for claims past 24 months, or past 6 months for Medicare cross-over claims. Of this amount, \$9,240,391.11 was paid to DMR, \$12,267,619.40 was paid to Children's Services, \$50,307.87 was paid to long-term care institutions, and \$58,737.11 was paid for Medicare cross-over claims.

The Bureau has system edits within the TennCare Management Information System (TCMIS) that appropriately prevent the payment of claims filed 12 months after the service dates for Children's Services, DMR, long-term care claims, and Medicare cross-over provider claims, consistent with federal regulations. However, according to TennCare staff, personnel knowingly override these edits for Children's Services, long-term care, and Medicare cross-over provider claims. In addition, TennCare does not use the system edit necessary to prevent payments of untimely filed claims from DMR.

When claims are not received in a timely manner, the computer edits could be utilized to halt payments to Children's Services, DMR, Medicare cross-over providers, and long-term care providers. By not using edits and overriding edits, TennCare cannot ensure that these claims are denied, and enables the state departments to continue to defy federal regulations with no consequences. When claims are received in a timely manner, late processing of claims by the Bureau could result in use of state funds for payment of the old claims, without federal participation.

### **Recommendation**

The Director of TennCare should ensure that HCBS-MR waiver, Children's Services, and long-term care provider claims are received within 12 months of the date of service, that the claims are paid within 24 months of the date of service, and that Medicare cross-over provider claims are paid within 6 months after receiving notice of the disposition of the Medicare claim. In addition, the Director should ensure that the system edit within TCMIS for the timely filing of claims is used and not overridden.

### **Management's Comment**

We do not concur. While it is true that some claims were processed outside of the timelines quoted in the finding, we need to review the claims in question in order to determine the

reasons for the delay. Processing can appropriately occur outside of the timelines listed for a variety of reasons. We will review our policies surrounding this to ensure they are appropriate.

### **Rebuttal**

As stated in the audit finding, federal regulations require that TennCare require providers to submit all claims no later than 12 months from the date of service. TennCare must pay all claims within 12 months of the date of receipt. Thus, TennCare's paying of claims over 24 months after the dates of service violates this regulation. This regulation also requires that Medicare cross-over claims be paid within 6 months after receipt of the claim. The audit revealed that TennCare paid \$21,617,055.49 for claims that fall into these categories.

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### **33. The Bureau's overall compliance with the special terms and conditions of the TennCare program needs improvement**

#### **Finding**

As noted in the prior audit, the TennCare Bureau has not complied with all of the TennCare waiver's Special Terms and Conditions (STCs). There are 37 special terms and conditions for the TennCare Waiver; however, only 24 were applicable for the audit period. These special terms and conditions required by the federal Health Care Financing Administration (HCFA) describe in detail the nature, character, and extent of anticipated federal involvement in the TennCare waiver. HCFA's approval of the waiver and federal matching contributions are contingent upon the Bureau's compliance with the STCs.

A review of the Bureau's controls and procedures to ensure compliance with the STCs revealed that many areas still need improvement. Management concurred with the prior-year audit finding stating that the Bureau was working with HCFA to ensure compliance with the STCs. Although management stated they would work with HCFA to ensure compliance, evidence of this effort was limited. However, the testwork performed revealed instances of noncompliance for 9 of the 24 applicable special terms and conditions. Seven of the 9 STCs were out of compliance in the prior-year audit. The 9 STCs that require improvement are

- STC 1 – All contracts and modifications of existing contracts between the state and managed care organizations must be approved by HCFA prior to the effective date of the contract or modification of an existing contract. No federal financial participation will be available for any contract or modification of an existing contract not approved by HCFA in advance of its effective date. In order to comply with this STC, the Bureau must submit a final contract or modification of an existing contract 30 days prior to the effective date of the contract. The Bureau did not provide proposed contract amendments to HCFA in a timely manner to allow HCFA the full 30 days for review.

- STC 3 – The state will conduct beneficiary surveys each operational year of the demonstration. The state shall conduct a statistically valid sample of all TennCare enrollees. Results of the survey and an electronic file containing the raw data collected must be provided to HCFA by the ninth month of each operational year. As noted in the last audit, the Bureau still did not include all TennCare enrollees in its sample methodology. The survey was conducted with a Computer Assisted Telephone Interviewing System, utilizing a random-digit dialing based sample that did not include hard-to-reach beneficiaries who were not included in the sample methodology (e.g., homeless beneficiaries). In addition, the survey results and an electronic file containing the raw data collected were not provided to HCFA by the ninth month of the operational year ended September 30, 2000.
- STC 4 – The state must perform periodic reviews, including validation studies, in order to ensure compliance. The state shall have provisions in its contracts with health plans to provide the data and be authorized to impose financial penalties if accurate data are not submitted in a timely fashion. The STC requires validation studies to ensure accuracy. Validation of encounter data should include medical record reviews. In a letter of correspondence from the U.S. Department of Health and Human Services (HHS) to the Commissioner of the Department of Finance and Administration regarding the Single Audit of the State of Tennessee for the period July 1, 1998, through June 30, 1999, HHS noted that this was a material instance of noncompliance and a material weakness. HHS recommended “procedures be implemented . . . to ensure the review of medical records be conducted in a timely manner.” According to staff at TennCare, although MCOs and BHOs were penalized for not providing encounter data timely, the MCOs and BHOs still did not provide encounter data in a timely manner. Furthermore, the Bureau did not have any plans to conduct validation studies to include medical record reviews during the audit period.
- STC 5 – The state’s plan for using encounter data to pursue health care quality improvement must focus on the following priority areas: childhood immunizations, prenatal care, pediatric asthma, and two clinical conditions based upon the population served. It appears that the Bureau has still not established an exact deadline for the MCOs to submit the encounter data for the studies. Furthermore, annual updates have not been provided for the childhood immunizations and pediatric asthma studies. The continuation of these studies is required by the STC.
- STC 9 – The state must develop internal and external audit plans to monitor the performance of the program. The Bureau has created a written comprehensive internal plan for monitoring the performance of the TennCare program and submitted the internal monitoring plan to HCFA for approval on December 3, 1999. Although the Bureau has some reasonable external monitoring procedures in place, management has chosen not to implement the internal monitoring plan to evaluate the performance of the TennCare program because HCFA has not given feedback to the Bureau.
- STC 12 – HCFA will provide federal funding to the Bureau for actual expenditures for providing services to a TennCare enrollee residing in an Institution for Mental Diseases (IMD) for the first 30 days of an inpatient episode, subject to an aggregate

annual limit of 60 days. Testwork revealed that the Bureau's method of determining expenditures for a TennCare enrollee residing at an IMD is based upon estimated expenditures rather than actual. Therefore, the Bureau of TennCare may be under- or overbilling actual expenditures for providing services to a TennCare enrollee residing in an IMD.

- STC 23 – The state must continue to ensure that an adequate management information system is in place. The TennCare Management Information System still needs improvement. (See finding 4.)
- STC 24 – The state must continue to assure that its eligibility determinations are accurate. The Bureau's internal control over eligibility determinations is still inadequate. (See finding 5.)
- STC 35 – The state must provide a detailed explanation of the grievance procedures currently in place at the state level and at each MCO, as well as planned modifications to those procedures, including a timetable for any changes. The Bureau still had only a draft version of the grievance procedures in place during the audit period.

Without adequate controls to ensure overall compliance with the Special Terms and Conditions, TennCare may lose federal participation in the program.

### **Recommendation**

The Director of TennCare should ensure compliance with all Special Terms and Conditions. The Director should consider holding regular meetings with personnel responsible for monitoring the STCs to ensure the Bureau complies with the Special Terms and Conditions.

### **Management's Comment**

We concur in part. The Bureau is currently in compliance with STC #1. With respect to STC #3, we respectfully disagree with the auditors' position that the annual beneficiary survey should be redesigned. This survey has been done every year since 1993 and provides valuable longitudinal data for comparison from year to year. It is a telephone survey, but it is weighted for people at lower incomes to insure that people at all income levels—including those who do not have a telephone—are represented. Both the survey results and an electronic file containing the raw data were provided to HCFA on schedule, by the end of September 2000.

STC #23 will be addressed as part of the overall review of the TCMIS. Work is ongoing on STC #24. The grievance procedures required by STC #35 are now incorporated in state rules, although they may have been in draft form at the time of the audit because the State was responding to a lawsuit regarding updating the appeals procedures.

We concur with STC #12. We have requested updated information from Mental Health and Mental Retardation.

## Auditor's Comment

Management fully concurred with this audit finding last year. Regarding STC #3, it was HCFA, the federal grantor, not State Audit, that originally voiced the concern regarding the telephone survey not including hard-to-reach beneficiaries. It would seem to be very difficult to adequately weight a telephone survey to represent individuals who do not have telephones.

Management's comments regarding the survey results and an electronic file containing the raw data pertained to dates outside the scope of this audit. For the current audit period, TennCare did not submit the survey results that were due on September 30, 1999, until October 15, 1999.

Management did not address STCs 4, 5, and 9 in their comments.

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**34. Internal control over provider eligibility and enrollment was not adequate to ensure compliance with Medicaid provider regulations**

### Finding

As noted in the prior audit, the TennCare program did not have adequate internal controls for provider eligibility and enrollment to ensure compliance with Medicaid provider regulations. TennCare had the following internal control weakness and noncompliance issues:

- the licensure status of out-of-state Medicare cross-over providers was not verified at enrollment;
- the licensure status of Medicare cross-over, managed care organization (MCO), and behavioral health organization (BHO) providers was not reverified after the providers were enrolled;
- the Division of Mental Retardation Services (DMR) did not reverify the licensure of individual and Home Health Care Agency providers;
- TennCare's contract with the Department of Children's Services (Children's Services) did not require this department to comply with Medicaid provider rules and regulations, and as a result, Children's Services did not comply;
- TennCare did not provide DMR with the Medicaid provider rules and regulations that they should follow, and as a result, DMR did not comply;
- TennCare did not monitor the enrollment of Medicaid providers at Children's Services and DMR;
- provider agreements did not comply with all applicable federal requirements;
- departmental rules were not followed;

- not all providers had a provider agreement, as required; and
- documentation that the providers met the prescribed health and safety standards was not maintained for all long-term care facilities.

