

Department of Finance and Administration

**For the Year Ended
June 30, 2002**

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**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

State Capitol
Nashville, Tennessee 37243-0260
(615) 741-2501

John G. Morgan
Comptroller

April 3, 2003

The Honorable Phil Bredesen, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and

The Honorable Dave Goetz, Commissioner
Department of Finance and Administration
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the financial and compliance audit of the Department of Finance and Administration for the year ended June 30, 2002.

The review of management's controls and compliance with policies, procedures, laws, and regulations resulted in certain findings which are detailed in the Objectives, Methodologies, and Conclusions section of this report.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/aj
02/073



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

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January 17, 2003

The Honorable John G. Morgan
Comptroller of the Treasury
State Capitol
Nashville, Tennessee 37243

Dear Mr. Morgan:

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, 2002.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. 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 instances of noncompliance to the Department of Finance and Administration's management in a separate letter.

Sincerely,

A handwritten signature in black ink that reads "Arthur A. Hayes, Jr." in a cursive script.

Arthur A. Hayes, Jr., CPA,
Director

AAH/aj

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Financial and Compliance Audit
Department of Finance and Administration
Including TennCare
For the Year Ended June 30, 2002

AUDIT SCOPE

We have audited the Department of Finance and Administration for the period July 1, 2001, through June 30, 2002. Our audit scope included those areas material to the *Tennessee Comprehensive Annual Financial Report* for the year ended June 30, 2002, and the *Tennessee Single Audit Report* for the same period. These areas included the Medical Assistance Program (Medicaid/TennCare), the State Children's Insurance Program (SCHIP), 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 statewide subrecipient monitoring, budgeting, the Division of Accounts, capital projects and real property management, developmental center operations, the Financial Integrity Act, Title IX of the Education Amendments of 1972, and Title VI of the Civil Rights Act of 1964. The audit was conducted in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

AUDIT FINDINGS TENNCARE

There are a total of 39 findings related to TennCare. Of these 39 findings for this year, 7 are new, one has been repeated for seven years, one has been repeated for six years, 3 have been repeated for five years, 3 have been repeated for four years, 11 have been repeated for three years, 6 have been repeated for two years, and 7 have been repeated for one year. Presented below are summaries for 19 of the TennCare findings. Please refer to the complete audit report for all the TennCare findings and details about the problems noted in the findings.

Top Management Still Has Failed to 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 25).

Internal Control Over TennCare Eligibility Is Not Adequate**

As noted in the seven prior audits, internal control over TennCare eligibility is not adequate. TennCare has inadequate staff to verify information on uninsurable applications and does not verify information on the

applications for individuals losing Medicaid. In addition, there are ineligible enrollees on TennCare (page 46).

TennCare Did Not Recover Fee-For-Service Claims Paid to Providers and Used Federal Matching Funds for Capitation Payments Paid to Managed Care Organizations for Deceased Individuals Including Those Who Had Been Dead for More Than a Year**

For the fifth consecutive year, TennCare did not recover capitation payments made to managed care organizations for deceased individuals (who had been dead for more than a year), and for the second year, TennCare did not recover fee-for-service payments made for deceased enrollees; this has resulted in new federal questioned costs of \$207,499 and additional costs to the state of \$118,479 (page 99).

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 142).

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 128).

TennCare's Monitoring of the Payments for the \$850 Million Pharmacy Program Needs Improvement*

TennCare's monitoring of the pharmacy program payments, which exceeded \$850 million for TennCare enrollees who are both Medicare and Medicaid eligible as well as for behavioral health drugs, was inadequate (page 93).

TennCare Received Advertising Services Without Going Through the Required Procurement Process

The Bureau of TennCare improperly obtained advertising services by using a contract between the Department of Economic and Community Development; the Tennessee Film, Entertainment and Music Commission; and Akins and Tombras, Inc. This action circumvented the required competitive procurement process (page 34).

TennCare Did Not Require the Department of Human Services to Maintain Adequate Documentation of the Information Used to Determine Medicaid Eligibility*

TennCare did not require the Department of Human Services to maintain adequate documentation to support Medicaid eligibility information including income, resources, and medical expenses (page 40).

TennCare Does Not Have a Court-Approved Plan to Redetermine or Terminate the TennCare Eligibility of SSI Enrollees that Become Ineligible for SSI**

Because TennCare does not have a court-approved plan, TennCare does not redetermine or terminate the TennCare eligibility of Supplemental Security Income (SSI) enrollees that become ineligible for SSI. As a result, TennCare does not terminate SSI recipients unless the recipient dies, moves out of state and is receiving Medicaid in another state, or requests in writing to be disenrolled (page 44).

TennCare Paid the Department of Children's Services \$193,266 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 should be provided by Behavioral Health Organizations (page 68).

TennCare Made Payments on Behalf of Full-Time State Employees, Resulting in Federal Questioned Costs of \$54,106 and an Additional Cost to the State of \$31,019**

TennCare paid \$85,125 in capitation payments on behalf of full-time state employees who are

classified as uninsured or uninsurable in the TennCare Management Information System (page 58).

TennCare Reimbursed the Department of Children's Services for Unallowable Costs Resulting in Questioned Costs of \$241,287**

TennCare has paid the Department of Children's Services for ineligible incarcerated youth, unallowable leave days, and undocumented services. TennCare also inappropriately overrode system edits (page 62).

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 Office of Program Accountability Review to provide this service, the monitoring effort still needs improvement (page 69).

TennCare Unnecessarily Paid Administrative Leave With Pay for Employees Who Terminated Employment

TennCare unnecessarily paid administrative leave with pay to two employees who terminated employment, which is not in compliance with the Department of Personnel Policy (page 111).

The TennCare Bureau Continued to Operate Without an Approved Cost Allocation Plan**

The Bureau of TennCare has continued to operate without an approved cost allocation plan, which has prevented the collection of federal matching funds for indirect costs for the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (page 92).

TennCare's Monitoring of the Medicaid Waiver for the Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Was Not Adequate**

The TennCare Bureau's monitoring of the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled is inadequate to provide the federally required assurances of health and welfare and of financial accountability (page 73).

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

TennCare has not ensured that the Division of Mental Retardation Services appropriately reviews and authorizes the eligibility of and the allowable services for recipients under the Medicaid Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Waiver and the Elderly and Disabled waivers (page 87).

TennCare's Monitoring of the Payments for TennCare Select Needs Improvement

The audit revealed that TennCare has not adequately monitored payments to Volunteer State Health Plan for services provided to TennCare Select enrollees (page 95).

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

Management did not comply with 3 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 125).

AUDIT FINDINGS NON-TENNCARE

Presented below are summaries of three of the non-TennCare findings. Please refer to the complete audit report for all the findings and details about the problems noted in the findings.

The Tennessee Insurance System (TIS) Is Not Functioning Efficiently and Effectively**

TIS has not been designed, implemented, and maintained in a manner which allows it to function efficiently and effectively. As a result, changes are being made directly to the TIS database through a software program, necessitating manual reconciliations and adjustments (page 8).

* This finding is repeated from the prior audit.

** This finding is repeated from prior audits.

The Division of Insurance Administration (DIA) Does Not Monitor the Claims Processed by Insurance Companies on Behalf of the State

DIA has not been monitoring claims processing by the insurance companies to ensure that only allowable claims are processed (page 10).

Control Over the Recording of Land in the Land Inventory System Needs Improvement

Due to a lack of a review system, land maintained on the Land Inventory System (LIS) was not always properly valued, and the number of acres did not calculate correctly (page 153).

"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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Audit Report
Department of Finance and Administration
For the Year Ended June 30, 2002

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Department of Finance and Administration For the Year Ended June 30, 2002

INTRODUCTION

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 nine divisions: Budget, Administration, Accounts, Office for Information Resources, Insurance Administration, Resource Development and Support, Capital Projects and Real Property Management, TennCare, and Mental Retardation.

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 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 30 was issued on March 8, 2002, and completed the transfer of all administrative support functions for the Division of Mental Retardation to the Department of Finance and Administration after July 1, 2002.

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.

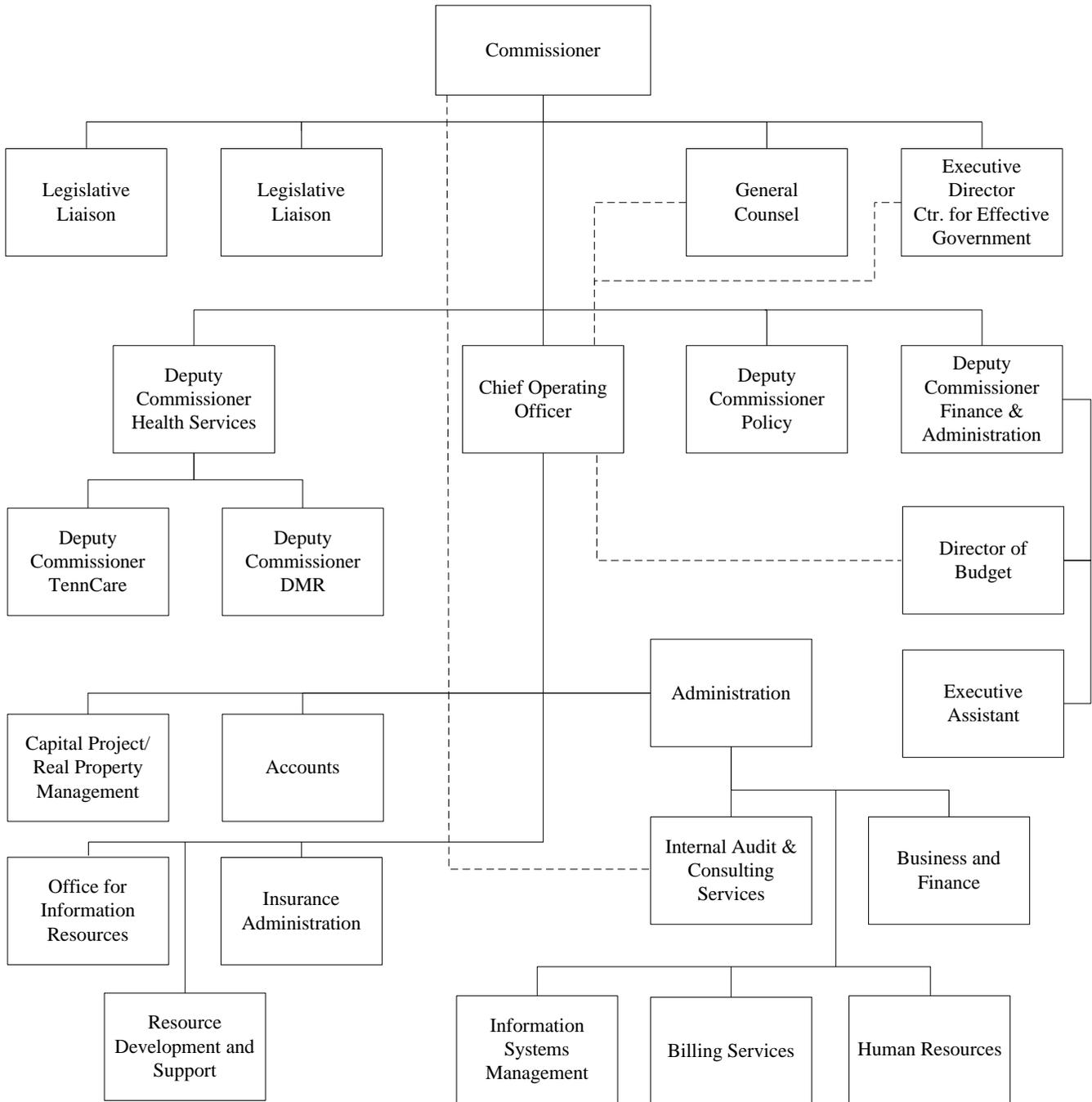
AUDIT SCOPE

We have audited the Department of Finance and Administration for the period July 1, 2001, through June 30, 2002. Our audit scope included those areas material to the *Tennessee Comprehensive Annual Financial Report* for the year ended June 30, 2002, and the *Tennessee Single Audit Report* for the same period. These areas included the Medical Assistance Program (Medicaid/TennCare), the State Children's Insurance Program (SCHIP), 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 statewide subrecipient monitoring, budgeting, Division of Accounts, capital projects and real property management, developmental center operations, the financial integrity act, Title IX of the Education Amendments of 1972, and Title VI of the Civil Rights Act of 1964. The audit was conducted in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

PRIOR AUDIT FINDINGS

Section 8-4-109, *Tennessee Code Annotated*, requires that each state department, agency, or institution report to the Comptroller of the Treasury the action taken to implement the recommendations in the prior audit report. The Department of Finance and Administration filed its report, except for the Medical Assistance Program, with the Department of Audit on August 1,

DEPARTMENT OF FINANCE AND ADMINISTRATION



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

2002. The follow-up report on findings related to the Medical Assistance Program (Medicaid/TennCare) was received September 13, 2002. A follow-up of all prior audit findings was conducted as part of the current audit.

RESOLVED AUDIT FINDINGS

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

- unsupported and incorrect Application Facility Changes,
- inadequate contracts,
- system security over the ACCENT system,
- controls over financial change requests,
- TennCare's payment rates to the Department of Children's Services,
- payments for incarcerated adults,
- monitoring of the graduate medical schools,
- TennCare's not having adequate due process procedures in place for enrollees,
- revisions to the TennCare waiver,
- untimely activities related to the Office of Program Accountability Review, and
- failure to follow billing policies.

REPEATED AUDIT FINDINGS

The prior audit report also contained findings concerning

- inefficiency of the Tennessee Insurance System;
- TennCare's numerous and serious administrative and programmatic deficiencies;
- revision of TennCare's departmental rules;
- inadequate documentation of Medicaid eligibility;
- TennCare's lack of a plan for the redetermination of eligibility for individuals who have lost Supplemental Security Income benefits;
- internal control over TennCare eligibility;
- unallowable payments for full-time state employees;
- controls over eligibility of state-only enrollees;

- unallowable payments to the Department of Children’s Services;
- payments to the Department of Children’s Services that should have been made to Behavioral Health Organizations;
- 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;
- 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;
- monitoring of the payments for the pharmacy program;
- TennCare’s untimely payment of claims;
- recovery procedures for payments on behalf of deceased enrollees;
- claiming federal matching funds for premium taxes;
- the approval and monitoring of contracts;
- Medicare cross-over claims processing;
- TennCare’s noncompliance with purchasing guidelines, usage of incorrect vendor authorization forms, and circumventing the competitive bid process for purchases for legal services;
- TennCare’s not requiring contractors and providers to make disclosures concerning suspension and debarment;
- TennCare’s premium reporting;
- compliance with the Department of Finance and Administration’s Policy 22;
- compliance with TennCare’s Special Terms and Conditions;
- internal control over provider eligibility and enrollment;
- unnecessary utilization of care and services and suspected fraud;
- the TennCare Management Information System’s lack of flexibility and internal control;
- controls over access to the TennCare Management Information System;
- Automated Data Processing risk analysis and system security review;
- lack of internal control at the developmental centers;
- inadequate recordkeeping for equipment at Greene Valley Developmental Center;
- the department’s exclusion of TennCare from the Financial Integrity Act reports; and

- the department's exclusion of TennCare from the Title IX implementation plan.