Compliance with applicable rules and regulations, as well as a system of internal control to ensure compliance, is necessary to ensure that the providers participating in the TennCare program are qualified and that they meet all eligibility requirements.

Responsibility for TennCare provider eligibility and enrollment is divided among the Provider Enrollment Unit in the Division of Provider Services, Bureau of TennCare; the Division of Resource Management in Children's Services; and the East, Middle, and West Tennessee regional offices in DMR. The Provider Enrollment Unit is responsible for enrolling MCO and BHO providers; Medicare cross-over individual and group providers (providers whose claims are partially paid by both Medicare and Medicaid/TennCare); and long-term care facilities, which include skilled nursing facilities and intermediate care facilities.

Children's Services is responsible for the eligibility of the providers it pays to provide Medicaid-covered services to eligible children. DMR is responsible for the eligibility of the providers it pays to provide services under the Home and Community Based Services Waiver for the Mentally Retarded (HCBS-MR waiver) program. (DMR is responsible for the daily operations of this Medicaid program.) TennCare reimburses Children's Services and DMR for payments to these providers.

#### Provider Licensure Not Verified

The TennCare Provider Enrollment Unit did not require out-of-state Medicare cross-over providers to submit a copy of their license when enrolling. Without obtaining a copy of the providers' license, the Provider Enrollment Unit cannot ensure that only licensed providers are enrolled. The *Rules for the Tennessee Department of Health*, Section 1200-13-1-.05, "Providers," states that participation in the TennCare/Medicaid program is limited to providers that "Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice."

#### Provider Licensure Not Reverified

The TennCare Provider Enrollment Unit and DMR enroll providers licensed by the Division of Health Related Boards in the Department of Health. Although the Division of Health Related Boards does not notify the Provider Enrollment Unit and DMR when a provider's license is suspended or terminated, the Division of Health Related Boards has two systems, one on the Internet and an automated telephone system, so that the current status of a provider's license can be verified. During the year ended June 30, 2000, neither the Provider Enrollment Unit nor DMR used either system to reverify licensure.

The TennCare Provider Enrollment Unit, DMR, and Children's Services also enroll providers licensed or certified by the Board for Licensing Health Care Facilities (Health Care Facilities) in the Department of Health. Health Care Facilities notified the Provider Enrollment

Unit when a provider's certification was suspended or terminated; however, Health Care Facilities did not notify Children's Services or DMR when a provider's license was suspended or terminated. Although these departments were not notified, Children's Services took the initiative to reverify licensure, but DMR did not.

Because of the lack of reverification of providers, the Provider Enrollment Unit and DMR cannot ensure that only licensed providers are enrolled in the TennCare program as required by the *Rules of the Tennessee Department of Health*, Section 1200-13-1-.05.

### Children's Services and DMR Did Not Always Comply With Medicaid Provider Rules and Regulations

The contract between TennCare and Children's Services does not state, as it should, that Children's Services is required to follow Medicaid federal and state provider rules and regulations. Also, TennCare did not provide DMR with the Medicaid federal and state provider rules and regulations that DMR should follow. The contract between TennCare and DMR requires TennCare "To provide TDMH/MR (DMR) with complete and current information which relates to pertinent statutes, regulations, policies, procedures and guidelines affecting the operation of this contract." In addition, TennCare did not monitor the enrollment of Medicaid providers at Children's Services and DMR. The Financial Systems Consulting Group within F&A performed fiscal monitoring procedures at Children's Services during the year ended June 30, 2000, for the Bureau of TennCare. At that time, F&A verified that providers had a current license. However, TennCare did not require F&A to monitor Children's Services' provider enrollment procedures.

As a result, Children's Services and DMR did not always comply with Medicaid provider rules and regulations. For example, as discussed in the next two sections of the finding, Children's Services and DMR did not comply with criteria (3) of the *Code of Federal Regulations* (CFR), Title 42, Part 431, Section 107, "Required Provider Agreement," and criteria 4 and 6 of the *Rules of the Tennessee Department of Health*, 1200-13-1-.05, "Providers."

### Provider Agreements Not Adequate

Children's Services and DMR's provider agreements did not comply with federal requirements. In addition, TennCare's provider agreements did not comply with federal requirements, except for its agreements with long-term care facilities. Section 4.13(a) of the Tennessee Medicaid State Plan says, "With respect to agreements between the Medicaid agency and each provider furnishing services under the plan, for all providers, the requirements of 42 CFR 431.107. . . are met." *Code of Federal Regulations*, Title 42, Part 431, Section 107 (b)(1)(2)(3) states,

A State plan must provide for an agreement between the Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to: (1) Keep any records necessary to disclose the extent of services the provider furnishes to recipients; (2) On request, furnish to the Medicaid agency, the Secretary, or the State Medicaid fraud control unit . . . any information maintained under paragraph (b)(1) of this section and any

information regarding payments claimed by the provider for furnishing services under the plan; (3) Comply with the disclosure requirements specified in part 455, subpart B of this chapter.

Children's Services and DMR provider agreements did not meet the criteria in (3) which refers to 42 CFR 455, subpart B, "Disclosure of Information by Providers and Fiscal Agents," and requires providers to disclose ownership and control information and information on a provider's owners and other persons convicted of criminal offenses against Medicare or Medicaid. TennCare's agreement for individual cross-over, MCO, and BHO providers did not meet the criteria in (1), (2), and (3). The agreement for group cross-over providers did not meet the criteria in (1) and (2).

The Medicare program, which is administered by the federal government, enrolls cross-over providers before the Provider Enrollment Unit enrolls them in Medicaid/TennCare. According to the manager of the Provider Enrollment Unit, Medicare providers must also meet the requirements of 42 CFR 431.107, and Medicaid/TennCare has relied on Medicare's enrollment procedures since the beginning of the Medicaid program. Auditors requested that management provide documentation from the grantor that would indicate it was permissible for TennCare to rely on Medicare in this area; however, no documentation was provided. In addition, the auditors did not find any references in the CFR or Tennessee Medicaid State Plan that indicated that reliance on Medicare is permitted.

#### Departmental Rules Not Followed

The TennCare Provider Enrollment Unit, Children's Services, and DMR did not limit participation to providers that complied with the *Rules of the Tennessee Department of Health*, Section 1200-13-1-.05 (1)(a), "Providers." This rule states,

Participation in the Medicaid program will be limited to providers who:

1. Accept, as payment in full, the amounts paid by Medicaid or paid in lieu of Medicaid by a third party . . . ;
2. Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice;
3. Are not under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs...;
4. Agree to maintain and provide access to Medicaid and/or its agency all recipient medical records for five (5) years from the date of service or upon written authorization from Medicaid following an audit, whichever is shorter;
5. Provide medical assistance at or above recognized standards of practice; and
6. Comply with all contractual terms and Medicaid policies as outlined in federal and state rules and regulations and Medicaid provider manuals and bulletins.

The TennCare Provider Enrollment Unit did not require Medicare cross-over, MCO, and BHO providers to comply with the criteria in 1, 3, 4, 5, and 6. In addition, Children's Services and DMR did not require providers to comply with the criteria in 4 and 6.

## Not All Providers Had an Agreement, and TennCare Did Not Have Documentation That All Providers Met Prescribed Health and Safety Standards

Samples of payments to skilled nursing facilities and to intermediate care facilities were tested to determine if TennCare had documentation that the provider met the prescribed health and safety standards and that a provider agreement was on file for the dates of services for which each payment was made. Skilled nursing facilities and intermediate care facilities are long-term care providers. Each time the Board for Licensing Health Care Facilities recertifies a long-term care provider, it sends TennCare a Certification and Transmittal Form (C&T), and TennCare issues a new provider agreement to the long-term care provider for the certification period. The Office of Management and Budget A-133 Compliance Supplement requires long-term care providers to meet the prescribed health and safety standards. The C&T form is TennCare's documentation that the provider has met the prescribed health and safety standards. As mentioned above, the State Plan and 42 CFR 431.107 require that providers have a provider agreement. TennCare paid approximately \$945 million to long-term care facilities for the year ended June 30, 2000.

Of the 61 payments to skilled nursing facilities tested, totaling \$194,662.82, testwork revealed that for 7 payments (11%), TennCare did not have a provider agreement with the provider for the dates of service tested. Also, for 3 of the 61 tested (5%), TennCare did not have a C&T form. The original dollar error amount totaled \$20,870.76. However, after testwork was performed, five of seven provider agreements were negotiated with providers, and two of three C&T forms were obtained from the Board for Licensing Health Care Facilities to correct the errors. The total amount of uncorrected errors noted above was \$7,154.34. Federal questioned costs totaled \$4,514.21. An additional \$2,640.13 of state matching funds was related to the federal questioned costs. We believe likely questioned costs would exceed \$10,000.

Of the 26 payments to intermediate care facilities tested totaling \$70,884.54, testwork revealed that for 4 payments (15%), TennCare did not have a provider agreement. Also, for 3 of 25 payments (12%), TennCare did not have the C&T form for the dates of service tested. The original dollar error amount totaled \$19,015.75. However, after testwork was performed, three of four provider agreements were negotiated with providers, and three of three C&T forms were obtained from the Board for Licensing Health Care Facilities to correct the errors. The total amount of uncorrected errors noted above was \$12,672.29. Federal questioned costs totaled \$7,995.90. An additional \$4,676.39 of state matching funds was related to the federal questioned costs. We believe that likely questioned costs would exceed \$10,000.

In addition, of the six long-term care providers that did not have a provider agreement on file for the dates of service tested in the prior-year audit, testwork revealed that for two the of six (33%), TennCare was unable to locate the provider agreements that covered the fiscal year ended June 30, 2000.

### **Recommendation**

The Director of TennCare should ensure that adequate internal control exists for determining and maintaining provider eligibility. Management and staff should comply with all

Medicaid federal and state provider rules and regulations. Participation should be limited to providers that meet the requirements of the departmental rules. Out-of-state Medicare cross-over providers should submit a copy of their license when enrolling. The Director should ensure that procedures are implemented to reverify licensure and to prevent future payments to non-licensed providers.

Children's Services and DMR should comply with all Medicaid federal and state provider rules and regulations. The Director of TennCare should ensure that these departments are informed of their responsibilities for compliance, and these requirements are added to the contract with Children's Services. The Director should ensure that a knowledgeable staff monitors the enrollment of Medicaid providers at Children's Services and DMR.

In addition, all Medicaid/TennCare providers should have a provider agreement and otherwise be properly enrolled before they are allowed to participate in the program. Management should ensure that documentation is maintained showing that the long-term care providers have met the prescribed health and safety standards. The provider agreements should be revised to comply with the State Plan and the *Code of Federal Regulations*. Management should also consider obtaining permission from the grantor to change the State Plan to allow reliance on Medicare for cross-over provider agreements.

### **Management's Comment**

We concur. Effective immediately all out-of-state providers submitting applications to enroll in the TennCare/Medicaid program must submit a copy of their current license and/or license renewal. The licensure status of out-of-state Medicaid crossover providers cannot be verified by our TDH Licensure Verification system. Therefore, we will use the internet web-site for those out-of-state providers to verify license status. We will also maintain a phone list of states to contact for verification when update information is unavailable on the web-site. All documentation and verification information will be filed in the provider's permanent file.

The Provider Enrollment unit is currently working on procedures to implement a license reverification process. This process will ensure providers participating in the Medicaid program maintain a valid license. In addition, we are working with the TDH, to obtain monthly reports of providers due to renew their license. This report will be used to verify all provider licenses requiring renewal. The new license renewal information will be updated on the mainframe provider file. This change may require changes to the mainframe provider file.

Providers participating in the Medicaid program were previously notified of the Medicaid participation requirement through the Provider manual. These manuals were routinely sent to all providers upon enrollment under the old Medicaid program. Providers are now mailed provider manuals by request only. We will begin working with Bureau staff to develop a provider participation agreement form to mail with all enrollment applications requiring the provider's signature.

The Enrollment unit uses the internet service to verify the status of providers' licenses. Providers are required to submit a copy of their license and/or renewal with the initial application. This information is maintained in the provider's permanent file.

The audit finding reflected cases of SNF and ICF provider files missing the required provider agreement forms and/or documentation. To ensure all intermediate care and skilled nursing facilities provider files contain the required documents, effective immediately the reviewer must complete an enrollment checklist. The reviewer must verify that all required documents are present and correct. In addition, we are working with the TDH to obtain monthly reports of all nursing home facilities needing recertification. The Enrollment Unit will also create an Excel database to track all nursing facilities recertification due dates.

With respect to DMRS, we concur. DMRS will revise policies and procedures to verify at least annually that all Home Health Agencies and providers licensed by Department of Health continue to have a valid license.

Many of the providers who provide services to enrollees in the MR waiver are not traditional Medicaid or Medicare providers. The Division of Long Term Care will work with the Provider Enrollment Division and DMRS to establish procedures for TennCare enrollment and maintenance of provider agreements with non-Medicare providers. Other states will be contacted to determine best practices for enrollment of providers who participate in the waiver who do not otherwise provide Medicaid/Medicare services.

DMRS and the TennCare Division of Long Term Care have established a schedule of twice monthly meetings to discuss operational issues for the MR waiver programs. Provider rules and regulations will be addressed in these meetings. Necessary revisions to the TennCare/DMRS contract and DMRS provider agreements will be discussed and made. Monitoring of DMRS' enrollment procedures will be included in the TennCare Waiver State Assessment process.

**Time frame for completion:** Revision of policies for reverification of licensure will be completed within 2 months. Enrollment of providers and possible revisions of all provider agreements is expected to take 1 to 2 years with direct payment of providers taking at least 3 years. TennCare/DMRS contract revisions will be completed within 6 months.

With respect to DCS, we concur in part. The agency itself is the Medicaid provider, rather than its individual contractors. DCS contracts with residential providers for a comprehensive array of services to children in its custody. These services include room and board, social services, educational services, and other kinds of services other than medical care. These agencies are licensed and monitored by DCS, and they are paid a single daily rate that includes the treatment and the non-treatment portions of their services. The treatment portion is calculated according to a cost allocation plan approved by HCFA and is billed to TennCare by DCS. Treatment services must be delivered according to requirements outlined in the Medicaid/Title V Agreement.

TennCare completed, as mentioned in the prior audit finding, a written provider eligibility and enrollment policies and procedures manual.

### **Auditor's Comment**

We do not believe the Department of Children's Services is a provider. As stated in management's response Children's Services contracts with various residential providers to perform various services for children in state custody. Management has concurred with issues concerning DMR even though DMR also contracts with providers and pays for services in a similar manner as Children's Services.

We asked management for any documentation that would exempt providers of Medicaid services enrolled by Children's Services from being considered Medicaid providers. No such documentation was provided. We believe the entities providing the direct services for treatment are Medicaid providers and should be enrolled as providers under Medicaid regulations. Since Medicaid/TennCare funds are used to reimburse Children's Services for Medicaid-covered services provided to Medicaid-eligible recipients, Children's Services' providers should be subject to the Medicaid provider requirements as are the providers enrolled by TennCare's provider enrollment unit. Also, because of the decentralized nature of provider enrollment, it is important for TennCare to adequately monitor Medicaid provider eligibility and enrollment procedures at Children's Services.

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35. **TennCare did not comply with federal regulations and the Tennessee Medicaid State Plan concerning unnecessary utilization of care and services and suspected fraud**

### **Finding**

As noted in the previous audit, the Bureau of TennCare has not complied with federal regulations and the Tennessee Medicaid State Plan concerning unnecessary utilization of care and services and suspected fraud for areas of the program that are still under the fee-for-service arrangement. Management concurred with the finding and stated that

TennCare will review current procedures for compliance with federal regulations and the Tennessee Medicaid State Plan relative to unnecessary utilization of care and services and suspected fraud. As determined necessary, amendments to the Tennessee Medicaid State Plan will be submitted to HCFA for approval to address changes in procedures that have occurred to the Medicaid/TennCare Program.

However, the State Plan was not amended.

In a letter of correspondence from the U.S. Department of Health and Human Services (HHS) to the Commissioner of the Tennessee Department of Finance and Administration regarding the Single Audit of the State of Tennessee for the period July 1, 1998, through June 30, 1999, HHS stated:

This is a material instance of noncompliance. We recommend procedures be implemented to ensure a surveillance and utilization control program be implemented.

In 1994, the state received a waiver from the Health Care Financing Administration to implement a managed care demonstration project. However, the services provided in the long-term care facilities, services provided to children in the state's custody, and services provided under the Medicaid Home and Community Based Waiver for the Mentally Retarded and Developmentally Disabled are still processed on a fee-for-service basis. Discussions with key TennCare management revealed that

- TennCare has no "methods or procedures to safeguard against unnecessary utilization of care and services," except for long-term care institutions;
- for all types of services, including long-term care, there are no procedures for the "ongoing post-payment review . . . of the need for and the quality and timeliness of Medicaid services"; and
- there are no methods or procedures to identify suspected fraud related to "children's therapeutic intervention" claims and claims for the Home and Community Based Services waiver for the mentally retarded.

According to the Office of Management and Budget "A-133 Compliance Supplement," which references the *Code of Federal Regulations*, Title 42, parts 455, 456, and 1002,

The State Plan must provide methods and procedures to safeguard against unnecessary utilization of care and services, including long-term care institutions. In addition, the State must have: (1) methods or criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and, (3) procedures, developed in cooperation with legal authorities, for referring suspected fraud cases to law enforcement officials. . . .

The State Medicaid agency must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. The agency must have procedures for the ongoing post-payment review, on a sample basis, of the need for and the quality and timeliness of Medicaid services.

In addition, the TennCare Bureau has told the federal grantor in the Tennessee Medicaid State Plan that

A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services

available under this plan and against excess payments, and that assesses the quality of services.

However, audit testwork revealed there is no statewide program of surveillance and utilization control.

Management stated that the program-wide surveillance and utilization control program was eliminated when the state began the managed care program under the TennCare waiver. Auditors requested that management provide documentation from the grantor that would indicate that the federal regulations concerning utilization control and fraud were not applicable to the fee-for-service based areas of the TennCare program. However, no documentation was provided. Although much of the TennCare program operates differently than the former Medicaid fee-for-service program, for areas that still operate under the Medicaid fee-for-service program, effort is needed in the form of program-wide surveillance and utilization control and identification of suspected fraud, to help ensure that state and federal funds are used only for valid medical assistance payments.

### **Recommendation**

The Director of TennCare should either take the appropriate steps to ensure compliance with the federal regulations and State Plan provisions concerning utilization control and identification of fraud for the areas of the program that are still fee-for-service based or obtain documentation from the grantor that compliance is not required and amend the State Plan.

### **Management's Comment**

We concur. A number of the procedures that have been developed to date are discussed in other sections of this audit, under findings having to do with the relationship of TennCare to DCS and to the Division of Mental Retardation Services. Nevertheless, the TennCare Bureau will develop and implement within the next twelve months a comprehensive plan to address surveillance and utilization control and identification of suspected fraud in those areas of the program that still operate on a fee-for-service basis.

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## **36. TennCare did not comply with audit requirements for long-term care facilities**

### **Finding**

As noted in the previous audit, the Bureau of TennCare did not ensure that audits of long-term care facilities were performed as required by the Tennessee Medicaid State Plan and the departmental *Rules for Medicaid*. Management concurred with the finding and stated, "TennCare will submit a state plan amendment to delete the requirement for independent CPA audits of

nursing home cost reports and require audits as determined reasonable and necessary. The Comptroller will continue to perform desk reviews and field audits as determined reasonable and necessary.” Management did submit a State Plan amendment, with a proposed effective date of April 1, 2000, to the Health Care Financing Administration (HCFA) on June 29, 2000, to delete the requirement for independent CPA audits of nursing home cost reports and require audits as determined reasonable and necessary. However, HCFA has not approved the amendment as of September 29, 2000.

According to the existing State Plan, “Each cost report [of the long-term care facilities] submitted in accordance with the Plan shall be audited by a Certified Public Accountant or a licensed Public Accountant, engaged by the provider, and shall include the auditor’s report.” Until April 5, 2000, the departmental *Rules for Medicaid* (Rule 1200-13-6-09, item 32) stated, “It is the responsibility of the management of the facility to engage an independent certified public accountant or public accountant to audit the facility. . . . The audit must be completed in accordance with the agreed upon procedures explained in the auditor’s report which is a part of the cost report.” The Bureau of TennCare has not required these audits for several years.