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

OBJECTIVES, METHODOLOGIES, AND CONCLUSIONS

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 basic 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 basic 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, 2002, the Department of Finance and Administration had the Medical Assistance Program (Medicaid/TennCare) and the State Children's Insurance Program (SCHIP) which were 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 and SCHIP 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 basic financial statements of the State of Tennessee for the year ended June 30, 2002, and have issued our report thereon dated January 17, 2003. The opinion on the financial statements is unqualified. The *Tennessee Single Audit Report* for the year ended June 30, 2002, 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 is not functioning efficiently and effectively.
- The Division of Insurance Administration does not monitor the claims processed by insurance companies on behalf of the state.

1. The Tennessee Insurance System is not functioning efficiently and effectively

Finding

As noted in the six 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, changes are being made directly to the TIS database through the Application Development Facility (ADF) software program, necessitating manual reconciliations and adjustments. Management responded to the prior audit finding by stating that the TIS upgrade project began in March 2000, accounting transactions had been brought up to date, and accounting positions had been added to the Division of Insurance accounting section. Also, management stated that in addition to the TIS upgrade project, the division had implemented the TIS automated reconciliation project. Our review indicated that most accounting transactions were up to date, positions were added, and the TIS upgrade project is in progress. We also found that the automated reconciliation process is functioning and items that still require manual reconciliation are being handled appropriately. However, the automated reconciliation process

does not eliminate the need for additional manual reconciliation, and the upgrade project and Master Transaction Study are not complete. The TIS Upgrade Project is to be completed in June 2005. The TIS Master Transaction Study scheduled to begin after July 1, 2003, has been modified and is now a TIS Master Transaction Task that is to be rolled into the TIS Upgrade Project and will be initiated within the TIS Upgrade Project at no predetermined time. Therefore, ADF is still used, and differences between TIS and the State of Tennessee Accounting and Reporting System (STARS) still occur that result in manual processing.

The division is still using ADF to manually adjust participants' accounts 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 continues to use 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, the State of Tennessee Accounting and Reporting System (STARS) is not updated concurrently. As a result, the two systems do not agree. We noted that differences between the daily net change in the TIS database and the cumulative accounting transactions passed from TIS to STARS daily during the year ended June 30, 2002, ranged from (\$10,000) to \$9,507.93. Differences in the daily net change must be researched and adjusted as necessary. However, if the system had been designed and was functioning properly, there would not be a need for these additional manual procedures.

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 is scheduled to be completed by June 2005. As the system problems are corrected, the use of ADF changes should be minimized and, if possible, eventually eliminated. 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. As stated previously, the issue of reconciliation between TIS and STARS has been the topic of considerable effort on the part of the Division. The Division has implemented a number of changes that focus on this issue. Two years ago, accounting transactions were brought up to date, and the backlog of accounting transactions was eliminated. Positions were added to the accounting section to assist in this task. The TIS Automated Reconciliation Project has been completed. All of these improvements have positively addressed the TIS to STARS balancing problem.

Insurance Administration, Information Systems Management, and the Office of Information Resources are also engaged in a multiple-year effort to upgrade the Tennessee Insurance System (TIS). TIS is the basic business tool that provides the eligibility, enrollment, and premium collection activities to support the state-sponsored plans. TIS began operation in the summer of 1991.

Planning, analysis, and general design phases of the TIS Upgrade Project were complete in March 2002. Detailed design and programming will be completed in stages rather than in its entirety. The components specifically related to the balancing of TIS and STARS are scheduled early in the overall work program. In its totality, the project should be completed by the middle of 2005. The TIS upgrade project is intended to enhance the capabilities of the present system, provide some flexibility in reconfiguring specific TIS components and activities, and improve maintainability. Every effort is being made to correct as many problems as possible in the current version of TIS while designing the upgraded TIS so that current use of ADF will be minimized. The TIS Master Transaction Study has been combined with the TIS Upgrade Project.

In summary, the Division of Insurance Administration, while only one of the organizational units responsible for the upgrade project, is committed to correcting the deficiencies in the Tennessee Insurance System; to the judicious use of ADF changes; and to resolving the issue of TIS to STARS balancing.

2. **The Division of Insurance Administration does not monitor the claims processed by insurance companies on behalf of the state**

Finding

The Division of Insurance Administration does not monitor claims processing by the insurance companies. During the year ended June 30, 2002, the insurance fund plans became entirely self-insured which means that the state is responsible for 100% of the payments to health care providers. The insurance companies do not participate in the cost of services and therefore do not have a monetary incentive to ensure that the claims are valid and reasonable. The insurance companies are paid an administrative fee, based on the total number of members, to process the claims. As the claims are processed, one of the insurance companies, BlueCross

BlueShield of Tennessee (BCBS), writes checks from the state account to pay the claim. BCBS then sends the last page of the check register, which shows the total amount paid, as support for the payments. Insurance companies other than BCBS pay claims and then bill for reimbursement from the state.

The Division of Insurance Administration does not monitor the claims processing by these companies to ensure that only allowable claims are being processed and that claims are being processed correctly. Without this control, the insurance companies have the ability to pay unallowable claims with state funds or be reimbursed with state funds. This could result in increased claim payments for the state and unnecessary insurance premium increases.

Recommendation

The Director of Insurance Administration should implement a monitoring process that enables the Division of Insurance Administration to closely monitor claims processing by the insurance companies to ensure that claims being paid are in fact allowable and that they have been processed correctly.

Management's Comment

We concur. In the past, the Division of State Audit has, at the request of the Division of Insurance Administration, conducted claims audits of the payment of claims by BlueCross BlueShield of Tennessee. The purpose of these audits was to determine whether claims were paid in accordance with plan benefits and the contract between BlueCross BlueShield of Tennessee and the state. The Division agrees that the process of auditing claims for all self-insured plans needs to be reinstated. The Division therefore intends to request that the Division of State Audit continue to assist the Division by periodically auditing claims payments for all the self-insured plans. If the Division of State Audit is unavailable, the Division will secure these services through a contract for these services.

MEDICAL ASSISTANCE PROGRAM (MEDICAID/TENNCARE) AND THE STATE CHILDREN'S INSURANCE PROGRAM (SCHIP)

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 and provide significant controls over the expenditures of Medicaid funds. The State Children's Insurance Program (SCHIP) provides coverage to eligible children under age 19 with incomes at or below 100% of the federal poverty level.

Our audit of the Medicaid/TennCare and SCHIP 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 Deferred Revenue); and
- TennCare Management Information System General Controls.

The primary audit objectives, methodologies, and our conclusions for each area are stated below. For each area, we 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, we made inquiries of management and staff; completed internal control questionnaires; reviewed policies, procedures, and grant requirements; prepared internal control memos; performed walk-throughs; performed tests of controls; and assessed risk.

General Internal Control

Our primary objectives for the area of general internal control for the Medicaid/TennCare and SCHIP programs were to determine if

- the bureau had an adequate control environment,
- controls over financial change requests were adequate,
- contracts were properly approved and monitored,
- the bureau followed its rules concerning Medicare crossover claims, graduate medical education, and the HCBS waiver,
- adequate methods are used for allocating program costs, and
- proper procedures were followed for obtaining advertising services.

To meet these objectives we obtained an understanding of, documented, and assessed controls for each of these functions. We considered overall compliance with program regulations, any improvements in internal control, and progress in reducing the number of audit findings. For financial change requests we selected a nonstatistical sample of requests and determined if the request was appropriately approved and entered into the TennCare Management Information System (TCMIS). We examined selected contracts and their approvals. We discussed contract monitoring activities with key personnel and examined related documentation. To determine if the department followed its own rules for Medicare crossover claims, graduate medical education, and the HCBS waiver we determined the progress made by TennCare in updating the rules and evaluated TennCare's compliance with the new rules. To determine if the methods used to allocate program costs were adequate, we obtained an understanding of the methods used to allocate costs and tested the process by selecting a non-statistical sample of weekly allocations of costs and agreed the allocations to supporting documentation. We also discussed the procedures used to obtain advertising services with department personnel.

The results of our procedures indicated that

- several deficiencies existed in management's general controls over the TennCare program, as described in finding 3;
- controls over financial change requests were adequate;
- contracts were not approved before the beginning of the contract period and that the monitoring of contracts needs improvement as noted in finding 6;
- TennCare still had not adequately complied with its rules that were in effect during the audit period, as discussed in finding 7;
- TennCare relies on inaccurate system reports to allocate TennCare costs, as described in finding 4; and
- TennCare circumvented state rules to obtain advertising services and inappropriately used a contract initiated by another department, as noted in finding 5.

Activities Allowed or Unallowed and Allowable Costs / Cost Principles

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

To determine if grant funds were expended for allowable activities and allowable costs only, we selected a nonstatistical sample of 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 and Medicare crossover claims) to determine if the claims were paid correctly. We determined if

pricing policies were adequate to ensure the proper pricing of Medicare crossover claims. We also examined a nonstatistical sample of pre-admission evaluations to determine if the pre-admission evaluations which document the enrollee's eligibility were maintained by the vendor, approved by TennCare, and signed by a physician. Using CAATs, we determined if TennCare paid provider claims in a timely manner. CAATs were used to search the payment data files for payments made on behalf of deceased enrollees.

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. We obtained case notes from the vendors and reviewed the notes 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, unallowable payments for leave days, and for services that should be covered by the BHOs.

We also obtained an understanding of TennCare's monitoring of payments for the pharmacy program. We interviewed key employees and selected a nonstatistical sample of pharmacy claims and determined if the correct amounts were paid and the individuals were eligible for TennCare on the dates of service according to the TennCare Management Information System (TCMIS).

We obtained an understanding of TennCare's monitoring of payments for TennCare Select. We interviewed key employees and selected a nonstatistical sample of TennCare Select claims and determined if the individuals were eligible for TennCare on the dates of service according to TCMIS, if the correct amounts were paid for the claims, if TennCare made the appropriate administrative fee payments for the periods covering the dates of service of the claims, and if the dates of service were not before TennCare Select began on July 1, 2001.

For the Home and Community Based Services for the Mentally Retarded and Developmentally Disabled waiver (HCBS MR/DD), we reviewed the HCBS MR/DD waiver and inquired about its operation. Key employees were interviewed at the Division of Mental Retardation Services (DMRS) for information concerning the division's responsibilities with the waiver. A nonstatistical sample of claims was selected to test expenditure allowability. We performed an assessment of the claims processing and evaluated for compliance with the HCBS MR/DD waiver. We also evaluated TennCare's monitoring process for the HCBS MR/DD waiver.

We selected a nonstatistical sample of fee-for-service claims to determine if there was documentation that the services that were billed were actually provided, medically necessary and consistent with the medical diagnosis, and coded correctly as to the procedure.

We documented the efforts to develop a cost allocation plan to enable TennCare to collect federal funds for the payment of administrative costs associated with the HCBS MR/DD program.

To determine if federal funds were expended for allowable activities and allowable costs, we obtained and examined supporting documentation for all significant expenditure items. 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. We determined if TennCare inappropriately claimed federal matching funds for premium taxes incurred in the pool payment process.

We obtained a listing of employees that received administrative leave with pay to determine the reasonableness of management's discretion in allowing administrative leave with pay. We obtained an understanding of, documented, and tested the methods used by TennCare to determine Certified Public Expenditures (CPE). We examined support for CPE costs and discussed CPE with key management. We selected a nonstatistical sample of SCHIP expenditures to determine if the expenditures were allowable, properly classified, and in compliance with Circular A-87 basic guidelines, which require costs to be supported by adequate documentation, authorized, and not prohibited by state or local laws or regulations.

The results of this area were as follows:

- We determined that TennCare calculated the correct amounts to pay to the MCOs.
- We determined that the procedures TennCare used to calculate payments to the BHOs were reasonable.
- We determined that TennCare paid nursing home claims correctly.
- We determined that TennCare did not ensure that the nursing homes had an approved pre-admission evaluation as noted in finding 24.
- TennCare has not complied in all material respects with federal allowable cost requirements. As noted in finding 13, TennCare paid Children's Services for unallowable costs (i.e., payments for incarcerated youth and leave days). As noted in finding 27, TennCare paid for claims where the documentation obtained from the Children's Services' provider did not support the services billed. As noted in finding 14, TennCare paid Children's Services for services that are covered by and should be provided by the BHOs. As noted in finding 15, TennCare has not adequately monitored Children's Services to ensure the allowability of costs.
- As noted in finding 19, TennCare has not amended its cost allocation plan, which prevented the collection of federal funds.
- As noted in finding 23, TennCare does not retroactively recover all payments made on behalf of deceased enrollees.

- As noted in finding 25, TennCare needs to improve policies and procedures and processing of Medicare cross-over claims.
- As noted in finding 29, TennCare did not pay provider claims in a timely manner.
- As noted in finding 20, TennCare has not adequately monitored the payments for the pharmacy program.
- We determined that TennCare paid the correct amount for pharmacy claims and that the claims were paid for individuals that were eligible for TennCare on the dates of service according to TCMIS except for the deceased enrollees reported in finding 23.
- As noted in finding 21, TennCare has not adequately monitored the payments for TennCare Select.
- We determined that enrollees who had TennCare Select claims paid were eligible for TennCare on the dates of service according to TCMIS except for the deceased enrollees reported in finding 23. We determined that the correct amounts were paid for the claims. TennCare made the appropriate administrative fee payments for the periods covering the dates of service of the claims. We also determined that the dates of service on the claims were not before TennCare Select began on July 1, 2001.
- TennCare does not have adequate procedures in place to provide reasonable assurance that HCBS MR/DD waiver and elderly and disabled waiver funds were expended only for waiver-allowable activities as noted in finding 18.
- TennCare has not paid claims for the mentally retarded and developmentally disabled in accordance with the HCBS MR/DD waiver as noted in finding 17.
- TennCare and DMRS did not have an effective formal monitoring process in place for the HCBS MR/DD waiver program as noted in finding 16.
- We determined that not all providers had documentation that the service billed was actually provided, medically necessary and consistent with the medical diagnosis, and coded correctly as noted in finding 27.
- We determined that TennCare unnecessarily paid administrative leave with pay for employees who terminated employment or used leave for personal reasons as noted in finding 28.
- We determined that CPE was overstated as discussed in finding 26.
- Based on testwork performed, SCHIP expenditures were allowable, properly classified, and in compliance with Circular A-87 basic guidelines.
- 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. However, TennCare improperly

claimed federal matching funds for premium taxes. See finding 22 for further details regarding this matter.

Cash Management

Our primary objective for Medicaid/TennCare 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). Our primary objective for SCHIP was to determine if management complied with the cash management requirements for programs not covered under the State-Treasury Agreement.

For Medicaid/TennCare, we tested a nonstatistical sample of federal cash drawdown transactions for compliance with the State-Treasury cash management agreement. For SCHIP, we obtained an understanding of the cash management requirements for programs not covered under the State-Treasury Agreement and interviewed key employees to determine if management complied with these requirements.

Based on the testwork performed, we determined that management had complied, in all material respects, with the State-Treasury cash management agreement. We also determined that management had complied, in all material respects, with the cash management requirements for the SCHIP program.

Eligibility

Our primary objectives for Medicaid/TennCare were to determine whether controls over eligibility determinations and reverifications were adequate and if TennCare enrollees were eligible according to rules and regulations. Other objectives of this area were to determine if adequate internal control existed involving eligibility of recipients of Home and Community Based Services (HCBS) waiver services and to determine if recipients were eligible for services under the appropriate HCBS waiver. Our primary objective for SCHIP was to determine whether controls over SCHIP eligibility were adequate to ensure that only children that met the SCHIP requirements were on the program. Another objective for SCHIP was to determine that enrollees classified as SCHIP enrollees met the eligibility requirements. Our primary objectives for “state-only” enrollees were to determine if internal control was adequate to ensure that enrollees classified as state-only were eligible for the state-only category, to ensure that these enrollees were eligible as a state-only, to determine that TennCare did not pay for Managed Care Organization (MCO) capitation for state-only enrollees, and to determine that TennCare did not claim federal matching funds for state-only enrollee costs. (State-only enrollees are only eligible for mental health services, and the cost of care is paid for with 100% state funds.)