The Bureau amended the departmental *Rules for Medicaid* (Rule 1200-13-6-09, item 32), effective April 5, 2000, deleting the requirement for independent CPA audits of nursing home cost reports.

Audits of long-term care facilities are required by the *Code of Federal Regulations*, Title 42, Part 447, Section 253(g), which states, “The Medicaid Agency must provide for periodic audits of the financial and statistical records of participating providers.” The March 2000 Office of Management and Budget *Compliance Supplement* references this citation and states, “The specific audit requirements will be established by the State Plan. . . . Such audits could include desk audits of cost reports in addition to field audits. These audits are an important control for the State Medicaid agency in ensuring that established payment rates are proper.”

According to the State Plan,

on-site audits of the financial and statistical records will be performed each year in at least 15% of the participating facilities. At least 5% of these shall be selected on a random sample basis and the remainder shall be selected on the basis of the desk review or other exception criteria. The audit program shall meet generally accepted auditing standards. This program shall provide procedures to certify the accuracy of the financial and statistical data on the cost report and to insure that only those expense items that this Plan has specified as allowable costs have been included by the provider.

The Bureau of TennCare contracts with the Medicaid/TennCare Section of the Comptroller’s Office for the provision of these auditing services and establishment of reimbursable cost rate(s) for the Tennessee Medicaid Title XIX and TennCare Waiver Programs. The Medicaid/TennCare Section of the Comptroller’s Office performs desk reviews of all long-

term care facility cost reports. However, 15% of the long-term care facilities do not receive field audits as indicated in the State Plan. Only four audit reports, for the field audits of three intermediate care facilities for the mentally retarded (ICF/MR) and one intermediate care facility (ICF), were released in the year ended June 30, 2000.

There are 322 long-term care facilities (including intermediate care facilities for the mentally retarded) in Tennessee that receive Medicaid funds. During the year ended June 30, 2000, TennCare paid approximately \$946 million to these facilities for long-term care services. The cost reports are used to set the rates that the facilities are paid. If the cost information is not verified through the required audit process, errors, fraud, illegal acts, and other noncompliance may not be detected. Potentially a facility could record inaccurate information on its cost report in order to receive a higher rate. The result of inaccurate cost reports of the intermediate care facilities could be added cost for the TennCare program.

### **Recommendation**

The Director of TennCare should take the appropriate steps to ensure compliance with the provisions of the State Plan concerning audits of long-term care facilities. Otherwise, the Director should obtain approval from HCFA for the amendment to the State Plan that deletes these requirements.

### **Management's Comment**

#### Bureau of TennCare

We concur. The state plan amendment submitted was approved in July 2000. Under Medicaid regulations regarding approval of state plan amendments, a plan is "deemed approved" if no response is received after ninety days of submission. The ninety days expired in July 2000.

#### Medicaid/TennCare Section

We concur. The TennCare Bureau has filed the requisite state plan amendments and the expectation is that the Health Care Financing Administration will approve the amendments. It should be noted that each nursing facility and mental retardation center cost report is subject to a thorough desk review before rates are set.

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37. **TennCare has not established a coordinated program for ADP risk analysis and system security review**

## Finding

As noted in the prior three audits, TennCare does not have a coordinated program for ADP (automated data processing) risk analysis and system security review of the TennCare Management Information System (TCMIS). Management concurred with the prior-year finding and stated that the HCFA Regional Office Staff Analyst confirmed that TennCare's procedures are a coordinated program for ADP analysis. However, auditors requested that documentation be provided to support this claim. No such documentation was provided. Furthermore, TennCare's procedures do not comply with the requirements specified for such programs by federal regulations. For example, the review is to be followed by a "written summary of the State's findings and determination of compliance with these ADP security requirements." These reports are to be produced by TennCare along with supporting documentation to be available for federal onsite reviews. However, TennCare has not filed such a summary. In addition, in a letter of correspondence from the U.S. Department of Health and Human Services (HHS) to the Commissioner of the Department of Finance and Administration regarding the Single Audit of the State of Tennessee for the period July 1, 1998, through June 30, 1999, HHS stated:

This is a material instance of noncompliance and a repeat finding. We recommend that procedures be strengthened to ensure an ADP risk analysis and system security review is performed periodically and appropriate action is taken in a timely manner.

The Bureau has relied on the Department of Finance and Administration's Office for Information Resources (OIR) for security of TCMIS. However, the Bureau has not complied with federal regulations which require establishing a program for ADP risk analysis and system security review.

According to Office of Management and Budget (OMB) Circular A-133 and the *Code of Federal Regulations*, Title 45, Subtitle A, Part 95, Section 621, such an analysis and a review must be performed on all projects under development and on all state operating systems involved in the administration of the Department of Health and Human Services' programs. TCMIS is such an operating system and is one of the largest in the state.

The risk analysis is to ensure that appropriate, cost-effective safeguards are incorporated into the new or existing system and is to be performed "whenever significant system changes occur." The system security review is to be performed biennially and include, at a minimum, "an evaluation of physical and data security operating procedures, and personnel practices."

If TennCare is to rely on TCMIS for the proper payment of benefits, a security plan, which includes risk analysis and system security review, must be performed for this extensive and complex computer system. OMB Circular A-133 requires the plan to include policies and procedures to address the following:

- Physical security of ADP resources
- Equipment security to protect equipment from theft and unauthorized use

- Software and data security
- Telecommunications security
- Personnel security
- Contingency plans to meet critical processing needs in the event of short- or long-term interruption of service
- Emergency preparedness
- Designation of an agency ADP security manager

### **Recommendation**

The Director of TennCare should ensure that the Director of Information Services promptly develops and implements procedures for ADP risk analysis and system security review. The Director of TennCare should look to staff to take the initiative in analyzing and reviewing these important areas with or without guidance from HCFA. Otherwise, the Director of TennCare should obtain documentation of concurrence by HCFA of TennCare's actions as a valid ADP risk analysis and system security review. Once procedures are in place, the Director of TennCare should monitor the procedures implemented and ensure that the appropriate actions have been taken.

### **Management's Comment**

We do not concur with the findings of this audit.

1. As provided in previous audit findings, TennCare received verbal approval from the HCFA regional office for TennCare to implement their BCCP (Business Continuity and Contingency Plan) for all system infrastructures.
2. HCFA has documented that the TennCare BCCP fulfills all federal requirements associated with infrastructure risk mitigation.
3. The TennCare BCCP is periodically reviewed and updated as per procedures detailed in the document.
4. TennCare updates the BCCP any time events occur which would dictate the necessity for such action.
5. Procedures for mitigating the ADP risks which could be anticipated at TennCare are detailed in the TennCare BCCP.
6. Procedures for returning to normal operations after emergency operations are detailed within the TennCare BCCP.

7. System recovery procedures are included as a component of the TennCare BCCP.
8. The TennCare BCCP includes events which will cause the associated section(s) of the document to be activated as well as conditions which must occur in order to define the associated emergency as concluded.
9. A personnel hierarchy, chain of command, and detailed contact information for vital personnel are detailed within the TennCare BCCP.

### **Rebuttal**

This is the fourth consecutive year that TennCare has not complied with the requirements for ADP risk analysis and system security review. Management has concurred with the audit finding in each of the previous three audits.

Although HCFA may have given verbal approval to implement the BCCP, it is not clear that they confirmed that TennCare's procedures qualify as an ADP risk analysis and system security review. TennCare has not provided documentation to support the claim that "HCFA has documented that the TennCare BCCP fulfills all federal requirements associated with infrastructure risk mitigation."

The federal government has also recognized TennCare's non-compliance with this requirement through their response to the 1999 Single Audit Report. Compliance with this requirement is also dependent upon submission of a summary report. TennCare has never filed such a report.

TennCare management has also acknowledged not fully complying with this federal regulation in the filing of the "State of Tennessee Summary Schedule of Prior Audit Findings for years 1999 and prior" required by Office of Management and Budget Circular A-133. In this report, they reported the status of the finding as "partially" corrected as of June 30, 2000.

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**38. TennCare did not follow its own rules and has not revised its rules**

### **Finding**

As noted in the prior four audits, the Bureau of TennCare has not followed several of the departmental rules it has created. Among the reasons cited for bypassing the rules were that some rules were out-of-date and no longer addressed the situation and that adherence to some of the rules was not feasible. Management concurred with each of the prior four findings and stated in the 1998 response that during 1997 the Bureau and the Office of General Counsel began an

extensive review to identify rules that needed to be revised to reflect current policy. Management stated that, as determined appropriate, the rules or procedures would be modified accordingly. However, once again the rules have not been modified. Also, management stated that monitoring efforts would be established to ensure that departmental rules are consistent with operating procedures. However, such monitoring efforts were not performed.

*Tennessee Code Annotated* prescribes the method for adopting departmental rules. Except for emergency or public-necessity rules, an agency must publish its proposed rule in the Secretary of State's monthly administrative register and include the time and place of a hearing on the rule. The legality of all proposed rules, including emergency and public-necessity rules, must be approved by the Attorney General and Reporter. Emergency and public-necessity rules are effective upon filing with the Secretary of State, and other rules are effective 75 days after filing.

Testwork revealed the following discrepancies:

- The Bureau is paying some providers more than is allowed by departmental rules. The method used to calculate outpatient hospitalization payments to providers caring for enrollees who are both TennCare and Medicare recipients sometimes results in payments that exceed limits.
- The Bureau has not revised its rules to include changes in the method it uses to determine payments to the state's medical schools for graduate medical education.
- The rules pertaining to the Home and Community Based Services waiver program have not been revised to reflect the changes in the program. For example, TennCare no longer pays provider claims based on a per diem rate.

Generally, rules are used to state a department's position on important matters, provide standard definitions of technical words and phrases, and define regulations and policies that affect parties outside state government. Departmental rules are to be developed in an open forum, using due process, so that the interests of all parties can be considered.

### **Recommendation**

TennCare management and staff should comply with the Bureau's rules, and the Director of TennCare should determine why the actions previously promised by management of TennCare have not been taken. He should take appropriate measures, including a system for monitoring relevant program changes, to ensure that the rules are revised as needed.