We selected a nonstatistical sample of payments made on behalf of Medicaid-eligible TennCare enrollees to determine if the individuals were eligible for Medicaid/TennCare on the dates of service for which the payment was made. We used information in the ACCENT system and the TCMIS to make this determination. We performed an assessment of internal control

over eligibility for the uninsured and uninsurable population (which includes the SCHIP population). We also performed an assessment of internal control over eligibility determinations and reverifications for the Medicaid-eligible population.

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). We performed an assessment of internal control over the state-only enrollees category. 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. We also examined TennCare's process for reducing federal matching funds for the costs related to state-only enrollees. In addition, CAATs were used to search TennCare's payment files for payments made for TennCare enrollees with invalid social security numbers.

Testwork was performed on a nonstatistical sample of TennCare enrollees with post office box addresses to determine if there was evidence that the enrollee was a resident of the State of Tennessee. We tested a nonstatistical sample of out-of-state address cases to determine if the appropriate steps were taken to investigate the out-of-state cases. We also searched TennCare's payment files for full-time state employees to determine if TennCare has taken the appropriate steps to discover and investigate these cases and, if necessary, terminate the enrollee's eligibility in accordance with court-approved policies.

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

We also performed an assessment of internal control over the eligibility of SCHIP enrollees. In addition, we selected a nonstatistical sample of SCHIP children to determine if the enrollees were eligible for the SCHIP program during the audit period.

The results of our procedures indicated TennCare has not complied in all material respects with federal eligibility requirements. Testwork revealed that internal control over eligibility was not adequate for the Medicaid-eligible enrollees or for the uninsured/uninsurable enrollees. Audit testwork revealed a lack of adequate documentation to support eligibility determinations as noted in findings 8 and 10. TennCare made payments on behalf of Medicaid-eligible TennCare enrollees that were not eligible for Medicaid/TennCare on the dates of service for which the payment was made. See finding 10. We determined that internal control over the eligibility of state-only enrollees was not adequate, that there were state-only enrollees who were not eligible according to the requirements, and that TennCare used federal dollars to pay for some of the health care costs for state-only enrollees. See finding 11 for further discussion. Our CAATs revealed that the only capitation payments made on behalf of "state-only" TennCare enrollees were payments to the BHOs.

We have noted weaknesses in internal control over eligibility for the uninsured and uninsurable population in finding 10. In the prior audit, we determined that TennCare did not have adequate due-process procedures in place for enrollees, and as a result, the United States

district court issued a temporary restraining order (TRO). In reaction to the TRO, TennCare ceased its eligibility reverification process for the uninsured and uninsurable enrollees. In the current audit, we determined that the court approved TennCare's due-process procedures and TennCare began the reverification process. Testwork also noted that TennCare did not verify all information on uninsurable applications as noted finding 10. Our CAATs also revealed that TennCare made payments for TennCare enrollees with invalid social security numbers. See finding 10 for further details regarding this matter. Based on the testwork performed on post office box addresses, we determined that there was evidence that the enrollee was a resident of the State of Tennessee. Based on the testwork performed on out-of-state address cases, it appears that TennCare took the appropriate steps to investigate these cases and terminate the enrollee's eligibility.

As noted in finding 12, TennCare made inappropriate payments on behalf of full-time state employees. We also determined that TennCare needs to develop a court-approved plan to redetermine the eligibility of SSI-eligible individuals as discussed in finding 9. In addition, testwork revealed that there was not an adequate process in place for review and approval of documentation needed to support HCBS MR/DD waiver recipient eligibility determinations as discussed in finding 18. Audit testwork on SCHIP revealed that internal control over SCHIP eligibility was not adequate as noted in finding 10. Testwork revealed that the SCHIP enrollees were eligible for the SCHIP program according to the information in TCMIS. However, as noted in finding 10 there was a lack of documentation of the information in TCMIS.

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

The primary objectives for Medicaid/TennCare and SCHIP 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 that administrative expenditures in the State Children's Insurance Program (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 complied in all material respects 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 for Medicaid/TennCare and SCHIP 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 all subawards, contracts, and agreements for purchases of goods or services contained a clause stating that the contractor had not been suspended or debarred.

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 that were initiated during the year ended June 30, 2002, 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 ensure that all required contractors and providers make necessary disclosures concerning suspension and debarment. See finding 31 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. As noted in finding 30, TennCare made purchases that were not in compliance with federal regulations.

Program Income

Our objective for Medicaid/TennCare 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 of the Tennessee Department of Finance and Administration, 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 enrollee premium reporting needs improvement, as discussed in finding 32. We also determined that TennCare appeared to bill the correct amounts to enrollees. Based on the testwork performed, it appeared that premiums received were used in accordance with the program requirements.

Federal Reporting

Our objective for Medicaid/TennCare and SCHIP 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.

For Medicaid/TennCare and SCHIP, 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 and submitted 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 for Medicaid/TennCare and SCHIP was to determine whether subrecipients (graduate medical schools) were properly monitored to ensure compliance with federal award requirements. Another objective of this area was to determine if the Bureau of TennCare complied with the Department of Finance and Administration's Policy 22 regarding subrecipient monitoring.

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's Policy 22 and determined TennCare's compliance with this policy.

The results of our work indicated that TennCare has adequately monitored the graduate medical schools to ensure compliance with federal award requirements and OMB Circular A-

133. However, testwork revealed that TennCare did not comply with the Department of Finance and Administration's Policy 22, as noted in finding 33.

Special Tests and Provisions

Special Tests and Provisions (ST&P) for Medicaid/TennCare 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 for Medicaid/TennCare were to determine whether the state had established, implemented procedures, and complied with federal regulations which require TennCare 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, program integrity, and identification of suspected fraud cases. 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 36 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 for Medicaid/TennCare 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 adequate to ensure compliance with federal and state requirements for long-term care facility audits, and that management had complied with the audit requirements.

Provider Eligibility and Provider Health and Safety Standards

Our primary objectives for Medicaid/TennCare 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;
- to determine whether TennCare required the providers to make the required disclosures to the state;
- to determine whether TennCare's provider agreements were in compliance with applicable laws and regulations; 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, TennCare Select providers, pharmacy providers, and providers for the HCBS MR/DD waiver 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, including the disclosure requirements 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. However, we determined that the providers were licensed. As noted in finding 35, we determined that TennCare did not require providers to make disclosures about ownership and control information as required. Also, management did not comply with all regulations for provider eligibility, and did not ensure provider agreements were in compliance with federal regulations. These matters are discussed further in finding 35. We determined that TennCare had documentation that the applicable providers met health and safety standards.

Managed Care

Our primary objective for Medicaid/TennCare was to determine compliance with the approved state waiver plan, including compliance with the special terms and conditions (STCs) of the TennCare waiver.

We reviewed the STCs of the TennCare waiver and determined which ones were applicable for the year ended June 30, 2002. 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 34 for more information concerning these matters.

Schedule of Expenditures of Federal Awards

Our objective for Medicaid/TennCare and SCHIP was to verify that the department's Schedule of Expenditures of Federal Awards was properly prepared and adequately supported. To determine that the schedule was properly prepared we verified the grant identification information on the Schedule of Expenditures of Federal Awards prepared by staff in the Division of Budget and Finance. To determine that the schedule was adequately supported we traced the total reported disbursement amounts 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 for Medicaid/TennCare and SCHIP 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;
- to determine if accrued liabilities were adequately supported and properly recorded in STARS; and
- to determine if amounts recorded as deferred revenue were appropriately classified as deferred revenue.

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

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. Accrued liabilities appeared to be adequately supported and recorded in STARS correctly in all

material respects. We determined that the recorded deferred revenue was appropriately classified as deferred revenue.

TennCare Management Information System General Controls

The primary objectives for Medicaid/TennCare and SCHIP for 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 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 38. We determined that system change procedures were adequate. However, we determined that TennCare did not comply with the requirements for ADP risk analysis and system security reviews. TennCare did not have policies and procedures that covered all the areas required. In addition, TennCare did not conduct and document system security reviews on a biennial basis. See finding 39 for further details regarding this matter. Also, the TCMIS's lack of flexibility and internal control has been noted in finding 37.

Findings, Recommendations, and Management's Comments

3. Top management still has failed to address the TennCare program's numerous and serious administrative and programmatic deficiencies

Finding

As noted in the previous three audits, 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 audit finding, as discussed throughout this finding. Although significant improvements were made through the

eligibility reverification process (see the “Observations and Comments” section of this report for further details regarding this matter), many serious problems still exist.

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 organizational 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. In addition, this finding reflects ongoing unresolved shortcomings on the part of the program’s leadership. Other areas of this report reveal that TennCare management

- alleged existence of agreements from the Centers for Medicare and Medicaid Services that apparently do not exist (see finding 17);
- in prior management’s comments has misrepresented information (finding 17), was not aware of the status of corrective actions described (finding 15), did not take corrective action indicated, and failed to address grounds for nonconurrence with the audit finding (finding 25);
- demonstrated an indifference to noncompliance (see finding 17);
- has a lack of coordination and overview at the top (see finding 16);
- promises to develop policies or take other long-term, preparatory steps rather than working on the problem directly (see finding 20); and
- made decisions without performing a cost/benefit analysis (see findings 16 and 36).

In addition to these ongoing unresolved issues, there are seven new findings in this report. These findings addressed the following issues:

- TennCare’s providers did not substantiate the medical costs associated with fee-for-service claims or provide evidence that the service was actually provided (finding 27).
- TennCare’s monitoring of the payments for TennCare Select needs improvement (finding 21).
- TennCare circumvented state rules and obtained advertising services exceeding \$340,000 without going through the required procurement process and inappropriately used a contract initiated by the Department of Economic and Community Development (finding 5).

- The system reports used by TennCare's Fiscal/Budget department to allocate costs are inaccurate (finding 4).
- The Bureau of TennCare overstated the amount of Certified Public Expenditures (finding 26).
- A Medicaid enrollee's pre-admission evaluation was not on file, and medical necessity could not be substantiated (finding 24).
- TennCare inappropriately paid \$32,247 for administrative leave for the former Director and a former Assistant Commissioner who terminated employment (finding 28).

Because management has failed to establish proper internal control and to address the Bureau's operational and internal control weaknesses, 32 findings have been repeated from prior years.

The finding that has been included in seven previous audits covering the period July 1, 1994, to June 30, 2001, is as follows:

- Internal control over TennCare eligibility is still not adequate (finding 10).

The finding that has been included in six previous audits covering the period July 1, 1995, to June 30, 2001, is as follows:

- TennCare did not follow its own rules that were in effect during the audit period (finding 7)

The three findings that have been included in five previous audits covering the period July 1, 1996, to June 30, 2001, are as follows:

- TennCare has not adequately monitored TennCare-related activities at the Department of Children's Services (finding 15).
- TennCare needs to improve policies and procedures and processing of Medicare cross-over claims (finding 25).
- TennCare has not established a coordinated program for ADP risk analysis and system security review (finding 39).

The three findings that have been included in four previous audits covering the period July 1, 1997, to June 30, 2001, are as follows:

- For the fifth consecutive year, TennCare did not recover capitation payments made to managed care organizations for deceased individuals (who had been dead for more than a year), and for the second year, TennCare did not recover fee-for-service payments made for deceased enrollees; this has resulted in new federal questioned costs of \$207,499 and additional costs to the state of \$118,479 (finding 23).

- Management has misrepresented the corrective action taken regarding controls over access to the TennCare Management Information System (finding 38).
- The TennCare Management Information System lacks the necessary flexibility and internal control (finding 37).

The 11 findings that have been included in three previous audits covering the period July 1, 1998, to June 30, 2001, are as follows:

- Top management still has failed to address the TennCare program's numerous and serious administrative and programmatic deficiencies (finding 3).
- TennCare incorrectly reimbursed Managed Care Organizations, Consultec, Volunteer State Health Plan, and the Department of Children's Services for services that were unallowable or not performed, resulting in federal questioned costs totaling \$241,287; TennCare also claimed to have newly written procedures to address the Children's Services issues but would not provide those procedures during the audit (finding 13).
- TennCare incorrectly reimbursed the Department of Children's Services for services that are covered by and should be provided by the behavioral health organizations, resulting in federal questioned costs of \$123,067 (finding 14).
- TennCare still does not adequately monitor the Medicaid Home and Community Based Services Waivers (finding 16).
- TennCare is still not paying claims for services provided to the mentally retarded and developmentally disabled in accordance with the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (finding 17).
- The Bureau of TennCare has continued to operate without an approved cost allocation plan, which has prevented the collection of federal matching funds for indirect costs for the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (finding 19).
- TennCare has still failed to ensure 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 18).
- The Bureau's overall compliance with the special terms and conditions of the TennCare program needs improvement (finding 34).
- For the fourth consecutive year, internal control over provider eligibility and enrollment was not adequate to ensure compliance with Medicaid provider regulations (finding 35).
- TennCare still needs to improve enrollee premium reporting (finding 32).
- For the fourth consecutive year, TennCare did not comply with federal regulations and the Tennessee Medicaid State Plan concerning unnecessary utilization of care and services and suspected fraud (finding 36).

The six findings that have been included in two previous audits covering the period July 1, 1999, to June 30, 2001, are as follows:

- TennCare does not have a court-approved plan to redetermine or terminate the TennCare eligibility of SSI enrollees that become ineligible for SSI (finding 9).
- For the third consecutive year, TennCare made payments on behalf of full-time state employees, resulting in new federal questioned costs of \$54,106 and an additional cost to the state of \$31,019 (finding 12).
- TennCare should improve internal control over the eligibility of state-only enrollees and should ensure that no federal dollars are used for state-only enrollees (finding 11).
- For the third consecutive year, TennCare did not pay provider claims in a timely manner (finding 29).
- TennCare did not require all contractors and providers to make necessary disclosures concerning suspension and debarment (finding 31).
- The Department of Finance and Administration did not evaluate and report on the internal control of the Bureau of TennCare in accordance with the Financial Integrity Act (finding 47).

The seven findings that have been included in the previous audit covering the period July 1, 2000, to June 30, 2001, are as follows:

- TennCare did not require the Department of Human Services to maintain adequate documentation of the information used to determine Medicaid eligibility (finding 8).
- TennCare's monitoring of the pharmacy program payments still needs improvement (finding 20).
- For the second year, TennCare chose to go against the direction of the Centers for Medicare and Medicaid Services and inappropriately claimed federal matching funds for premium taxes related to the graduate medical education program and pool payments made to Meharry Medical College and essential provider hospitals (finding 22).
- TennCare did not ensure effective monitoring of contracts and did not approve contracts before the beginning of the contract period (finding 6).
- TennCare did not comply with purchasing guidelines, used incorrect vendor authorization forms, and used a delegated purchase authority to circumvent the competitive bid process for purchases for legal services (finding 30).
- TennCare did not comply with the Department of Finance and Administration's Policy 22, Subrecipient Monitoring (finding 33).

- The Department of Finance and Administration's Title IX implementation plan did not include TennCare, and Title IX and Title VI plans were not submitted in a timely manner (finding 48).

The Bureau resolved seven of the prior findings during this audit period, and two prior findings have been combined with other findings. Based on the number of repeat findings, it appears that management and others have not recognized the seriousness of all the findings.

In addition, some of the most serious problems are discussed below:

Inadequate Information System

Management concurred with the prior audit finding and stated,

TennCare concurs that it still does not have an adequate information system to meet the business demands it faces. Significant progress has, however, been made on changing this. The Bureau has invested a year in developing a procurement for a replacement TCMIS. This development process included many users and constituents, including other state agencies and affected outside parties. The procurement is expected to be public before the end of March 2002. The new system is to be implemented by October 1, 2003.

However, 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 the Director of Information Systems, the RFP (request for proposal) was released on April 22, 2002. According to Information Systems (IS) staff, the implementation of a new TCMIS is to occur in 2003 and is a top project for the Bureau of TennCare. See finding 37 for further details regarding this matter.

TennCare Lacks Stable Leadership and Adequate Staff Resources

Management stated in response to the prior audit finding,

Significant changes have also been made in staffing. A number of new positions have been hired into the Bureau. Staffing shortages still occur when appeals volumes peak, but overall staffing is substantially improved. The organization has also been restructured to include a stronger senior management structure. A new assistant commissioner for member services has been established to coordinate all activities directed at members, including eligibility policy, the member hotline, administrative appeals, and medical appeals. A new assistant commissioner for delivery systems has been hired to coordinate all of the ways in which TennCare delivers services, including the MCO program, behavioral health, pharmacy, dental, and long term care. In addition, a separate MCO program director has been created to coordinate all interaction with MCOs.

However, according to management, the TennCare program is still understaffed despite efforts to hire additional staff, and only one of the three individuals referenced in the above comment is still employed by the Bureau of TennCare. Furthermore, the TennCare program has continued to lack stable leadership. Since the beginning of the program in January 1994, and through December 2002, the program has had nine directors. In addition, during the year ended June 30, 2002, the Director of TennCare and the TennCare Deputy Director/Chief Operating Officer resigned.

Inadequate Written Operating Policies and Procedures and Inadequate Monitoring

Management stated in response to the prior audit finding, “All of TennCare’s eligibility and reverification procedures have been rewritten. A detailed manual has been created for the Department of Health staff.” Management corrected weaknesses regarding policies and procedures for financial change requests and eligibility. However, despite its size and complexity, TennCare still does not have adequate written operating policies and procedures for certain critical areas. 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. For example:

- TennCare’s policies and procedures manual for pricing cross-over claims is still not adequate. See finding 25 for further details regarding this matter.
- TennCare still has no written, comprehensive operating policies and procedures pertaining to utilization control and suspected fraud (finding 36).
- In addition, TennCare’s monitoring effort still needs improvement. See findings 6, 15, 16, 20, 21 and 33 for further details.

Recommendation

Note: The language in this recommendation is practically identical to that in the last three audits, reflecting little improvement.

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 administrative structure of the program.

The Director should also develop a plan to address the personnel requirements of the program. 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 adequate written and comprehensive operating policies and procedures are developed for all areas of the TennCare program still lacking critical policies and procedures. 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. The Director should ensure that adequate monitoring is performed.

Management's Comment

We concur with the overall recommendations made in this finding. However, for certain areas discussed in the finding, we do not concur and these matters are addressed in the responses to individual findings in this report.

While efforts have been made to correct these identified problems, obviously, not all of these efforts have been successful. However, TennCare management realizes the importance of the issues addressed in these findings and is committed to resolving each one. Bureau staff are developing corrective action plans for each finding and will meet monthly with the Director to review the progress made towards resolution of each finding.

We agree that the information system needs to be replaced and considerable resources have been put into developing a replacement model that will employ sophisticated, up-to-date strategies for assuring that data is reported, collected, and analyzed efficiently. This new system is due to be operational on October 1, 2003.

We also agree that staff turnover has been a problem in the past. In the past eight months, the following positions have been added: a new MCO Director, a new Policy Director, and a new Legislative Liaison. Administrative services have been consolidated into one area, and new support staff have been brought on board. Two recent recruits include a Chief Operations Officer whose last position was Director of the Regional CMS Office in Atlanta and who has a wealth of experience and expertise to offer to TennCare. A new Director of Member Services, who is an attorney with long-time experience in state government, has been also hired. In addition, there is less reliance on consultants than there has been in the past.

Managing the TennCare program so that it works efficiently and in the best interests of the state is a challenging responsibility. We have reported throughout this document on efforts we are making to address the problems that have been pointed out. We intend to be successful in solving these problems in the years ahead.

4. The system reports used by TennCare's Fiscal/Budget department to allocate costs are inaccurate

Finding

TennCare's Fiscal/Budget department relies on inaccurate system reports to allocate TennCare costs to the appropriate cost centers. TennCare's staff processes capitation payments and fee-for-service claims for TennCare enrollees through the TennCare Management Information System (TCMIS). The system then generates checks weekly to the Managed Care

Organizations, Behavioral Health Organizations, and the fee-for-service providers. After each week's checks are generated, TCMIS also generates a variety of reports that are used by TennCare fiscal/budget staff to reconcile and allocate costs paid through TCMIS. During the reconciliation process the fiscal staff attempt to balance the weekly check registers with amounts on various system reports. Frequently differences occur and fiscal staff force amounts from the system reports to agree with the check register. The accuracy of these reports is essential to ensure the proper recording and classification of payments in the State of Tennessee Accounting and Reporting System (STARS) and required federal reports. For example, one report, "Claims Paid By The Month of Service," is used to separate costs into the applicable year. However, when inaccuracies occur fiscal staff must force the reports to balance by adding or subtracting amounts from one of the years.

Testwork revealed that the check register balance did not agree with the "Claims Paid By The Month of Service" report for two of the four weeks tested.

- Although the amounts should have agreed, during the week of December 7, 2001, the Managed Care Organization capitation payment amount per the "Claims Paid By The Month of Service," report was \$189,858,215, and the amount per the check register was \$186,148,790, a difference of \$3,709,425. In this situation fiscal staff reduced the current yearly amount from the "Claims Paid By The Month of Service" report to make the total agree with the check register.
- The amount paid per the check register during the week of June 7, 2002, was \$186,982,681 while the amount per "Claims Paid By The Month of Service" report was \$186,982,335, a difference of \$346. This amount was deducted from current year expenditures so the total reported would agree with the check register.
- It was also noted for the quarter ending September 30, 2001, that three adjusting journal vouchers had to be completed by staff because of their concerns about the proper classification of expenditures reported in STARS.

Inconsistencies and inaccuracies between and within the reports used to allocate costs can lead to inaccurate state and federal reporting of TennCare costs. There are no questioned costs because TennCare did not allocate more costs than were indicated by the check register.

Recommendation

The Director of TennCare should ensure all system reports used by TennCare to allocate costs are consistent and accurate. Anytime unexplained inconsistencies occur between these reports, TennCare fiscal staff should coordinate efforts with the Division of Information Systems and the fiscal agent to ensure corrective action is taken. Corrective action could include correcting system logic used by TCMIS to create the system reports, or determining and documenting why the differences occur.

Management's Comment

We do not concur with the auditor's assertion that fiscal staff "force" amounts from the system reports to agree with the check register. The fiscal staff perform a reconciliation process that includes the use of several system generated reports and the check register. The Claims by Month of Service report always balances in total with the check register after adjustment for the total of any amounts not paid because the amounts owed providers were so small they did not currently warrant a check (Report CP-O-14 adjustment). The amount reported agrees with the check register. Accounting adjustments are recorded for any items identified during the reconciliation process that may have been recorded incorrectly originally. This is a normal process when reconciling accounting reports and does not indicate that amounts were forced.

We concur that some immaterial adjustments may be recorded in the current waiver year that represent activity of a prior year. Because of the timing and volume of transaction activity, certain transactions may be processed after the close of a year and some of those may be recorded as current period activity rather than prior period activity. During the reconciliation process, it is not possible to review the details of every transaction because of the volume. However, the fiscal staff is aware of any material transactions that relate to a prior period and ensure during the reconciliation process that these transactions are recorded and reported in the proper period. It is anticipated that implementation of the new system this year will enable the fiscal staff to identify all transactions by waiver year.

Rebuttal

Management acknowledges that "it is not possible to review the details of every transaction because of the volume." We believe that this is, in effect, an admission that management does not know why all the adjustments are necessary. As a result, since not all reconciling amounts were supported and management could not tell us why the reconciling items were necessary, we believe the adjustments were made only in an attempt to balance the reports.

5. **TennCare circumvented state rules and obtained advertising services exceeding \$340,000 without going through the required procurement process and inappropriately used a contract initiated by the Department of Economic and Community Development**

Finding

The Bureau of TennCare improperly obtained advertising services by using a contract between the Department of Economic and Community Development; the Tennessee Film, Entertainment and Music Commission; and Akins and Tombras, Inc. This action circumvented the required competitive procurement process. The services provided to the Bureau were not within the scope of services as described in the contract.

The *Rules of the Department of Finance and Administration*, Chapter 0620-3-3-.03 (1)(a), state, “. . . contracts representing the procurement of services shall be made on a competitive basis. (b) To be competitive, a procurement method must include a consideration and comparison of potential contractors, based upon both cost and quality. . . .” Furthermore, Chapter 0620-3-3-.12 allows the Commissioner of Finance and Administration to make exceptions to the rules. Approved exceptions are to be filed with the Comptroller of the Treasury. However, TennCare did not get an exception from the Commissioner of Finance and Administration to forego the competitive procurement process.

In addition, TennCare received services that were outside the scope of services detailed in the contract previously mentioned. Section A.1 of the contract states that the contractor will provide advertising and marketing “as needed to best promote the business advantages of Tennessee” and that “would best reach prospective industrial and corporate clients.” The contractor will also “make specific promotional and media recommendations on how to promote and advertise Tennessee to prospective clients” and “maintain an expert knowledge of all media opportunities and options available to best reach Tennessee’s potential customer.” Section C.9 of the contract states that the services of the Contractor may be extended: “. . . to perform work related to Workforce Development Initiative for other departments and agencies of the State of Tennessee.”

However, according to TennCare Bureau management, the types of advertising services utilized by the Bureau consisted of television advertisements informing TennCare participants that the Bureau would be re-verifying all participants’ TennCare eligibility. The services rendered for the Bureau are therefore not related to promoting the business advantages of Tennessee, promoting the state of Tennessee to prospective clients and customers, or the Workforce Development Initiative.

The *Rules of the Department of Finance and Administration*, Chapter 0620-3-3-.05 also state, “The purpose of a written contract is to embody, in writing, the complete agreement between parties. No terms shall be left to an unwritten understanding. A contract shall be explicit and clearly state the rights and duties of each party.” However, TennCare was not a party to this contract, and the scope of services mentioned in the contract did not include the advertising services that were provided.

As of December 10, 2002, TennCare had not yet paid for these advertising services; however, according to TennCare staff, TennCare plans to pay over \$342,000 for these services.

The purpose of the state’s purchasing rules is to ensure that the state’s agencies and departments enter into arrangements with firms that are in the best interest of the state. Not having all services documented in the contract could lead to confusion as to the scope of services, payment terms, and other conditions. Not obtaining bids could result in the state paying more for the desired services than is necessary. Finally, circumventing bid requirements contributes to the perception that management of the TennCare program is not committed to proper accountability.

Recommendation

The Director of TennCare should not bypass bidding procedures by obtaining services through other state contracts. Initiation of new contracts for services should follow the states' competitive procurement requirements. All agreements with contractors should be sufficiently detailed to outline each party's responsibilities.

Management's Comment

We do not concur. Although we agree that bidding procedures should be routinely followed, certain events necessitate alternative negotiation methods and state contracting rules clearly allow for non-competitive negotiation on contracts when the transaction is in the best interests of the state. The fact that this project was not bid out by TennCare does not indicate that management is not committed to proper accountability. Costs incurred for this project were reasonable and necessary costs of the program.

The advertising services referenced in this finding were necessary because TennCare had to quickly inform its 1.4 million members of the reverification process and the need to apply for enrollment at the local offices of the Department of Human Services. There was not sufficient time available to complete an RFP process for this project. TennCare management could have negotiated a non-competitive contract for these services but utilized an existing state contract instead.

TennCare management had no intention to circumvent state procurement rules and acted in good faith in acquiring services under the existing contract. TennCare was not aware and was not notified in advance that the advertising contract language was not sufficiently broad to cover the TennCare project.

Rebuttal

As stated in the finding, the *Rules of the Department of Finance and Administration* allow the Commissioner of the Department of Administration to grant exceptions to the required rules when necessary. However, TennCare did not obtain this exception from the Commissioner of the Department of Finance and Administration. Furthermore, as stated in the finding, the contract is limited to work related to the Workforce Development Initiative.

It does not appear that a non-competitive contract would be appropriate in this situation because the services provided (e.g., development of television advertisements) could be provided by numerous other contractors.

6. TennCare did not ensure effective monitoring of contracts and did not approve contracts before the beginning of the contract period

Finding

As noted in the three previous audits, the Bureau of TennCare has not effectively monitored its contracts and, as noted in the prior audit, TennCare did not approve contracts before the beginning of the contract period.

Management concurred in part with the prior audit finding and stated that they would continue to work with the Department of Finance and Administration's Program Accountability Review (PAR) section to refer appropriate contracts for monitoring. However, not all contracts that required monitoring were referred to PAR for monitoring.

Discussions with an Assistant Commissioner of Finance and Administration revealed that TennCare did not conduct fiscal audits of the external quality review organization (EQRO) contractor as required by TennCare's contract with the EQRO contractor. Management concurred with this portion of the prior finding and stated that a determination will be made as to whether a fiscal audit is warranted. An Assistant Commissioner for Finance and Administration stated that as of December 6, 2002, a determination was made that a fiscal audit is not warranted and the contract language will be amended when a new contract is negotiated.

Furthermore, according to the Chief Financial Officer of TennCare, the Bureau does not have any policies and procedures for subrecipient monitoring. Management concurred with this portion of the prior finding and stated that a process to identify contracts that should be monitored had been developed, and this process was performed at the time the contract is executed. However, this process was not in writing during the current audit period. Furthermore, TennCare's noncompliance with the Department of Finance and Administration's Policy 22, Subrecipient Monitoring, resulted in inadequate subrecipient monitoring. See finding 33 for further details regarding this matter.

Although management stated that TennCare had assigned responsibility for monitoring each contract to various Bureau of TennCare employees, testwork revealed that sufficient monitoring procedures for each contract were not performed. Examples of contracts that had not been monitored include

- an interdepartmental contract with the Department of Commerce and Insurance to conduct examinations of the Managed Care Organizations and Behavioral Health Organizations to ensure financial viability and compliance with statutory and contractual obligations;
- a contract with the Department of Children's Services to provide non-medical treatment and case management services (see finding 15);

- a contract with the Department of Health’s Office of Health Licensure and Regulation to certify healthcare facilities; and
- a contract with University of Tennessee – Memphis and Erlanger Medical Center/T.C. Thompson Children’s Hospital in Chattanooga to conduct a high-risk regional perinatal program.

Without effective monitoring procedures in place, the Bureau cannot ensure compliance requirements of each contract are being met or that the services contracted for have been performed.