## Management's Comment

We concur.

- Policy staff attended November 20, 2000 meeting in which a rule change was agreed upon. Rule 1200-13-1-.05(3)(c) has been modified to assure that the systems activities correspond with the rules. The rule will state:  

“(c) the total amount paid by a combination of Medicaid as deductible and co-insurance shall not exceed the limit of the Medicaid fee schedule for the covered services in question *or, where there is no Medicaid fee schedule for the covered service, reasonable billed charges, and:*”
- The Graduate Medical Education Waiver period ended June 30, 2000. The Bureau has requested an extension of this waiver. The Bureau will draft rules to reflect the program as submitted.
- HCBS Rules are in Office of General Counsel for revisions to include Grier/appeals language; however, a letter has been drafted to withdraw the SPA. HCBS Rules have been revised to reflect changes in the HCBS Waiver programs. Proposed rules went through rulemaking hearing and were sent to the Attorney General's Office on December 11, 1998. The rules were returned to the Office of General Counsel for review to amend language to comply with the Grier Consent Decree Order.

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### 39. **Controls over the eligibility of state-only enrollees need improvement**

#### Finding

Controls over the eligibility of state-only enrollees need improvement. As a part of the TennCare Partners Program, TennCare provides behavioral health coverage to individuals who would not be eligible for the TennCare program under the Medicaid rules. Individuals classified as state-only enrollees include non-United States citizens, prisoners, those who have mismatched social security numbers, and non-Tennessee residents. The state-only enrollees' coverage is funded totally with state funds. Currently there are over 1300 individuals who are classified as state-only enrollees.

The Bureau of TennCare does not monitor or reverify the eligibility of state-only enrollees. The Department of Mental Health and Developmental Disabilities is responsible for the initial eligibility determination of state-only enrollees. However, the Bureau does not have any procedures to reverify the eligibility of state-only enrollees, nor are the enrollees selected in the TennCare reverification process. According to management, the state-only category was designed to be a temporary situation for the enrollees; however, because there are no monitoring

and reverification procedures, these enrollees have remained on TennCare without any redetermination of their eligibility.

To be eligible as a state-only enrollee, the applicant's income should not exceed the poverty level income standard. However, testwork revealed that there were 107 state-only enrollees whose income recorded in the TennCare Management Information System (TCMIS) exceeded the poverty level income standard required to be eligible for the program. Since there are no redetermination procedures, these individuals have remained in the program at a cost to the state of \$10,623 for the year ended June 30, 2000. Furthermore, by TennCare's not ensuring that a consistent eligibility criteria is applied, the fairness of the state-only eligibility process could be called into question and could create an additional legal liability to TennCare and ultimately the State of Tennessee.

### **Recommendation**

The Director of TennCare should develop and implement monitoring procedures to ensure that individuals classified as state-only enrollees remain eligible for the program. The Director should determine which enrollees are not eligible and remove those enrollees from the program.

### **Management's Comment**

We concur. Enrollment and disenrollment of State-only enrollees is the responsibility of the Department of Mental Health and Developmental Disabilities, as documented in a Memorandum of Understanding dated January 31, 2000. We will direct DMHDD to complete the requested procedures and assure compliance with this finding.

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## **SUBRECIPIENT MONITORING**

Our objectives were to determine whether

- the Division of Resource Development and Support (RDS) was properly monitoring subrecipients in accordance with the Single Audit Act;
- RDS was properly billing departments and divisions which used RDS to monitor subrecipients;
- RDS was properly performing its duties as the lead agency for the statewide monitoring system required by Finance and Administration Policy 22, "Subrecipient Monitoring";
- The Criminal Justice Division (CJD) and the Tennessee Commission on National and Community Service (TCNCS) submitted their annual monitoring plan and annual

report by the deadlines, properly identified subrecipients, and performed proper risk assessments; and

- RDS was ensuring that subrecipients received a single audit and if the monitors reviewed the subrecipient's single audit and followed up on any findings.

We interviewed key personnel and reviewed the procedures that were being used by RDS. We reviewed RDS's activity report and written agreements with the departments and divisions to determine whether RDS had performed a monitoring review for all subrecipients that it contracted to monitor. We tested a nonstatistical sample of subrecipients to determine if the proper risk assessments were performed by the departments; the RDS monitors' work covered all core areas; and if the monitoring reports were complete, properly documented, and issued timely. In addition, we tested a nonstatistical sample of billings to determine if the billings had adequate support, appeared proper, and were mathematically accurate. We reviewed the procedures used by management to ensure other departments submitted their annual monitoring plans and reports by the required deadlines. We reviewed the procedures used by management to ensure that all subrecipients are included in the plans submitted by the other departments. We also discussed with management the procedures used to determine if subrecipients should be receiving a single audit. We determined through discussions whether the monitors reviewed the subrecipients' single audit reports and if follow-up was performed on any findings noted in the subrecipients' audit reports.

To determine if the CJD and TCNCS were in compliance with Finance and Administration Policy 22, we reviewed their annual monitoring plan and annual report, their determination of subrecipients versus vendors, and their risk assessments for subrecipients. We obtained a listing of all organizations that were paid during the audit period by CJD and TCNCS for professional and administrative services or as grantees and used this listing to determine if their lists of subrecipients were accurate.

Testwork revealed that RDS was adequately monitoring subrecipients and was properly performing its duties as required by Policy 22. CJD and TCNCS properly identified subrecipients and performed proper risk assessments in their annual monitoring plans and annual reports. Monitors reviewed applicable single audits and followed up on any findings. However, we determined that RDS was not properly billing applicable departments and divisions that used RDS as discussed in finding 40.

## **Finding, Recommendation, and Management's Comment**

### **40. Labor charges related to monitoring were not supported**

#### **Finding**

Department of Finance and Administration (F&A) Policy 22 became effective for fiscal years beginning after June 30, 1998. Policy 22 was developed to establish a coordinated and centralized monitoring system that eliminates duplication of monitoring efforts. With the

implementation of Policy 22, the Division of Resource Development and Support (RDS) within F&A is responsible for monitoring contracts and subsequently billing the agency for which monitoring was performed. The policy is being implemented in phases. Monitoring occurred during the year ended June 30, 2000, for the Department of Children's Services, the Department of Human Services, the Department of Labor and Workforce Development, the Commission on Aging, the Board of Probation and Paroles, the Office of Criminal Justice Programs, the Commission on National and Community Service, and TennCare.

Policy 22 monitors maintain time sheets to document the time spent on each department or program by index codes. The time sheet information is entered into an accounting system for the accumulation of costs. Direct labor charges and a portion of administration are then charged to the agency through the accounting system. The interdepartmental contracts between F&A and the affected agencies include the following clause:

The Contractor shall be compensated based on the following formula . . . actual salary for actual time spent by employees in specific program areas or activities plus the equitable share of administrative costs.

The RDS cost allocation plan included as an attachment to the contracts states

The personnel costs reflect the actual time spent by employees in specific program areas or activities according to the index codes as recorded in the employee time sheet.

The monitors' time sheets for four pay periods were reviewed to determine if the time recorded on the time sheets supported the time recorded in the system. Five of the 166 time sheets could not be located. Of the remaining 161, errors that could have affected departmental billings were noted on 29 of the timesheets (18%). Based on this review, it appears that the Department of Human Services was overcharged 16 hours, the Board of Probation and Paroles was overcharged 15 hours, and the Department of Children's Services was overcharged 5 hours. Other areas affected included the Office of Criminal Justice (undercharged 41 hours), the Department of Labor and Workforce Development (undercharged 15 hours), and the Commission on Aging (undercharged 2.5 hours). Errors that did not affect billings were noted on 10 additional time sheets. In addition, three time sheets appeared on a screen of the system twice. However, the related State of Tennessee Accounting and Reporting System (STARS) reports were reviewed, and there was no evidence that this resulted in a double billing.

According to RDS personnel, many of the monitors do not know how to fill out the time sheets correctly and the department is conducting training in this area. Also, corrections to the employee-submitted time sheets were not documented and a comparison of the time sheets with the amounts entered into the system was not occurring.

The lack of documentation for time sheet corrections and the lack of review of hours entered in the system could result in overcharges or undercharges to other departments. The overcharges could then be passed on to federal programs resulting in possible questioned costs.

## Recommendation

Training should continue to ensure that monitors are recording their time correctly to minimize adjustments to the original time sheets. All changes to the time sheets should be explained on the document and agreed to by the monitor. The data entered into the accounting system should be compared with the original approved time sheet. The Director of RDS should evaluate the system to determine why some entries appeared twice on the screen.

## Management's Comment

We concur. Continued training efforts will be made to help ensure monitors' activities are accurately recorded on their time sheets and in the timekeeping system, and any adjustments to the monitors' original time sheets are appropriately documented and approved.

An evaluation of the time keeping and accounting system will be performed to identify why differences are occurring between the data entered from the time keeping system and data reported from the accounting system.

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## BUDGETING

Our objectives were to determine whether

- the 1999-2000 approved appropriation bill reconciles to the original budget recorded on the State of Tennessee Accounting and Reporting System (STARS);
- the original budget reconciled to the final budget per STARS and if there was adequate support and authority for any revisions made to the original budget;
- the budget document contained the information required in Section 9-6-106, *Tennessee Code Annotated*;
- the appropriation bill contains the information required in Section 9-6-108, *Tennessee Code Annotated*;
- the percentage increase in the recommended appropriations from state tax revenues does not exceed the percentage increase of estimated Tennessee personal income for the succeeding fiscal year unless the legislature passes a bill allowing a larger increase;
- the State Funding Board has reviewed the report on estimated growth of the state's economy for June 30, 2000, and commented on its reasonableness; and
- the State Funding Board provided a list of approved state tax revenue sources to the Department of Finance and Administration, and whether the department estimated revenues from the sources provided by the Board as required by Section 9-4-5104, *Tennessee Code Annotated*.

We interviewed key personnel to obtain an understanding of the budgeting process from the initial proposals submitted by departments and agencies to the final budget recorded on STARS. We then obtained the appropriation bill for 1999-2000 and reconciled, for a nonstatistical sample of agencies, the approved appropriation bill amounts to the original budget recorded on STARS. We also reconciled the original budget to the final budget per STARS and reviewed the support and authority for any revisions made by the department to the original budget. We reviewed the budget document and the appropriations bill to determine whether they contained the required information. By reviewing the State Funding Board minutes, we determined if the State Funding Board has reviewed and commented on the reasonableness of the report on the estimated rate of growth of the state's economy for the year ended June 30, 2000. Also, by reviewing Board minutes, we determined if the State Funding Board provided a list of approved state tax revenue sources to the Department of Finance and Administration and whether Finance and Administration estimated revenue from the tax sources provided by the Board. Using this information we determined if the percentage increase of recommended appropriations from state tax revenues did not exceed the percentage increase of estimated Tennessee personal income for the succeeding fiscal year.

Based on the testwork performed, we determined that the budget document and appropriation bill reconciled to amounts recorded in STARS, contained the information required in *Tennessee Code Annotated*, and that revisions were adequately supported and authorized. The percentage increase in the recommended appropriations from state tax revenues exceeded the percentage increase of estimated Tennessee personal income for the succeeding fiscal year, and a bill was passed as required to allow for the increase. The State Funding Board reviewed the report on estimated growth of the state's economy, commented on its reasonableness, and provided a list of approved state tax revenue sources to the department. The department estimated revenues for these sources as required by *Tennessee Code Annotated*.

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## **REAL PROPERTY AND CAPITAL PROJECTS MANAGEMENT**

Our objectives were to determine whether

- building commission contracts are only awarded as is required by Section 4-15-102(f)(1), *Tennessee Code Annotated*, to reputable building contractors that are principally located within the state and who have demonstrated by past experience their ability to perform construction projects properly;
- procedures used to accumulate the total of state buildings presented in the project accounting system appear proper;
- expenditures charged to building commission contracts are properly classified, documented, approved, and in accordance with state laws, regulations, and contract terms;
- procedures used to dispose of buildings appear proper;

- controls are adequate to ensure complete inventories are maintained in permanent form of all state-owned real property and property leased by the state;
- real property purchases and donations are appraised and valued; and
- real property disposals have proper supporting documentation on file.

We interviewed key personnel about the procedures being used for acquisition and construction of state buildings and real property and determined if these procedures were in accordance with applicable laws and regulations. We tested a nonstatistical sample of contract payments to determine if the contracts were awarded in accordance with state laws and regulations. We tested a nonstatistical sample of State Building Commission construction expenditures to determine if payments were in compliance with state laws, regulations and contract terms. We also tested to determine if the payments were properly approved and properly classified in the project accounting system and STARS. We tested a nonstatistical sample of real property parcels to determine if there were properly completed deeds on file. We tested a nonstatistical sample of real property purchases to determine if there was adequate appraisal documentation on file. We tested a nonstatistical sample of real property disposals to determine if there was a properly executed quitclaim deed on file and if the property was removed from the land value report timely. In these samples, we also determined if the proper amounts were shown in the state's inventory records for the parcels.

Based on the testwork performed, it appeared that building commission contracts were awarded properly; procedures used to accumulate the total of state buildings and procedures used to dispose of buildings were adequate; and expenditures charged to building commission contracts were properly classified, documented, approved, and in accordance with state laws, regulations, and contract terms. We also determined that controls appeared adequate to ensure complete inventories of real property are maintained, real property purchases and donations were appraised and valued, and real property disposals were supported.

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## **DEVELOPMENTAL CENTER OPERATIONS**

The objectives of our procedures at Arlington and Clover Bottom Developmental Centers were to determine whether

- adequate controls were in place to ensure that the centers properly administered and accounted for resident trust funds, including patient payroll;
- controls over cash receipts, expenditures, equipment, and inventory at the centers were adequate to ensure that transactions were made in compliance with state rules and regulations;
- the centers recorded accurate equipment information on the Property of the State of Tennessee System (POST); and

- controls over specific purpose accounts are adequate and in place to ensure the funds are handled properly.

We interviewed key personnel about the procedures used and compared these procedures to the applicable laws and regulations. We tested a nonstatistical sample of patient trust fund receipts and withdrawals to determine if they were properly supported and approved. We also tested a nonstatistical sample of resident timesheets to determine if resident payroll was properly credited to patient trust funds. We tested a nonstatistical sample of equipment to determine the accuracy of the information recorded by the centers on POST. For a nonstatistical sample of inventory items, we compared the quantity per the perpetual inventory records to the actual number of items on hand to assess the accuracy of the inventory records. We tested a nonstatistical sample of center expenditures to determine if they were properly approved, properly recorded in STARS, and handled in accordance with state purchasing rules and regulations. We tested a sample of transactions involving specific purpose accounts to determine if the funds were used for the intended purpose.

Testwork revealed that controls over cash receipts, expenditures, and inventory at the centers were adequate, and controls over specific purpose accounts were adequate to ensure the funds were handled correctly. When examining equipment, we determined that recordkeeping at Clover Bottom Developmental Center was inadequate. The center had not performed its annual inventory and did not maintain accurate property records (see finding 41). We also determined that adequate controls existed to ensure that the centers properly administered and accounted for resident trust funds; however, residents' payroll was not always calculated correctly at Clover Bottom Developmental Center (see finding 42).

## **Findings, Recommendations, and Management's Comments**

### **41. Recordkeeping for equipment is inadequate**

#### **Finding**

As noted in the prior two audits, Clover Bottom Developmental Center (CBDC) in Nashville has not performed its annual inventory and does not maintain accurate property records. In the prior year, management responded that actions had been taken to ensure that property records are updated as inventory changes occur and annual inventories are conducted. However, as of July 5, 2000, the property and equipment inventory for the year ended June 30, 2000, had not yet been completed. Although a count was performed at the end of June, it was considered by management to be inaccurate and incomplete. This can be attributed to the fact that property items continue to be moved during the course of the count. The Property Management System Policy and Procedures Manual, section 4(D), states, "At least annually, the Property Officer will conduct an inventory of all the areas at CBDC. . . . During this time period, there will be no movement of any property." The lack of a complete inventory and the movement of items increases the risk of inaccurate property records.

Equipment was verified by selecting 25 items with the highest dollar value. Twenty-five additional sensitive items were also selected for verification. The results of our examination were

- Seventeen of 50 property items selected (34%) from the Property of the State of Tennessee (POST) property listing could not be located. The missing items included four refrigerator/freezers with a total cost of \$58,940, a hospital bed costing \$10,790, nine televisions with a total cost of \$2,293, two video players with a total cost of \$407, and a video camera costing \$540.
- Two of the 33 items located (6%) were missing the required state tag. The items were identified by their serial numbers. One of the items was a video player, the other a television.

If equipment records are not regularly updated, the center will find it increasingly difficult to know what equipment it has and what should be purchased or surplused. In addition, unauthorized removal of equipment will become increasingly difficult to detect.

### **Recommendation**

The property officer should promptly update POST as changes in the center's equipment occur. Annual physical inventories should be performed in accordance with Clover Bottom Developmental Center policies and procedures. Existing policies on state property tags should be followed, and missing tags should be replaced.

### **Management's Comment**

We concur. Clover Bottom Developmental Center is implementing new procedures to correct previous problems with recordkeeping. When serial numbers are taken and POST is updated, a second person will verify information. More complete property descriptions will be entered on the POST system. Property locations are being updated and checked annually. POST is being updated. Surplused items are being documented and removed from POST. The Property Office is in the process of locating all/any missing items. The refrigerators/freezers mentioned in the report were moved for use at other facilities. We are working with TDMHDD to identify those facilities. Appropriate documentation will be completed and POST will be updated with findings. The Property Office has initiated new documents to track movement of property from location to location. A document has also been created to track movement of property that goes with individuals into the community. These documents are being used to delete and change property locations immediately. Additionally, the property officer during the audit period has been reassigned to other duties and another person now has responsibility for ensuring accurate and timely property records.

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**42. Residents' payroll was not calculated correctly**

**Finding**

At Clover Bottom Developmental Center in Nashville, the residents are permitted to work at various jobs, if they are able, and are paid minimum wage for their work. For some jobs, residents are paid an hourly wage while on others, they are paid a piece rate. There is not a procedure in place for payroll accountants to recalculate the amount paid. Supervisors prepare timesheets for the residents and submit the timesheets to the rehabilitation services clerk for processing. The clerk then submits the timesheets and the spreadsheet that she prepared to an accountant for check preparation. A sample of 25 timesheets was tested, and in nine instances (36%), the pay was not calculated correctly. Residents were overpaid 2% to 385% in seven of the nine cases. Residents were underpaid 6% and 30% in the other two instances. Although the largest individual error was only \$4.62, because of the modest pay that residents receive, it appears that this matter requires corrective action.

Adequate internal control would require a mechanism to ensure that amounts paid to residents are correct. Since the residents are, in some cases, unable to determine if they were paid properly, errors would probably go unnoticed.

**Recommendation**

The superintendent of the center should ensure that competent persons are selected for payroll jobs and are properly trained. The superintendent should require the accountant to compare timesheets to the spreadsheet and to recalculate all payroll calculations involving the residents.

**Management's Comment**

We concur. Timesheets will be attached to the payroll spreadsheets. Accounting will audit each spreadsheet to make sure that the calculating of time is correct before submitting for payment to Finance and Administration. All discrepancies will be resolved in a timely manner.

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**FINANCIAL INTEGRITY ACT**

Section 9-18-104, *Tennessee Code Annotated*, requires the head of each executive agency to submit a letter acknowledging responsibility for maintaining the internal control system of the agency to the Commissioner of Finance and Administration and the Comptroller of the Treasury by June 30, 1999, and each year thereafter. In addition, the head of each executive agency is also

required to conduct an evaluation of the agency's internal accounting and administrative control and submit a report by December 31, 1999, and December 31 of every fourth year thereafter.

Our objectives were to determine whether

- the department's June 30, 2000, responsibility letter and December 31, 1999, internal accounting and administrative control report were filed in compliance with Section 9-18-104, *Tennessee Code Annotated*;
- documentation to support the department's evaluation of its internal accounting and administrative control was properly maintained;
- procedures used in compiling information for the internal accounting and administrative control report were in accordance with the guidelines prescribed under Section 9-18-103, *Tennessee Code Annotated*; and
- corrective actions have been implemented for weaknesses identified in the report.