In addition, as noted in the prior-year audit, the Bureau of TennCare did not ensure that the contracts with the four Tennessee graduate medical schools were approved before the contract period began. In addition, there were other contracts that were not approved before the contract period began. Chapter 0620-3-3-.06(3) of the *Rules of the Department of Finance and Administration* states that “Upon approval by the Commissioner of Finance and Administration a contract shall be fully approved. . . .” A contract should serve as the legal instrument governing the activities of TennCare as they relate to the contractor and should specify the scope of services, grant terms, payment terms, and other conditions.

Including the four graduate medical schools, we found 20 contracts or amendments to contracts that were not approved timely. These contracts were approved from four days to 363 days after the effective date of the contract with an average of 165 days. In addition, TennCare paid \$2,582,263 for services provided during fiscal year 2002 to Alexian Village Nursing Home during the year ended June 30, 2002, before the contract was approved on September 10, 2002. An additional \$932,811 was paid from July 1, 2002, through September 10, 2002, for services provided under this contract during fiscal years 2002 and 2003.

Not having an executed contract in place at the beginning of the contract term can lead to confusion between the parties regarding the scope of services, grant terms, payment terms, and other conditions. In addition, if contracts are not approved before the contract period begins and before services are rendered, the state could be obligated to pay for unauthorized services.

Recommendation

Once again, the Director of TennCare should ensure that written policies and procedures are developed and implemented as necessary to ensure effective contract monitoring. In addition, the Director should ensure once again that all contracts are signed before the effective date and should ensure that funds are not paid before contracts are signed. In addition, the Director should ensure that requirements for a fiscal audit, if not needed, are removed from the EQRO contract.

Management's Comment

We concur. In September 2002, we completed a monitoring plan for many of the contracts in place for Bureau operations for fiscal year 2003. However, revisions to the monitoring plan are needed to ensure all contracts requiring monitoring are included in the plan. These revisions will be made and appropriate policies and procedures will be put in place. The EQRO contract will be modified as soon as practical to remove the requirement for a fiscal audit.

Every attempt will be made to ensure contracts are signed before the effective date. However, because of the extenuating circumstances regarding certain agreements, it is not always possible to accomplish this. Approval for the Alexian Village agreement, for example, was delayed because the contractor had to be transitioned from a PACE waiver provider to a permanent provider in accordance with federal regulations. The State entered into a three-way agreement with the provider and the federal government. Many steps had to be performed to accomplish this transition resulting in a delay in the approval of the contract. Nevertheless, we realize the importance of having contracts in place at the effective date and will attempt to correct this issue.

7. TennCare did not follow its own rules that were in effect during the audit period

Finding

As noted in the prior six 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 has finally initiated steps to revise its rules to conform with current practices. TennCare corrected a portion of the prior year audit finding by implementing rules pertaining to Medicare crossover claims. However, other rules pertaining to graduate medical education and the HCBS waiver were not in place and effective.

Testwork revealed the following recurring discrepancies:

- The Bureau has drafted rules to include changes in the method it uses to determine payments to the state's medical schools for graduate medical education. However, these rules were not effective during the audit period. Management stated in response to the prior audit finding that the rules "are under review and will be put in place as soon as possible." Discussions with management during fieldwork regarding this matter revealed that there was a hearing on April 19, 2002 regarding these rules. As a result of the hearing, approval of the rules was postponed because the graduate medical schools wanted changes to the rules. According to TennCare staff as of December 3, 2002, the Chief Financial Officer is to provide written responses to the concerns of the graduate medical schools. After approval of the rules by the Director of TennCare and the Commissioner of Finance and Administration, the rules will be

submitted to the Attorney General and the Secretary of State for approval. The rules would then be effective 75 days after approval.

- Not all the rules contained in the *Rules of the Tennessee Department of Finance and Administration Bureau of TennCare* pertaining to Home and Community Based Services waiver programs were effective during the audit period. Management stated in the prior audit that “rules have been implemented since the end of the audit period for . . . the HCBS waiver program.” On November 18, 2002, TennCare had a public hearing for rule 1200-13-1-.17. As of December 3, 2002, TennCare still must respond to comments received at the hearing. After the comments are addressed, the rules must be approved by the Director of TennCare, the Commissioner of Finance and Administration, the Attorney General, and the Secretary of State. As of December 3, 2002, Rule 1200-13-1-.26 pertaining to the American Disabled for Attendant Programs Today (ADAPT) Elderly and Disabled Waiver and rule 1200-13-1-.27 pertaining to the Shelby County Elderly and Disabled Waiver have been written and are awaiting approval from the Director of TennCare. These rules when approved by the Director of TennCare and the Commissioner of Finance and Administration will be sent to the Attorney General and the Secretary of State for approval.

Recommendation

The Director of TennCare should ensure that the comments from the hearings are addressed as soon as possible. When finished the Director should ensure that the rules are promptly approved by the Director of TennCare and the Commissioner of Finance and Administration, and sent to the Attorney General and the Secretary of State for approval.

Management’s Comment

We concur. We anticipate that written responses to comments concerning the GME rules will be completed shortly and the final rules promulgated within six months. We also anticipate that responses to HCBS rule 1200-13-1-.17 will be completed shortly and the three HCBS waiver rules (1200-13-1-.17, 1200-13-1-.26, and 1200-13-.27) will be promulgated within six months.

8. **TennCare did not require the Department of Human Services to maintain adequate documentation of the information used to determine Medicaid eligibility**

Finding

As noted in the prior audit, the Bureau of TennCare did not require the Department of Human Services (DHS) to maintain adequate documentation of the enrollee’s information used to determine Medicaid eligibility. The Department of Human Services performs Medicaid eligibility determinations under an interdepartmental contract with the Bureau of TennCare.

DHS uses the Automated Client Certification and Eligibility Network (ACCENT) system to determine eligibility for Medicaid. During the enrollment process, county DHS eligibility counselors meet with the potential enrollees in face-to-face interviews. Each applicant is required to provide hard-copy documentation to support various eligibility criteria. This information includes income, resources, medical expenses, family information, social security numbers, date of birth, etc. During the enrollment process, eligibility counselors examine documentation supporting the information that is entered into ACCENT. For example, before entering income into the system, an eligibility counselor would examine such documentation as employment pay stubs or federal tax returns. At the end of the enrollment process, the documentation supporting the information entered into the system is then returned to the applicant/enrollee. ACCENT makes the eligibility determination based upon the information entered into the system by the eligibility counselor.

DHS transmits eligibility updates from ACCENT daily to the Bureau of TennCare to update TennCare eligibility information in the TennCare Management Information System (TCMIS).

Auditor inquiry revealed that the enrollee's application is the only paper documentation consistently kept by DHS. Although ACCENT maintains electronic case notes, there is no documentation kept to support the eligibility information entered into ACCENT. Without adequate documentation of the information entered into ACCENT, the risk is increased that ineligible enrollees may be enrolled on Medicaid.

Discussions with management at DHS revealed that the department relies heavily upon information from the Tennessee Department of Labor and Workforce Development, the Social Security Administration (SSA), the Tennessee Department of Health, and the Internal Revenue Service (IRS) for verification of eligibility information. From the Department of Labor and Workforce Development, DHS receives monthly data on Unemployment Insurance Benefits that can be used to verify unemployment income.

DHS also receives monthly beneficiary and earnings data, daily social security number verification, and daily information on Supplemental Security Income (SSI) recipients from SSA. The data from SSA provide DHS a method of verifying an individual's Social Security payments, social security number, Medicare eligibility status, and SSI eligibility status. Through the Office of Vital Records within the Department of Health, DHS has daily access to birth records. This information can be used to verify ages and relationships needed when making an eligibility determination. DHS also receives wage data from the Department of Labor and Workforce Development. However, not all employers are required to report employee wages to the state. Employers that are not required to report include churches, regardless of the size of payroll or number of employees, and non-government organizations with a small payroll and/or few employees. Furthermore, this information is sometimes several months old and is reported on a quarterly basis. Medicaid eligibility is determined based on current monthly income. In addition, the information DHS receives from the IRS concerning income that is reported on an individual's IRS 1099 form is delayed several months and is reported on a yearly basis.

Although DHS receives information from outside sources, not all eligibility requirements can be verified through this information. These outside information sources do not provide a systematic way to verify all types of income an enrollee might have. In addition, none of the updates received from other departments include documentation of other resources for non-SSI recipients or medical expenses that could affect an eligibility decision.

Management did not concur with the prior finding. It is management's position that keeping copies of supporting documents is unnecessary because:

- a. much of the information supporting the eligibility of recipients is verified through data matches described above,
- b. the Department of Human Services has a quality control process that samples a portion of the recipient population monthly,
- c. the federal Departments of Health and Human Services and Agriculture approved the design of and funded the creation and operation of the ACCENT system with full knowledge of the "paperless" aspects of the system,
- d. the system has been in place since 1992 without any indication from the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, that the process in place was not adequate to meet federal requirements, and
- e. the State Attorney General issued an informal opinion in 1992 that the application form and the electronic file satisfied the legal requirements for determining eligibility and would be admissible evidence in legal proceedings and that there were no federal requirements specifying that written documentation other than the signed application form be maintained.

We believe that management's arguments are not unreasonable. However, we believe that there are sufficient counter points to these arguments such that management should either implement a process to maintain supporting documentation or obtain explicit approval from the appropriate federal authorities for maintaining the "paperless" system. The counter points to management's arguments are:

- a. while the data matches do verify much of the necessary information for many of the recipients, they do not verify such things as other resources and medical expenses for most recipients, they do not verify income information for all recipients, and they do not always provide timely information,
- b. at best, a quality control system provides after-the-fact inferences about the accuracy of eligibility determinations; and the system used by DHS does not include all Medicaid enrollees in the population sampled,

- c. neither TennCare nor DHS has been able to produce evidence that the federal Department of Health and Human Services specifically approved the “paperless” aspects of the system,
- d. CMS has not specifically stated that the process in place is adequate to meet federal requirements, and
- e. while federal regulations do not state what specific documentation is needed to support eligibility determinations for the Medicaid program, OMB Circular A-87 does state that costs must be adequately documented to be allowable under federal awards.

Furthermore, without maintaining the documentation, the Bureau of TennCare cannot ensure that the information entered into ACCENT is accurate and Medicaid enrollees are eligible at the time benefits are awarded. Not maintaining this documentation also reduces accountability for information entered and makes researching cases more difficult.

Recommendation

The Director of TennCare should ensure that DHS keeps documentation of the information entered into ACCENT that is used to determine Medicaid eligibility or obtain explicit approval from the appropriate federal authorities for maintaining the “paperless” system.

Management’s Comment

We do not concur. Approval of the ACCENT system design, which includes the electronic recording of eligibility data, was obtained from the U.S. Department of Health and Human Services before implementation of the system in 1992. There has never been any indication from the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, that the process in place was not adequate to meet federal requirements. In addition, the State Attorney General also issued an opinion in 1992 that the use of an electronic eligibility file and the application form satisfied legal requirements for determining eligibility.

As required by federal law and to ensure program integrity, the Department of Human Services (DHS) has had a quality control system in place since implementation of TennCare (and previously under the Tennessee Medicaid program). In this quality control system, called Medicaid Eligibility Quality Control (MEQC), each month DHS uses a random sampling of Medicaid cases to validate eligibility determinations, whether active (eligible) or negative (denied). The MEQC system is designed to reduce erroneous expenditures by monitoring eligibility determinations, third party liability activities, and claims processing (State Medicaid Manual, Part 7, Quality Control). MEQC programs approved in Section 1115 waiver states are relieved of any liability for disallowances for Medicaid eligible enrollees and for individuals

added under the waiver resulting from errors that exceed the 3 percent tolerance level established by federal regulations.

TennCare believes that the eligibility procedures, including the level of documentation, and the MEQC reviews and follow-up activities provide adequate internal controls over the eligibility process and meet federal requirements. However, consideration will be given as to whether any additional monitoring of the process in place at DHS should be performed.

Rebuttal

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, 2000, through June 30, 2001, HHS stated:

This is a material weakness. We recommend procedures be developed and implemented to ensure client eligibility is adequately documented and the documentation is retained.

In addition, according to the *Code of Federal Regulations* (CFR), 42 CFR 431.17(d), “Conditions for optional use of microfilm copies,”

The agency may substitute certified microfilm copies for the originals of substantiating documents required for Federal audit and review [emphasis added]

While federal regulations do not explicitly define the form of the documentation to be maintained, this regulation establishes that there is an expectation that the department maintain original documentation of the information received.

9. TennCare does not have a court-approved plan to redetermine or terminate the TennCare eligibility of SSI enrollees that become ineligible for SSI

Finding

As noted in prior audit findings in the previous two audits, TennCare does not redetermine or terminate the TennCare eligibility of Supplemental Security Income (SSI) enrollees that become ineligible for SSI. This is because TennCare does not have a court-approved plan which allows TennCare to make a new determination of the eligibility of these enrollees. According to 1200-13-12-.02(1)(c) of the *Rules of the Tennessee Department of Finance and Administration, Bureau of TennCare*, “The Social Security Administration determines eligibility for the Supplemental Security Income (SSI) program. In Tennessee, SSI recipients are automatically eligible for Medicaid. All SSI recipients are therefore TennCare eligibles.” However, when an individual enrolled in TennCare as an SSI enrollee is terminated

from SSI, TennCare does not redetermine or terminate the enrollee's eligibility. Currently, TennCare does not terminate SSI recipients unless the recipient dies, moves out of state and is receiving Medicaid in another state, or requests in writing to be disenrolled. Management concurred with the prior finding and stated,

The Director will ask the Attorney General to take action to bring this issue back before the court for final disposition. . . . The AG will be asked to present this decision, coupled with assurances that eligibility review will be performed by the Department of Human Services to determine whether the individual qualifies for any other category of TennCare benefits (including the right to appeal if DHS determines that the individual is no longer eligible for any category of benefits) to the Court with a request to set aside or modify its November 13, 1987, Order. A positive finding by the Court could lift the injunction and permit the disenrollment, if appropriate, of those individuals who have been provided continuous Medicaid and TennCare benefits following termination of SSI.

In response to the finding, TennCare has drafted a plan dated July 12, 2002, that will allow the Bureau to make a new determination of the eligibility of enrollees that become ineligible for SSI, once the court approves the plan. Management stated that the plan will be submitted to the Attorney General, who will in turn present the plan to the court for court approval.

The *Cluster Daniels et al. vs. the Tennessee Department of Health and Environment et al.* court order states,

. . . defendants are hereby ENJOINED from terminating Medicaid benefits without making a de novo [a new] determination of Medicaid eligibility independent of a determination of SSI eligibility by the Social Security Administration. The Court further ENJOINS defendants to submit to the Court and to plaintiffs, within thirty (30) days of entry of this Order, the plan by which defendants have implemented de novo determination of Medicaid eligibility. . . .

Furthermore, the court has required that the Medicaid program must make a determination whether or not the recipient's termination from SSI was made in error.

Management has stated that TennCare follows the direction of the Attorney General's office concerning how to comply with the court order. We requested information from the Attorney General's office on this matter and received a response dated October 17, 2001, which stated,

There is no reason that the affected state agencies (Bureau of Medicaid/TennCare, Department of Human Services) cannot or should not proceed to attempt to comply with the district court's orders and injunction by devising a plan which would satisfy the requirements of those orders. (Under the terms of the Court's orders, the Court will have to approve any State plan to make de novo

determinations of Medicaid eligibility independent of determinations of SSI eligibility by the Social Security Administration.) Furthermore, we understand that a number of efforts have been made over the years following entry of those orders to devise a plan which would satisfy the orders' requirements. The efforts have included extensive negotiations between counsel for plaintiffs, counsel for the federal defendants, the Attorney General's office and the Tennessee Department of Human Services (which makes, under law, the Medicaid eligibility determinations). Unfortunately, these efforts have been unsuccessful to date.

By not having a court-approved plan that would allow TennCare to determine if terminated SSI recipients are still eligible for TennCare and to terminate ineligible enrollees, TennCare is allowing potentially ineligible enrollees to remain on TennCare until they die, move out of state and receive Medicaid in another state, or request in writing to be disenrolled.

Recommendation

The Director of TennCare should ensure that TennCare complies with all court orders and injunctions that relate to the eligibility of SSI enrollees. TennCare should develop and implement a court-approved plan that would allow TennCare to determine if terminated SSI recipients are still eligible for TennCare and terminate ineligible enrollees.

Management's Comment

We concur. In an effort to obtain Court approval, the proposal referenced in the finding was submitted to the Attorney General with a request that it be submitted to the Court for approval. The Attorney General has requested additional information regarding systems and programmatic implementation of the proposal. This information is to include such things as a detailed methodology for systems matching to determine current addresses for persons terminated from SSI who have not utilized TennCare benefits. In addition, the Department of Human Services is developing a process to provide the reviews required by the Daniels Order to determine if persons who have been terminated from SSI qualify for other distinct categories of benefit eligibility. The Attorney General will submit the proposal to the Court when the implementation plans are complete. When the Court has reviewed the proposal and approved or modified it, it will be implemented.

10. Internal control over TennCare eligibility is still not adequate

Finding

As noted in the seven prior audits of the Bureau of TennCare, internal control over TennCare eligibility is not adequate. Management concurred in part with the prior audit findings, as discussed throughout this finding. In response to the prior-year finding, management

corrected weaknesses regarding policies and procedures, recipients enrolled on TennCare twice, and enrollees with out-of-state and post office box addresses. However, serious internal control issues still exist.

During the year ended June 30, 2002, the responsibility of initial eligibility determination for the uninsured and uninsurable population, which represents approximately 43% of all TennCare enrollees, was divided between the county health offices in the Department of Health and the Member Services Unit in the Bureau of TennCare. For the Medicaid population, the Department of Human Services (DHS) has the responsibility for eligibility determinations. The Department of Children's Services (Children's Services) is responsible for eligibility determinations of children in state custody.

As of July 1, 2002, DHS began enrolling the uninsured and uninsurable population, which is now called TennCare Standard, in addition to the Medicaid population, which is now called TennCare Medicaid. Children's Services enrolls children in state custody in both TennCare Standard and TennCare Medicaid.

Inadequate Staff to Verify Information on Applications

This issue was first reported in the audit for year ended June 30, 2000. The audit reported that the unit that reviews the uninsurable applications was understaffed. Management responded to that finding and stated that a new Member Services Unit would be formed to handle all member communications. However, in the audit for year ended June 30, 2001, we reported that although a new Member Service Unit had been organized, the unit within Member Services was still understaffed.

Management concurred with this portion of the prior audit finding and stated,

Members Services reorganized resources to assure that all services related to members were under one TennCare Division. However, staffing of the uninsurable unit has not increased. The unit is still not staffed to verify all information on all TennCare applications. Under the modifications to the TennCare waiver, submitted to U. S. Department of Health and Human Services in February 2002, the Department of Human Services would be the single point of entry for all TennCare applications. This process will include a face-to-face interview with verification of critical eligibility components. If approved, the modified waiver would become effective January 1, 2003, with eligibility determinations to begin July 1, 2002, at the county Department of Human Services offices.

As stated in management's comments, the unit that reviews the uninsurable, uninsured with limited benefits, and uninsured with COBRA termination applications was still understaffed during the audit period. These applications also include enrollees in the State Children's Insurance Program (SCHIP). The unit receives approximately 1,000 applications weekly. During the first nine and a half months of the audit period, there were only two individuals who initially reviewed the applications to verify the information for completeness and accuracy.

During the transition period (the last two and a half months of the audit period) of moving enrollment to DHS, there were four individuals, with additional job duties, who initially reviewed the applications to verify the information for completeness and accuracy. However, because these four individuals were assigned other job duties, they could not devote 100 percent of their time to the application review process. As a result, for the entire year, not all the information on the applications (e.g., income, access to insurance, address, and citizenship status) was verified for accuracy. Not verifying information on these applications increases the risk that ineligible recipients will be enrolled.

No Verification of Applications for Individuals Losing Medicaid

This issue was first reported in the audit for year ended June 30, 2000. That audit reported that the applications were entered on the TennCare Management Information System without verification of information contained on the application. Management then responded that they believed accuracy of eligibility determinations would be improved with the new Member Services Unit. However, in the report for year ending June 30, 2001, we reported that the Bureau still did not verify information contained on applications for individuals losing Medicaid eligibility

Management concurred with this portion of the 2001 audit finding and stated,

The new waiver design, which upon approval is intended to go into effect in July, requires that persons applying for the demonstration population, including those who are exiting the Medicaid program, go into Department of Human Services offices to have all information checked in a face-to-face interview process. This process will be more rigorous than the process that is currently in place and will resolve this finding, we believe.

However, during the audit period, the Bureau did not verify information contained on applications for individuals losing Medicaid eligibility. According to 1200-13-12-.02(5)(a) of the *Rules of the Tennessee Department of Finance and Administration, Bureau of TennCare*,

. . . Persons losing Medicaid eligibility for TennCare who have no access to insurance may remain in TennCare if they are determined to meet the non-Medicaid TennCare eligibility criteria. . . .

These applications were entered on the TennCare Management Information System (TCMIS) and processed without verification of information contained on the application. Without verifying the information on the applications, the Bureau of TennCare cannot ensure that the applicant meets non-Medicaid TennCare eligibility or SCHIP criteria. In addition, not verifying the information on the applications can result in inaccurate premium amounts based upon the unverified and possibly inaccurate income amounts reported by the recipient.

Inadequate Documentation of Eligibility Information (This portion of the finding has not been reported in prior years)

During fieldwork, we examined the applications and all supporting documentation maintained by the Bureau of TennCare for a sample of 60 uninsured and uninsurable enrollees (including SCHIP enrollees). For 57 out of 60 enrollees (95%), we determined that TennCare did not have adequate documentation (such as pay stubs or tax returns) to support the income amounts reported by the enrollee on the TennCare application.

As a result of inadequate income documentation, we could not verify that the income amounts reported by the enrollee were accurate, nor could we determine that correct amounts were used to determine premiums for enrollees or that SCHIP enrollees were eligible. Not maintaining adequate documentation of income increases the risk that incorrect premiums are charged to enrollees.

In addition, we noted that TennCare did not require the Department of Human Services to keep adequate documentation of the information used to determine Medicaid eligibility. See finding 8 for further details regarding this matter.

Invalid and Pseudo Social Security Numbers Again Discovered

This issue was first reported in the audit for the year ended June 30, 1997. In that audit we discovered that several thousand TennCare participants had fictitious or “pseudo” social security numbers. In response to that finding, management stated that the reverification project would help to ensure that valid numbers are obtained from enrollees. The audit report for year ended June 30, 1998, reported that there were still 84 enrollees on TennCare’s system with uncorrected “pseudo” social security numbers. In response to that finding, management stated that “Health Departments included information in their training that addressed validation of Social Security Numbers and obtaining a valid number for enrollees with pseudo numbers.” In the audit report for year ended June 30, 1999, we reported that there were still 68 enrollees on TennCare’s system with uncorrected “pseudo” social security numbers. The response to that finding did not discuss “pseudo” social security numbers. In the audit report for year ended June 30, 2000, we reported that TennCare had 79 enrollees with uncorrected “pseudo” social security numbers. In response to that finding, management stated that it “is our intent to address this issue as a part of our planning for the new TCMIS.” In the audit report for year ended June 30, 2001, we reported that 76 individuals had uncorrected “pseudo” social security numbers in TennCare’s system.

Management concurred with the 2001 audit finding and stated,

There are pseudo social security numbers in the TCMIS and the Bureau is working on a means of validating and correcting them through the Social Security Administration (SSA). The TCMIS assignment of pseudo social security numbers occurs for newborns to the system through the uninsured/uninsurable process. . . .

Similar to results noted in the five previous audits, when computer-assisted audit techniques were used to search TCMIS, the search revealed that 721 TennCare participants had invalid or pseudo social security numbers. Thirty-three of the 721 social security numbers were pseudo social security numbers that began with “888,” which are assigned by TCMIS. 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. The remaining 688 individuals had invalid social security numbers.

Testwork revealed that, during and after the end of the audit period, TennCare staff replaced 52 of the 721 invalid/pseudo social security numbers with valid numbers. However, the remaining 669 invalid or pseudo social numbers were still in the TCMIS system as of November 2002. Further testwork revealed that one TennCare enrollee had been enrolled in Medicaid with an invalid social security number since 1981. Another enrollee was enrolled since 1991 with a pseudo social security number.

Also, while it is not always possible to obtain social security information for newborns (zero to three months), auditors noted that several individuals with pseudo social security numbers were over one year old or had pseudo social security numbers for several months or years. The total amount paid for individuals with invalid social security numbers was \$583,253. Federal questioned costs totaled \$369,699. The remaining \$213,554 was state matching funds.

According to the *Code of Federal Regulations*, Title 42, Part 435, Section 910(a), “The agency must require, as a condition of eligibility, that each individual (including children) requesting Medicaid services furnish each of his or her social security numbers (SSNs).” In addition, according to the *Code of Federal Regulations*, Title 42, Part 435, Section 910(g), “The agency must verify each SSN of each applicant and recipient with SSA [Social Security Administration], as prescribed by the Commissioner, to insure that each SSN furnished was issued to that individual, and to determine whether any others were issued.” TennCare is also required to follow the *Rules of the Department of Finance and Administration, Bureau of TennCare*, Chapter 1200-13-12-.02 (2)(b), which state, “All non-Medicaid eligible individuals . . . 3. Must present a Social Security number or proof of having applied for one. . . .” Also, according to the *Rules of the Tennessee Department of Human Services, Division of Medical Services*, Chapter 1240-3-3-.02 (10), “As a condition of receiving medical assistance through the Medicaid program, each applicant or recipient must furnish his or her Social Security Number (or numbers, if he/she has more than one) during the application process. If the applicant/recipient has not been issued a number, he/she must assist the eligibility worker in making application for a number or provide verification that he/she has applied for a number and is awaiting its issuance.”

Ineligible Enrollees Discovered

This portion of the audit finding was first reported in the prior audit. Management did not concur with this portion of the prior audit finding and stated that,

We do not concur that individuals eligible under Medicaid categories in the TCMIS and not eligible in ACCENT [the Automated Client Certification and

Eligibility Network] represent ineligible TennCare enrollees. As stated in the audit finding, existing business rules allow certain categories of eligibles to be extended for up to 12 months of eligibility within the TCMIS. We concur that Medicaid enrollees could remain eligible beyond the twelve month extended end date as a result of pended/incomplete applications. TennCare generates notices to all Medicaid enrollees 30 days in advance of reaching their TCMIS end date. If an application is entered into ACCENT or the TCMIS within the window allowed, the end date is opened until the application is completed. TennCare Information Systems has worked closely with the Department of Human Services to ensure these pended applications are reported accurately to TennCare, and TennCare reviews any incomplete/pended uninsured/uninsurable applications. Beginning in November 2001 TennCare is identifying the population who have been extended for greater than 12 months of eligibility with aged/pended or incomplete applications, loading end dates to those records and re-sending the 30 day advanced termination notice.

In its comments, management stated that TennCare's unwritten "business rules" allow certain categories of Medicaid-eligible enrollees a 12-month extension of eligibility even though the enrollee's eligibility on ACCENT ends before the 12-month extension ends. We determined that the TennCare waiver allows TennCare to grant eligibility for one year only for "medically needy" enrollees if they are eligible for any month of a calendar year. This extension does not appear to apply to any other categories of eligibility. During audit fieldwork, auditors made numerous requests of management to provide written documentation and justification giving TennCare the authority to grant eligibility to "categorically needy" Medicaid enrollees in segments of 12 months, or to allow enrollees to remain Medicaid eligible until all applications are processed. However, as in the previous year no such documentation was provided.

In November 2001, to respond to the prior finding, TennCare identified and started the termination process for enrollees mentioned above rather than citing unsubstantiated existing "business rules."

A sample of the Medicaid population, excluding Supplemental Security Income (SSI) enrollees, was tested to determine if the enrollees were eligible for Medicaid on the date of service, based solely upon the information in ACCENT. Testwork revealed that TennCare did not ensure that DHS maintained adequate documentation of the information entered into ACCENT. See finding 8 for further details on this matter. Medicaid enrollees are enrolled through DHS and Children's Services using ACCENT. TennCare receives daily eligibility data files from ACCENT, which update information in TCMIS. The Bureau of TennCare pays the managed care organizations (MCOs) and behavioral health organizations (BHOs) a monthly capitation payment to provide services to these enrollees. For the year ended June 30, 2002, the Bureau paid capitation payments totaling over \$2.3 billion to MCOs and over \$357 million to BHOs for TennCare enrollees. Of the 60 capitation payments for Medicaid enrollees tested, testwork revealed 3 enrollees (5%) were not eligible for Medicaid on the date of service, based solely upon the information in ACCENT. Of the three ineligible enrollees, two enrollees were no longer eligible for Medicaid according to ACCENT, and one enrollee enrolled through

Children's Services was no longer in state custody. According to TennCare's eligibility policies and procedures manual, the two enrollees' Medicaid eligibility should have ended in TCMIS one month after eligibility ended in ACCENT.

Specific details from the sample testwork were as follows:

- For one enrollee, Medicaid ended per ACCENT on November 30, 1997, and should have ended in TCMIS on December 31, 1997. However, TennCare did not close the enrollee's Medicaid eligibility on TCMIS until December 31, 2001, which allowed this enrollee to continue receiving Medicaid services for four extra years. This enrollee was not classified as "medically needy."
- For another enrollee, Medicaid ended per ACCENT on August 31, 2001, after 18 months of "Transitional Medicaid." In Tennessee, Families First eligibility automatically qualifies an individual for Medicaid. According to the *Families First Policy and Procedure Manual*, "Transitional Medicaid" is Medicaid eligibility that is extended for 18 months after an individual loses Families First eligibility. This enrollee's Medicaid eligibility should have ended on September 30, 2001, in TCMIS. However, TennCare did not close this enrollee's Medicaid eligibility on TCMIS until February 1, 2002, which allowed this enrollee to continue to receive Medicaid services for an extra four months. This enrollee was not classified as "medically needy."
- One enrollee's Medicaid was open on ACCENT on the date of service, but the child was no longer in state custody. The Child Welfare Benefits Counselors within Children's Services are responsible for eligibility determinations and redeterminations of children in state custody. According to Children's Services' personnel, when a child leaves state custody, Children's Services ends the Medicaid eligibility in ACCENT after a 30-day extension. This enrollee was released from state custody on August 18, 2000. This enrollee's Medicaid eligibility should have ended on September 18, 2000. However, Children's Services did not end the Medicaid eligibility until March 31, 2002, which allowed this enrollee to continue receiving Medicaid services for an extra year and six months.

The Medicaid population, excluding SSI enrollees, makes up approximately 53% of the TennCare population. The total amount of capitation improperly paid during the audit period for all the errors noted above was \$541, out of a total of \$4,848 tested. Federal questioned costs totaled \$345. The remaining \$196 was state matching funds. We believe likely questioned costs exceed \$10,000.