We interviewed key employees responsible for compiling information for the internal accounting and administrative control report to gain an understanding of the department's procedures. We also reviewed the supporting documentation for these procedures. We reviewed the June 30, 2000, responsibility letter and the December 31, 1999, internal accounting and administrative control report submitted to the Comptroller of the Treasury and to the Commissioner of Finance and Administration to determine adherence to submission deadlines. To determine if corrective action plans had been implemented, we interviewed management and reviewed supporting documentation as considered necessary.

We determined that the Financial Integrity Act responsibility letter and internal accounting and administrative control report were submitted on time but did not include TennCare (see finding 43). For the report as it related to the other areas of the Department of Finance and Administration, the supporting documentation was properly maintained and procedures used were in compliance with *Tennessee Code Annotated*. Corrective action was being taken on the material weakness noted but will not be complete for several more years.

### **Finding, Recommendation, and Management's Comment**

#### **43. The Department of Finance and Administration's Financial Integrity Act reports did not include TennCare**

##### **Finding**

The Department of Finance and Administration did not include the Bureau of TennCare when filing the Financial Integrity Act responsibility letter and the internal accounting and administrative control report. Executive Order 23 was issued on October 19, 1999, to transfer the TennCare program and its related functions and administrative support from the Department of Health to the Department of Finance and Administration. The only material weakness

identified in the responsibility letter and the report was related to the Tennessee Insurance System. Numerous other material weaknesses should have been included if the Bureau of TennCare had been considered.

*Tennessee Code Annotated*, Section 9-18-102, requires that

Each agency of state government shall establish and maintain internal accounting and administrative controls, which shall provide reasonable assurance that: (1) Obligations and costs are in compliance with applicable law; (2) Funds, property and other assets are safeguarded against waste, loss, unauthorized use or misappropriation; and (3) Revenues and expenditures applicable to agency operations are properly recorded and accounted for to permit the preparation of accurate and reliable financial and statistical reports and to maintain accountability over the assets.

Furthermore, *Tennessee Code Annotated*, Section 9-18-104, states:

(a) By June 30, 1999, and each year thereafter, the head of each executive agency in accordance with the guidelines prescribed under § 9-18-103, shall submit to the commissioner of finance and administration and the comptroller of the treasury a letter acknowledging responsibility for maintaining the internal control system of the agency. (b)(1) By December 31, 1999, and December 31 of every fourth year thereafter, the head of each executive agency shall, on the basis of an evaluation conducted in accordance with guidelines prescribed under § 9-18-103, prepare and transmit to the commissioner of finance and administration and the comptroller of the treasury a report which states that: (A) The agency's systems of internal accounting and administrative control fully comply with the requirements specified in this chapter; or (B) The agency's systems of internal accounting and administrative control do not fully comply with such requirements. (2) In the event that the agency's systems do not fully comply with such requirements, the report shall include and identify any material weaknesses in the agency's systems of internal accounting and administrative control and the plans and schedule for correcting such weaknesses.

The purpose of the Financial Integrity Act is to ensure responsibility for internal control is assumed by top management. By excluding TennCare, the largest program in state government, management has not publicly acknowledged its responsibility for internal control over the program nor has it reported its plans and schedule for correcting weaknesses as required by law.

### **Recommendation**

The Commissioner of Finance and Administration should ensure that all areas of the department are included when acknowledging responsibility for controls over such areas. The commissioner should ensure that all material weaknesses are identified and corrective action is taken regarding those weaknesses.

## Management's Comment

We concur. The Bureau of TennCare has submitted a letter to the Commissioner of Finance and Administration and the Comptroller of the Treasury acknowledging responsibility for maintaining the internal control system. In the letter, we have indicated our intention to complete a Financial Integrity Act evaluation by September 30, 2001. Subsequent to the completion of this review, we will continue to comply with the requirements of the Act.

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## OBSERVATIONS AND COMMENTS

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### TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

*Tennessee Code Annotated*, Section 4-21-901, requires each state governmental entity subject to the requirements of Title VI of the Civil Rights Act of 1964 to submit an annual Title VI compliance report and implementation plan to the Department of Audit by June 30, 1994, and each June 30 thereafter. The Department of Finance and Administration filed its compliance report and implementation plan on June 30, 2000.

Title VI of the Civil Rights Act of 1964 is a federal law. The act requires all state agencies receiving federal money to develop and implement plans to ensure that no person shall, on the grounds of race, color, or origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal funds.

On October 15, 1998, the Commissioner of Finance and Administration notified all cabinet officers and agency heads that the Human Rights Commission is the coordinating state agency for the monitoring and enforcement of Title VI.

A summary of the dates state agencies filed their annual Title VI compliance reports and implementation plans is presented in the special report *Submission of Title VI Implementation Plans*, issued annually by the Comptroller of the Treasury.

### TITLE IX OF THE EDUCATION AMENDMENTS OF 1972

*Tennessee Code Annotated*, Section 4-4-123, requires each state governmental entity subject to the requirements of Title IX of the Education Amendments of 1972 to submit an annual Title IX compliance report and implementation plan to the Department of Audit by June 30, 1999, and each June 30 thereafter. The Department of Finance and Administration filed its compliance report and implementation plan on June 30, 2000.

Title IX of the Education Amendments of 1972 is a federal law. The act requires all state agencies receiving federal money to develop and implement plans to ensure that no one receiving

benefits under a federally funded education program and activity is discriminated against on the basis of gender.

## **REVIEW OF NURSING HOME TAXES**

As noted in the Tennessee Comprehensive Annual Financial Report for the year ended June 30, 2000, the Health Care Financing Administration (HCFA) has performed a review of the nursing home provider taxes collected for the period beginning fiscal year 1992 to the present. The purpose of the review was to determine the correlation between nursing home provider taxes and a state grant program for private pay patients of nursing homes (Grant Assistance Program). In a draft audit report dated June 15, 2000, HCFA stated that because they believe there is a correlation between the nursing home provider taxes and the nursing home grant assistance program, the provider taxes are impermissible for federal financial participation. The state responded to HCFA on July 14, 2000, by presenting their arguments opposing the findings in the draft report. A disallowance letter from HCFA dated January 19, 2001, requests that the State of Tennessee return to the federal government \$519,864,853 of impermissible nursing facility tax revenue for federal fiscal years 1993 through 2000. The state will appeal this request for financial recoupment.

## **AUDITOR'S COMMENT REGARDING TENNCARE**

In January 1994, Tennessee withdrew from the Medicaid Program and implemented an innovative managed care health care reform plan called TennCare. This new plan was implemented within existing revenues and extended health care, not only to Medicaid-eligible Tennesseans, but also to many uninsured or uninsurable persons using a system of managed care. In order to implement TennCare, the state was granted a waiver by the Health Care Financing Administration (HCFA) for a five-year demonstration project. At that time, state rules were promulgated to assist in administering the statewide program of managed health care. The initial demonstration project ended on December 31, 1998. HCFA then approved a waiver extension for three years beginning January 1, 1999, through December 31, 2001.

The Medicaid/TennCare program involves multiple managed care networks, multiple agencies of state government, and most of the state's healthcare providers. The program, therefore, is extremely complex in its operations. Stability of the \$4.5 billion program is critical. Due to the sheer size of the program, as well as the numerous federal and state regulations, it is essential that top officials in state government have commitment from all state departments and agencies that play a role in the delivery of health care to the state's Medicaid/TennCare-eligible population.

Federal regulations require the designation of a single state agency to administer the Medicaid/TennCare program. At the beginning of the audit period, the Department of Health was the designated state agency. However, in October 1999, the Bureau of TennCare was transferred from the Department of Health to the Department of Finance and Administration. In November

1999, federal approval was received to designate the Department of Finance and Administration as the single state agency. The single state agency is required to administer or supervise the administration of the state plan for the program. Given this authority, the single state agency must not delegate its authority to exercise administrative discretion in the administration or supervision of the state plan, nor may it delegate authority to issue policies, rules, and regulations on program matters. In addition, the authority of the single state agency must not be impaired if any of its rules, regulations, or decisions are subject to review or approval from other offices of the state.

The Bureau of TennCare and state officials are currently in the process of reforming the TennCare program. Although the state has saved money with the managed care system, top officials should continue to seek ways to maintain savings, improve payments to providers, and continue to provide quality health care services to the program's enrollees. Management should continue to strengthen the program from the foundation by focusing on strong internal controls and acquisition of an automated system designed specifically for the managed care environment. As noted in this report, the current TennCare Management Information System does not allow flexibility to efficiently and effectively support the massive Medicaid/TennCare program.

The current audit contains many findings, including repeat findings from several years. Success in some areas of the program will be dependent on the administration's commitment to the single state agency requirement. To make this commitment work, it will be necessary for the administration to require all of the commissioners of the various departments involved in the program to effectively coordinate, cooperate, and comply with the directives of the TennCare Bureau. Such efforts, which have not been successful in the past, cannot be directed by the TennCare program without the clear support of the office of the Governor.

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## APPENDIX

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### DIVISIONS AND ALLOTMENT CODES

Department of Finance and Administration divisions and allotment codes

317.01	Executive Offices
317.02	Division of Budget
317.03	Office for Information Resources
317.04	Insurance Administration
317.05	Division of Accounts
317.06	Criminal Justice Programs
317.07	Division of Resource Development and Support
317.10	Capital Projects and Real Property Management
317.11	Commission on National and Community Services
317.30	Management Information Systems Fund
317.86	Tennessee Insurance System
339.21	Mental Retardation-Administration
339.22	Developmental Disabilities Services
339.23	Community Mental Retardation Services
339.24	Arlington Developmental Center
339.25	Clover Bottom Developmental Center
339.26	Greene Valley Developmental Center
343.65	TennCare Administration
343.66	TennCare Services
343.67	Waivers and Crossover Services
343.68	Long-Term Care Services
355.02	State Building Commission
501.01	Facilities Revolving Fund
501.03	Facilities Management
501.04	Facilities Revolving Fund–Capital Projects
501.05	Facilities Revolving Fund–Debt Service

**TENNCARE MATERIAL WEAKNESSES AND QUESTIONED COSTS SUMMARY:**

The following table lists all TennCare findings which are classified as material weaknesses or contain questioned costs that are reported in the Single Audit Report for the State of Tennessee for year ended June 30, 2000.