Furthermore, because TennCare has not ensured that only Medicaid-eligible individuals are enrolled in TennCare as a Medicaid enrollee, ineligible enrollees could be inappropriately enrolled in other programs. For example, according to the *Code of Federal Regulations* Title 7, Part 247, Section 7(d)(2)(vi)(A), Medicaid enrollees are automatically income-eligible for the Department of Health's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Recommendation

Note: For the issues that have been repeated in this finding over the years, this is the same basic recommendation that has been made in the many past audits.

The Director of TennCare should ensure that adequate staff is assigned at DHS and Children's Services to verify information on all applications and that all information on the applications is verified. The Director of TennCare should ensure that documentation of all critical information used in an eligibility determination or premium determination is maintained in the enrollee's file.

The Director should ensure that valid social security numbers are obtained for all individuals in a timely manner. The Director should ensure that only eligible enrollees are receiving TennCare, and all ineligible enrollees should be removed from the program. When possible, TennCare should recover capitation payments made to the MCOs for ineligible enrollees.

Management's Comment

Inadequate Staff to Verify Information on Applications

We concur that during the audit period we had inadequate staff for verification of information on applications. Under the modifications to the TennCare waiver, approved by the U. S. Department of Health and Human Services on May 30, 2002, the Department of Human Services (DHS) is the single point of entry for all TennCare applications. This process includes a face-to-face interview with verification of critical eligibility components. Once approved, the modified waiver became effective January 1, 2003, with eligibility determinations beginning July 1, 2002, at the county Department of Human Services offices.

TennCare has a contract with DHS that requires performance of eligibility determinations and redeterminations including verification of critical eligibility components.

No Verification of Applications for Individuals Losing Medicaid

See comments above.

Inadequate Documentation of Eligibility Information (This portion of the finding has not been reported in prior years)

We concur in part. Effective July 1 2002, all eligibility determinations are made by DHS through face-to-face encounters. Proof of information regarding income is required at the time of each face to face interview for eligibility determination.

DHS enters all critical information into the ACCENT system. Approval of the ACCENT system design, which includes the electronic recording of eligibility data, was obtained from the U.S. Department of Health and Human Services before implementation of the system in 1992. There has never been any indication from the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, that the process in place was not adequate to meet federal requirements. In addition, the State Attorney General also issued an opinion in 1992 that the use of an electronic eligibility file and the application form satisfied legal requirements for determining eligibility.

As required by federal law and to ensure program integrity, DHS has had a quality control system in place since implementation of TennCare (and previously under the Tennessee Medicaid program). In this quality control system, called Medicaid Eligibility Quality Control (MEQC), each month DHS uses a random sampling of Medicaid cases to validate eligibility determinations, whether active (eligible) or negative (denied). The MEQC system is designed to reduce erroneous expenditures by monitoring eligibility determinations, third party liability activities, and claims processing (State Medicaid Manual, Part 7, Quality Control). MEQC programs approved in Section 1115 waiver states are relieved of any liability for disallowances for Medicaid eligible enrollees and for individuals added under the waiver resulting from errors that exceed the 3 percent tolerance level established by federal regulations.

In addition, TennCare contracts with the University of Tennessee for the performance of MEQC procedures for the uninsured and uninsurable population.

TennCare believes that the eligibility procedures, including the level of documentation, and the MEQC reviews and follow-up activities provide adequate internal controls over the eligibility process and meet federal requirements.

Invalid and Pseudo Social Security Numbers Again Discovered

We concur in part. The TCMIS assignment of pseudo social security numbers occurs for newborns to the system. Benefits for illegal/undocumented aliens are issued with pseudo numbers, since they cannot get a SSN legally. These are the only cases that will never have a 'real' SSN.

Effective July 1 2002, all eligibility determinations are made by DHS where eligibility information is entered into the ACCENT system. If a number is blank or invalid, ACCENT does

an automatic front end match of SSNs entered into the system and provides an 'alert' to the case worker if an adjustment needs to be made. DHS also has a systems report of individuals for those that cannot be matched (usually newborns) that workers are to check. DHS also uses State on-line Query (SOLQ) to verify a number if an individual does not have a card. ACCENT does not allow two individuals to use the same SSN.

Ineligible Enrollees Discovered

We do not concur that individuals eligible under Medicaid categories in the TCMIS and not eligible in ACCENT represent ineligible TennCare enrollees. As stated in the audit finding, business rules (Member Services Policy – MS-002) allowed certain categories of eligibles to be extended for up to 12 months of eligibility within the TCMIS. We concur that Medicaid enrollees could remain eligible beyond the twelve month extended end date as a result of pended/incomplete applications.

Upon implementation of TennCare, it was apparent that the nature of sudden and retroactive loss of Medicaid eligibility was not in keeping with a good managed care environment. Therefore, methodology was adopted to assure continuity of care for Medicaid enrollees as outlined in the goals for the Waiver and the TennCare Program. Since Families First Legislation extends benefits for eighteen (18) months, it is no longer necessary to provide an additional extension in order to achieve continuity of care for enrollees and we have discontinued this practice.

TennCare generates notices to all Medicaid enrollees 30 days in advance of reaching their TCMIS end date. If an application is entered into ACCENT or the TCMIS within the window allowed, the end date is opened until the application is completed. TennCare Information Systems has worked closely with DHS to ensure these pended applications are reported accurately to TennCare, and TennCare reviews any incomplete/pended uninsured/uninsurable applications. Beginning in November 2001 TennCare identified the population who have been extended for greater than 12 months of eligibility with aged/pended or incomplete applications, loading end dates to those records and re-sending the 30 day advanced termination notice. Significant re-verification efforts were implemented at this time. Effective July 1 2002, DHS became the single point of entry for all TennCare determinations and redeterminations including verification of critical eligibility components.

Rebuttal

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 for the State of Tennessee* for the period July 1, 2000, through June 30, 2001, HHS stated:

This is a material weakness, a material instance of noncompliance, and a repeat finding. We recommend 1) procedures be strengthened to ensure participant eligibility is accurately determined and periodically reviewed for any changes that would affect eligibility . . .

Regarding the lack of documentation, the *Code of Federal Regulations* (CFR), 42 CFR 431.17(d), “Conditions for optional use of microfilm copies,”

The agency may substitute certified microfilm copies for the originals of substantiating documents required for Federal audit and review [emphasis added]

While federal regulations do not explicitly define the form of the documentation to be maintained, this regulation establishes that there is an expectation that the department maintain original documentation of the information received.

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

Regarding the ineligible enrollees discovered we did not state that all individuals eligible under Medicaid categories in the TCMIS and not eligible in ACCENT represent ineligible TennCare enrollees. However, we did identify individuals in TCMIS who appear to be ineligible. Although management does not concur, it again has not provided any documentation to support the eligibility of those enrollees in question. Furthermore, there is no provision in the rules, written policies, or written “business rules” that allows individuals who submit incomplete applications to remain eligible for program services indefinitely. As stated in the audit finding, one enrollee’s Medicaid should have ended on December 31, 1997, but was not ended until four years later on December 31, 2001.

Management did not address the part of the recommendation concerning the recovery of capitation payments made to the MCOs for ineligible enrollees.

11. TennCare should improve internal control over the eligibility of state-only enrollees and should ensure that no federal dollars are used for state-only enrollees

Finding

As noted in the prior two audits, controls over the eligibility of state-only enrollees need improvement. During the fiscal year ended June 30, 2002, as a part of the TennCare Partners Program, TennCare provided behavioral health coverage to individuals (state-only enrollees) who would not be eligible for the TennCare program under the Medicaid rules. The individuals classified as state-only enrollees included non-United States citizens, prisoners, those who have provided invalid social security numbers, and non-Tennessee residents. The state-only enrollees’ coverage is to be funded totally with state funds. There were 1,155 individuals classified as state-only enrollees during the audit period.

Management concurred in part with the prior audit finding and stated,

The main responsibility for the eligibility of these enrollees is the DMHDD [Department of Mental Health and Developmental Disabilities], who determines the eligibility for the state only enrollees in the Partners program. . . . Certain policies and procedures were revised by DMHDD regarding . . . state onlys. . . . One of the provisions stated that DMHDD would review individuals enrolled as “state onlys” every 6 months to determine if they were still receiving services and if they were still eligible as state onlys. To further address this issue DMHDD drafted changes to the TennCare rules regarding the State Only category. They are currently in the process of rule promulgation. When these rules are promulgated, we essentially can begin termination of the individuals noted.

According to discussion with management at TennCare, enrollment for the state-only category closed June 30, 2000, but reopened on July 1, 2002. During the audit period, management at the DMHDD and the Bureau of TennCare reviewed the state-only eligibility process and revised the policies and procedures and TennCare rules regarding the state-only category. These policies, procedures, and rules did not go into effect until July 1, 2002. Therefore, neither DMHDD nor the Bureau of TennCare reverified and disenrolled ineligible state-only enrollees during the audit period. As a result, enrollees have remained in the TennCare Partners Program since 1998 without any redetermination of their eligibility.

According to the *Rules of the Tennessee Department of Finance and Administration* 1200-13-12-.02 (8)(b)(2), to be eligible as a state-only enrollee, the enrollee must have a family income that does not exceed 100% of the federal poverty level. However, testwork revealed that 75 of 1,155 state-only enrollees (6.49%) had an income recorded in the TennCare Management Information System (TCMIS) that exceeded the poverty-level income standard. The amount paid for the ineligible enrollees totaled \$39,457, which includes \$4,006 in Behavioral Health Organization (BHO) capitation payments and \$35,451 in pharmacy payments. These costs are funded totally with state dollars. As a result, there are no federal questioned costs associated with this condition.

In addition, testwork was performed to determine that no federal dollars were used to pay for the population of state-only enrollees. Testwork revealed that the Bureau uses an estimate to identify these enrollees’ costs. TennCare estimated the costs associated with all state-only enrollees to be \$222,144 and thus did not claim federal financial participation on the \$222,144 for the audit period. However, TennCare underestimated the actual costs for these enrollees. Testwork revealed that that amount actually paid for the population of state-only enrollees during the audit period was \$442,323, which included \$63,424 in BHO capitation payments and \$378,899 in pharmacy payments. As a result, TennCare incurred an additional \$220,179 over the estimate and inappropriately drew federal funds to cover these costs. Federal questioned costs totaled \$140,204. The remaining \$79,975 was state matching funds.

Recommendation

The Director of TennCare should ensure that state-only enrollees are reverified as soon as possible and ineligible enrollees are removed from the program. The Director should ensure that no federal dollars are used for state-only enrollees. The Director should ensure that the Bureau develops a mechanism for reporting actual dollars spent for state-only enrollees.

Management's Comment

We concur. The Department of Mental Health and Developmental Disabilities (DMHDD) continues to perform eligibility determinations for state only funded individuals in the TennCare Partners Program. TDMHDD is reviewing state-only eligible enrollees on a regular basis. The DMHDD Eligibility Unit began enrolling state-only individuals in August 2002. A review of eligibility will be performed for each individual classified as state-only every 6 months with the first review to begin in February 2003.

The Fiscal Budget section of the Bureau of TennCare is developing a report to identify actual costs for state-only enrollees. This report will be used to ensure that expenditures are reported accurately and that federal expenditure reports do not include costs for state-only enrollees.

12. **For the third consecutive year, TennCare made payments on behalf of full-time state employees, resulting in new federal questioned costs of \$54,106 and an additional cost to the state of \$31,019**

Finding

As noted in the prior two audits, TennCare made capitation payments on behalf of full-time state employees who are classified as uninsured or uninsurable in the TennCare Management Information System (TCMIS). However, according to personnel in the Department of Finance and Administration's Division of Insurance and Administration, all full-time state employees have access to health insurance at the time of hire or when the employee reaches full-time status.

According to *Rules of the Tennessee Department of Finance and Administration*, 1200-13-12-.02(2)(b), "All non-Medicaid eligible individuals must meet the following technical requirements: . . . 8. Must not be eligible for participation in an employer sponsored health insurance plan, either directly or indirectly through another family member, except that uninsured children under the age nineteen (19) whose family income is below 200% of the federal poverty level shall be eligible for TennCare even if they have access to employer sponsored health insurance through a parent . . ." Also, Bureau of TennCare rule 1200-13-12-.02(5)(b)(1) states, "Non-Medicaid eligibility for 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 concurred with the prior audit finding and stated,

A process was put in place in May 2001 to ensure that full-time employees of the State of Tennessee are removed from the TennCare rolls. The Department of Finance and Administration, Division of Insurance, sends a database from the Tennessee Insurance System to TennCare once a quarter of all new state employees. That database is then forwarded to TennCare Information Systems to complete an electronic match against the TennCare rolls. TCMIS sends Program Integrity a list of perfect [individuals with an exact name, date of birth, and social security number match] and imperfect matches [individuals with a similar, but not an exact match on name, date of birth and/or social security number].

For perfect matches, an employer verification letter is sent to the Department of Finance and Administration, Division of Insurance to complete. Once this verification letter is returned to Program Integrity, the TennCare eligibility screens are reviewed to determine the state employee’s (and family members, when applicable) TennCare enrollment type (Waiver, DHS, SSI) [and] the income level when there are children on the TennCare case. Referrals are made to Administrative Appeals for termination and to TCMIS to add TPL [third-party liability], if this is not already reported. . . .

When an imperfect match is received from TennCare IS, Program Integrity investigates to determine if there is an unreported marriage or divorce, or if the Social Security number on one of the databases is incorrect. If the investigation does not validate this information, the case is closed and no referral is made to Administrative Appeals for termination. When an investigation validates that the identity of the TennCare enrollee is the same as the state employee, the case is worked the same as the perfect matches. . . .

In May 2001, TennCare performed a match between the Department of Personnel’s records and TCMIS to identify full-time state employees who were on TennCare as uninsured or uninsurable enrollees. The Department of Personnel’s records provide information on state employees and include state employees who have accepted and declined state insurance. The enrollees that the Program Integrity Unit (PIU) identified and recommended for termination from the program were terminated by the end of fiscal year ended June 30, 2002.

During the fiscal year ended June 30, 2002, TennCare again performed matches between the TIS (Tennessee Insurance System) and TCMIS to identify and terminate full-time state employees who were on TennCare as uninsured or uninsurable enrollees. However, the match between TIS and TCMIS did not identify state employees who have declined state insurance. No matches were performed between the Department of Personnel’s records and TCMIS during the

fiscal year ended June 30, 2002, to identify and terminate full-time state employees who declined state insurance and were on TennCare as uninsured or uninsurable enrollees.

Using computer-assisted audit techniques to search all of TennCare's uninsured and uninsurable paid-claim records, we found 63 uninsured or uninsurable TennCare recipients enrolled during the audit period who were employed full-time by the State of Tennessee according to records from the Tennessee Department of Personnel. The 63 enrollees we discovered had not been terminated from the program for the following reasons:

- Fifty-six enrollees had declined state insurance but were not discovered during the fiscal year ended June 30, 2002, because a match between the Department of Personnel and TCMIS was not performed during the audit period.
- Two enrollees were not discovered during the matches between TIS and TCMIS. Management could not explain why these enrollees were not discovered.
- Two enrollees were recommended for termination from TennCare and received termination notices but were not terminated because their termination was not completely processed; therefore, TennCare coverage was not ended in TCMIS.
- One enrollee was recommended by PIU for termination but was not terminated because TennCare's Administrative Appeals Unit had no record of receiving the recommendation from the PIU.
- One enrollee's termination notice was returned to TennCare as undeliverable mail. TennCare's Administrative Appeals Unit requested another address from the PIU; however, no additional address was provided by the PIU, and the Administrative Appeals Unit did not follow up.
- For one enrollee, the PIU had a case file but incorrectly did not recommend this enrollee for termination because staff had miscalculated the enrollee's age and determined that the enrollee was under the age of 19 and thus could have access to insurance according to the rules cited above. However, this enrollee was actually 20 years old, had access to insurance, and should have been recommended for termination.