<b>Finding Title / Page No.</b>	<b>Finding Type</b>	<b>Federal Known Questioned Costs</b>
Top management must address the TennCare program’s numerous and serious administrative and programmatic deficiencies / 21	Material Weakness	
TennCare Management Information System lacks the necessary flexibility and internal control / 26	Material Weakness	
Internal control over TennCare eligibility is not adequate / 28	Material Weakness	\$27,226.28
TennCare should develop written procedures to reflect the eligibility procedures used / 33	Material Weakness	\$37,807,272.77
Because communication between TennCare and Children’s Services has been inadequate, TennCare incorrectly reimbursed the Department of Children’s Services for services that were unallowable, inadequately documented, or not performed, resulting in federal questioned costs of \$4,357,292 / 35	Material Weakness	\$4,357,292.46
TennCare incorrectly reimbursed the Department of Children’s Services over \$13 million for services that are covered by and should be provided by the behavioral health organizations / 42	Material Weakness	\$8,295,479.15
TennCare should exercise its responsibility to ensure the Department of Children’s Services’ new payment rates are reasonable and have been approved by the Health Care Financing Administration (The old rates set by the Department of Children’s Services were not based on an understandable methodology) / 46	Material Weakness	
TennCare continues to pay adjusted rates that may not be appropriate without written approval and clarification of grant requirements / 47	Material Weakness	
TennCare has not adequately monitored TennCare-related activities at the Department of Children’s Services / 49	Material Weakness	
TennCare’s monitoring of the Medicaid Waiver for Home and Community Based Services for the Mentally Retarded has not been adequate / 52	Material Weakness	
TennCare should ensure that the Division of Mental Retardation Services provides adequate monitoring of the Medicaid Home and Community Based Services / 56	Material Weakness	

Claims for services provided to the mentally retarded and developmentally disabled have not been paid in accordance with the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled / 58	Material Weakness	
TennCare has not ensured that adequate processes are in place for approval of the recipient and for the review and payment of services under the Medicaid Home and Community Based Services Waiver / 63	Material Weakness	\$38,206.62
The Bureau's overall compliance with the special terms and conditions of the TennCare program needs improvement / 95	Material Weakness	
Internal control over provider eligibility and enrollment was not adequate to ensure compliance with Medicaid provider regulations / 98	Material Weakness	\$12,510.11
TennCare paid capitation payments and fee-for-service payments on behalf of incarcerated enrollees, resulting in federal questioned costs of \$5,710,336 / 66	Reportable Condition	\$5,710,336.35
TennCare did not recover over \$800,000 of capitation payments and fee-for-service claims paid to managed care organizations and providers for deceased individuals / 69	Reportable Condition	\$534,491.66
TennCare continues to disregard its own rules regarding overpayments to providers and needs to improve processing of Medicare cross-over claims / 73	Reportable Condition	\$159.36 *
TennCare made payments on behalf of full-time state employees, resulting in federal questioned costs of \$367,476 / 71	Reportable Condition	\$367,476
The TennCare Bureau's failure to establish a cost allocation plan resulted in federal questioned costs of \$18,320,757 / 62	Reportable Condition	\$18,320,757

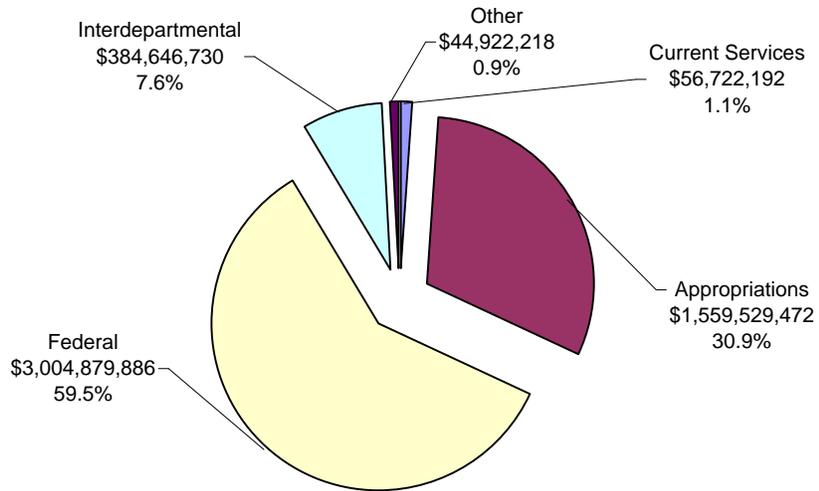
For the purpose of this table, a material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that noncompliance with applicable requirements with laws, regulations, contracts, and grants that would be material in relation to a major federal program being audited may occur and not be detected in a timely period by employees in the normal course of performing their assigned functions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over compliance that, in our judgement, could adversely affect the State of Tennessee's ability to administer a major federal program in accordance with applicable requirements of laws, regulations, contracts, and grants.

Known questioned costs are the actual dollar amounts of transactions discovered through audit testwork that the auditor believes were not spent in accordance with federal laws or regulations. Likely questioned costs are the estimated dollar amounts of transactions that are believed to exist in the population from which samples were drawn that were not spent in accordance with federal laws or regulations.

\* We believe likely federal questioned costs associated with this condition exceed \$10,000. We are required by the *Office of Management and Budget Circular A-133* to report all situations where known or likely questioned costs for a major federal program exceed \$10,000 for a type of compliance requirement.

## Departmental Funding Sources

Fiscal Year Ended June 30, 2000 (Unaudited)

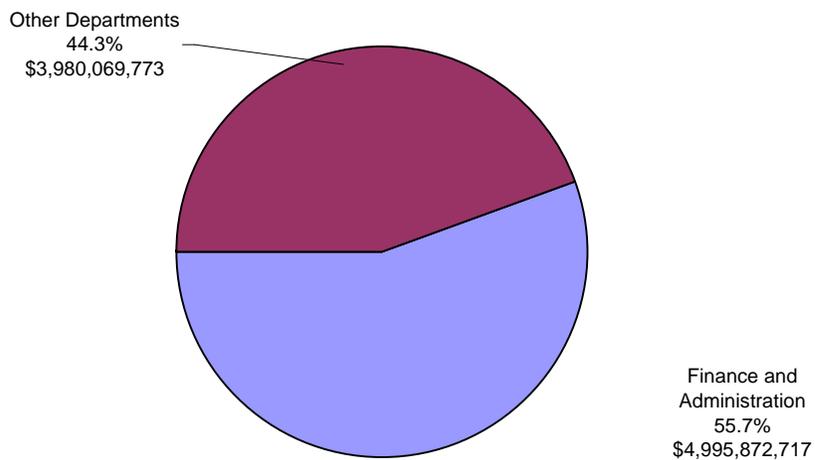


Source: Department of Finance and Administration

Note: OIR, Tennessee Insurance System, Facilities Revolving Fund, and State Building Commission are not included because they are not part of the General Fund.

## General Fund Expenditures

Fiscal Year Ended June 30, 2000 (Unaudited)

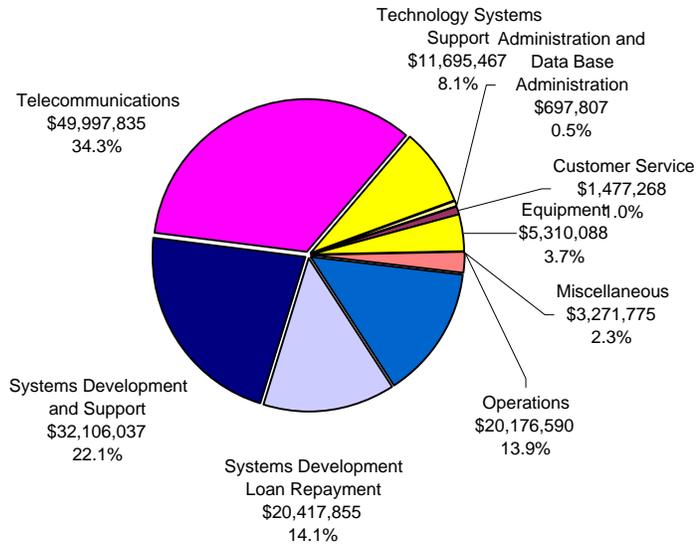


Source: Department of Finance and Administration

Note: OIR, Tennessee Insurance System, Facilities Revolving Fund, and State Building Commission are not included because they are not part of the General Fund.

### OIR Total Billable Services - \$145,150,722

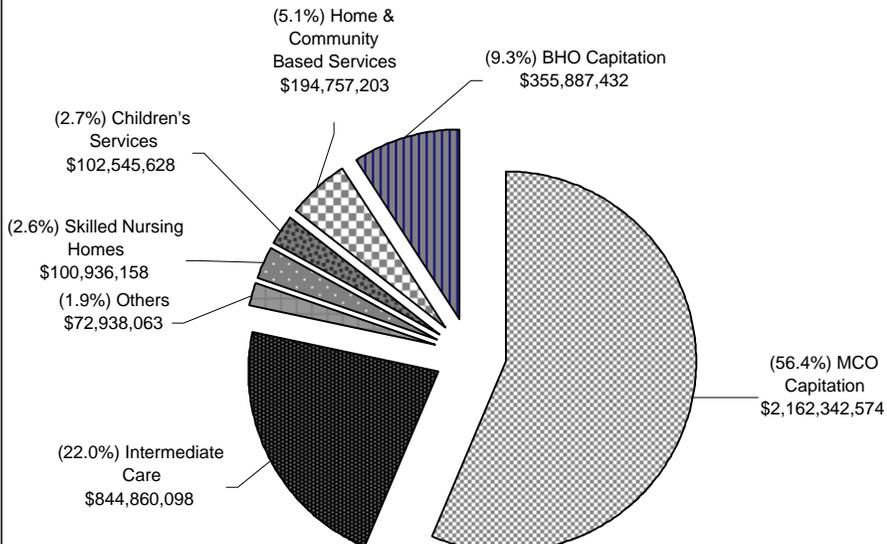
Fiscal Year Ended June 30, 2000 (Unaudited)



Source: Department of Finance and Administration

### TennCare Dollars Paid by Claim Type

Fiscal Year Ended June 30, 2000 (Unaudited)



Source: Bureau of TennCare