The PIU has now opened cases on the above enrollees. The total amount of capitation payments paid for the errors noted above was \$85,125. Federal questioned costs totaled \$54,106. The remaining \$31,019 was state matching funds.

Recommendation

Note: This is the same basic recommendation made in the prior two years.

The Director of TennCare should ensure that comprehensive matches are performed frequently to find full-time state employees with and without state insurance who are not eligible for TennCare as uninsured or uninsurable. Bureau management should ensure that full-time

employees of the State of Tennessee who are enrolled in TennCare as uninsured or uninsurable enrollees are removed from the TennCare rolls in accordance with court-approved procedures. This would include following up with the PIU and the Administrative Appeals unit to ensure that they have taken all action appropriate on identified files.

Management's Comment

We concur in part. While additional processes are needed and are in development, the Bureau has taken steps to identify and terminate non-eligible state employees. It should be noted that some state employees may be eligible under Medicaid regulations or certain other categories of eligibility.

The Department of Personnel (DOP) record match performed in May of 2001 was a lengthy process where state employees who were TennCare recipients were identified by a computer record match using records from the DOP, the Department of Finance and Administration, Division of Insurance, Tennessee Insurance System (TIS) and TennCare Management Information System (TCMIS). TIS identified all state employees with state sponsored insurance. The employing department of each recipient without state sponsored insurance had to be individually identified and an employer verification form sent, completed and returned to the Program Integrity Unit (PIU) for review and consideration for termination. The major obstacle in this type of verification was the amount of time spent by both the PIU and departmental human resources staff in processing each employer verification form.

In addition to the match described above, another process was in place during the audit period to ensure that full-time employees of the State are removed from the TennCare rolls if not eligible. The Division of Insurance monthly sends a data file consisting of new state employees with state sponsored insurance to TennCare. TennCare Information Systems staff then complete an electronic match against the TennCare rolls. The lists of perfect and imperfect matches are submitted to PIU for review and follow-up. The processes put in place have aided in reducing the level of payments being made on behalf of full-time state employees.

A new process is being developed and is in the final stages of testing that will allow an automated computer identification match of full time state employees, based on the Department of Personnel records. This match report will include identification of salaries and dependents. The salary information will allow PIU staff to determine if children of state employees are above poverty level and therefore potentially not eligible for TennCare. Additional review will be performed to determine if these individuals are eligible under other conditions. The process will be ready to implement when reverification is completed or when the current court order is resolved.

The PIU reviewed the 63 uninsured or uninsurable full time state employees identified by the auditors as having access to insurance and the results are as follows:

- a. 22 individuals had an incorrect full time code in the State Employee Information System (DOP System). These individuals were actually part time employees and not eligible for state sponsored insurance. No action could be taken on these employees.
 - b. 5 individuals with full-time codes had been terminated from state employment with no new hire information on file at the time that our review was performed.
 - c. 14 individuals with full-time codes are currently being held by PIU until the reverification process is completed. If, after completion of this process, they remain on TennCare, individual investigations will be initiated and appropriate recommendations made.
 - d. 22 individuals were submitted to TennCare with a recommendation for termination. Of those 22 cases, 2 state employees have appealed, 5 have not had any action taken by TennCare, and 15 have been terminated from TennCare.
13. **TennCare incorrectly reimbursed Managed Care Organizations, Consultec, Volunteer State Health Plan, and the Department of Children’s Services for services that were unallowable or not performed, resulting in federal questioned costs totaling \$241,287; TennCare also claimed to have newly written procedures to address the Children’s Services issues but would not provide those procedures during the audit**

Finding

As noted in the prior three audits, TennCare has paid the Department of Children’s Services (Children’s Services) for services that were unallowable 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. During the year ended June 30, 2002, TennCare paid approximately \$140 million in fee-for-service reimbursement claims to Children’s Services. The prior audit noted \$576,721 improperly paid to Children’s Services. The current audit showed some improvements made by Children’s Services had reduced these improper billings to \$199,809 for the current audit period.

The three previous audit findings addressed three specific types of unallowable payments made by TennCare to the Department of Children’s Services:

- payments for incarcerated youth,
- payments for children on leave status, and
- payments for children under the age of three.

Regarding the unallowable costs to children under three years of age, testwork revealed that for children under the age of three who received services, those services appeared to be medically necessary. However, the two other issues remain.

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, 2000, through June 30, 2001, HHS stated:

This is a repeat finding. We recommend 1) procedures be implemented to ensure Federal funds are not used for health care costs of a) children who are in youth development or detention centers, . . . c) children on runaway status, . . .

Testwork revealed the following deficiencies:

Payments for Incarcerated Youth

Since 1997, 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. Management concurred with this part of the prior audit finding and stated, "We will implement procedures to improve our monitoring of DCS's [Children's Services] billing activity to be sure that inappropriate payments requested are either denied or recouped, if payment has already occurred." The contract between TennCare and Children's Services requires Children's Services to submit monthly, beginning July 1, 2001, a listing of children who are incarcerated. However, based on discussions with TennCare's Children's Services liaison, TennCare received its first listing on June 7, 2002, and therefore was unable to perform necessary reviews of the billing activity for the period under audit.

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.

In addition, although TennCare's management had entered into a Memorandum of Understanding (MOU) in fiscal year 1999 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.

As in the previous audits, we used computer-assisted audit techniques (CAATs) to search TennCare's paid claims records to find that TennCare made payments totaling \$268,582 for the year ended June 30, 2002, for juveniles in the youth development centers and detention centers. Of this amount, \$127,410 was paid to MCOs; \$77,667 to Children's Services; \$51,116 for TennCare Select fee-for-service claims; and \$12,389 for drug claims paid through Consultec. Federal questioned costs totaled \$163,510. The remaining \$105,072 was state matching funds.

The payments to the MCOs were monthly capitation payments—payments to managed care organizations to cover TennCare enrollees in their plans. Since the Bureau did not receive a listing of incarcerated youth until June 7, 2002, and was not aware of the ineligible status of the children in the youth development and detention centers for most of the audit period, TennCare incorrectly made capitation payments to the MCOs on their behalf. As a result, TennCare is making payments on behalf of these individuals to the MCOs, which incur no costs for providing services.

Payments for Children on Leave Status

TennCare has paid Children's Services 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. In response to the audit for fiscal year ended June 30, 1999, management stated:

We concur. TennCare will review the services provided by the BHOs in relation to those services provided by DCS and will work with DCS to ensure their knowledge of those services that can be billed to TennCare and those that must be billed to the BHOs. TennCare will continue to work with DCS to determine the cause and resolution necessary to resolve problems addressed with this program. TennCare will 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.

Regarding payments for children on leave status in the audit for fiscal year ended June 30, 2000, management stated:

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.

Management again concurred with this portion of the prior audit finding in the 2001 audit report and stated that

TennCare should not be paying the Department of Children's Services (DCS) for services to incarcerated youth or for services for children on leave status. . . .

During fieldwork, management stated that TennCare had developed procedures and was in the process of reviewing these procedures. Although TennCare staff stated they were developing a procedures manual, we were unable to confirm its existence because TennCare would not provide it to us. In January 2003, management stated that they were still in the process of modifying some of the procedures. However, these procedures have not been implemented. As a result, the problems with this area continued during the audit period. 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. In related findings in Children's Services audits for the previous three audits, Children's Services' management concurred in part with the audit findings. Auditor inquiry revealed that Children's Services still does not notify TennCare when children are on runaway status or are placed in a medical hospital. TennCare relies upon Children's Services not to bill TennCare when the department has determined the child has run away or been 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. However, based upon HHS' response to the prior year audit findings as well as TennCare not obtaining written approval for the payment of leave days from CMS, Children's Services cannot bill TennCare for those leave days. 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 Children's Services for up to 21 days while the child is in the hospital, but as stated above Children's Services cannot bill TennCare for any hospital leave days. In spite of repeat audit findings, the Bureau still has no routine procedures, such as data matching, to check for such an eventuality. Therefore, the Bureau has again elected to pay Children's Services without assuring that treatment costs were incurred by the service providers. However, based on the prior findings, TennCare was aware of the possibility of such costs and should have taken appropriate action to identify such situations.

During fieldwork, we asked management about the "new eligibility file update system" referenced in last year's management's comment and how through this system, eligibility information is updated daily. Based upon discussion with management these electronic updates are related to moving the child from the current managed care organization into TennCare select and are not related to the fee-for-service payments to children's services.

As in prior years, using CAATs, we again performed a data match comparing TennCare's payment data to runaway records from the Tennessee Kids Information Delivery System (TNKIDS). The results of the data match indicated that for the year ended June 30, 2002, TennCare had improperly paid \$86,917 to Children's Services for children on runaway status. Federal questioned costs totaled \$55,347. The remaining \$31,570 was state matching funds.

In addition, as in prior years using CAATs, we again performed a data match comparing TennCare's payment data to medical records from the MCOs. The results of the data match indicated that for the year ended June 30, 2002, TennCare had improperly paid \$35,041 to Children's Services for children while they were in hospitals. Federal questioned costs totaled \$22,313. The remaining \$12,728 was state matching funds.

Targeted Case Management

The Department of Children's Services bills and receives reimbursement from TennCare for targeted case management. Targeted case management includes but is not limited to case manager visits with children, developing permanency plans, maintaining case files, and arranging TennCare related services such as health screenings and behavioral health services. Children's Services bills TennCare a daily rate for each child in its custody that has been assigned a case manager. Targeted case management billings were over \$56 million for the year ended June 30, 2002. We selected a sample of 42 children for which TennCare paid a total of \$10,719 to Children's Services for targeted case management. Based upon the testwork performed, there was no evidence that case management was provided to 2 of 42 children tested (5%) during the dates of services specified in the billing. TennCare paid \$184 for the two billings in question. Federal questioned costs totaled \$117. The remaining \$67 was state matching funds. We believe likely federal questioned costs exceed \$10,000 for this condition.

TPL Edits Overridden

It was also determined that TennCare overrides TPL (third-party liability) edits for Children's Services claims. The TPL edits are designed to identify enrollees who have other insurance and deduct/adjust the amount of claim reimbursement owed to the providers by TennCare. Because TennCare chose to override these edits, the state and the federal government are paying for services that are the legal obligation of third parties. OMB Circular A-133 requires that "states must have a system to identify medical services that are the legal obligation of third parties," so that costs are not passed on to the federal government. Similarly, the state should not have to pay for these costs.

In total, \$199,809 was improperly paid to Children's Services; \$127,410 to the MCOs; \$51,116 for TennCare Select fee-for-service claims; and \$12,389 for drug claims paid through Consultec. A total of \$241,287 of federal questioned costs is associated with the conditions discussed in this finding. The remaining \$149,437 was state matching funds.

Recommendation

Note: This is the same basic recommendation, for the repeated portions of the finding, made in the prior three audits.

In light of the multiple repeat findings over the years, the Director and staff of TennCare must realize the probability of such improper payments continuing in the absence of effective controls. They should at least ensure that computer-assisted monitoring techniques are developed by the Bureau to prevent or detect payments for incarcerated youth, children on runaway status, and children placed in medical hospitals. The Director of TennCare should ensure that Children's Services bills only for recipients who receive services and are eligible to receive services. The Director should ensure that targeted case management rates and billings by Children's Services are based on children receiving targeted case management services. The

Director should ensure that TennCare does not override the third-party liability edits for Children's Services claims and that TennCare does not pass on to the state and federal government the cost of services that are the legal obligation of third parties.

Management's Comment

We concur in part, including the notation that there were reductions in inappropriate billings. The staff of the Bureau worked assiduously with the Department of Children's Services (DCS) during the last quarter of fiscal year 2002 to develop policies and procedures for identifying and reporting children who are either in a youth development center (YDC) or on runaway status. According to the interagency agreement, beginning in June 2002, DCS provides a monthly list of children in YDCs and a list of children on runaway status. Currently, TennCare Fiscal staff review billings against these lists to identify any inappropriate billings and subsequently recoups any funds paid for ineligible services. This, as the report has noted, has resulted in a reduction in the amount of inappropriate billings for both incarcerated and runaway youth.

The policies and procedures referenced in the finding were in still in progress while the auditors were performing the audit. Although the policies and procedures have still not been finalized, the listings generated as a result of the work done on them are available and are being used as stated previously. TennCare did not release these policies and procedures because after extensive internal review, it was determined that they did not fulfill the requirements of the interagency agreement with DCS. Specifically, while the procedures identified children who are ineligible for certain services and allowed TennCare to recoup inappropriate billings, they did not fulfill the requirement that DCS prevent inappropriate billings, and submit only "clean" billings.

Accordingly, four new policies and procedures have been requested of DCS: One each for identification of children in a YDC or on runaway status and one each to prevent inappropriate billings of children in a YDC or on runaway status. TennCare has also requested the assistance of the Department of Finance and Administration, Office of Program Accountability Review (PAR) to validate the listings as part of the Bureau's monitoring of DCS. TennCare is now in the process of working with DCS to ensure that these policies and procedures are established.

We will review the processes in place over TPL and the related edits to determine whether any changes should be made.

While improvements have been made in developing DCS' infrastructure (their process for identifying children who are ineligible due to their incarcerated or runaway status) and in reducing or recouping inappropriate billings, the Bureau is committed to continuing to work with DCS to ensure billings reflect only eligible services.

14. TennCare incorrectly reimbursed the Department of Children’s Services for services that are covered by and should be provided by the behavioral health organizations, resulting in federal questioned costs of \$123,067

Finding

As noted in the prior three audits, TennCare has continued to incorrectly reimburse 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). The prior audit finding reported \$1,180,676 that TennCare paid Children’s Services for services that should be provided by BHOs. The current audit showed some improvements made by Children’s Services had reduced these improper billings to \$193,266 for the current audit period.

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. The TennCare/BHO contracts also provide all services to prevent children from entering state custody. With the exception of continuum services, behavioral services for children not in state custody should be provided through the TennCare BHOs. Enhanced behavioral health services for children in state custody and continuum services should be provided by Children’s Services. Continuum services are defined by TennCare’s contract with Children’s Services as “A broad array of treatment and case management services ranging from residential to community based services provided by DCS [Children’s Services] as medically necessary to meet the treatment needs of the child. Services are begun to children in DCS custody but may continue after a child is reunified to home.”

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, 2000, through June 30, 2001, HHS recommended that TennCare implement procedures to ensure that TennCare reimburses Children’s Services only for allowable costs for children in its care.

In response to prior findings, management stated that it would continue to request Children’s Services to cooperate in billing only for contracted services. Also, management has engaged the Department of Finance and Administration’s (F&A’s) Office of Program Accountability and Review (PAR) to monitor Children’s Services’ billing process to search for more types of unallowable payments. TennCare’s contract with Children’s Services was amended to require the transmission of information from Children’s Services to TennCare regarding children who are in state custody.

However, although management held meetings, amended the contract, and initiated monitoring efforts, TennCare still paid Children’s Services for children who were not in the state’s custody and therefore should have been covered by the BHOs. Although TennCare staff stated they were developing a procedures manual to identify services covered by the BHOs for children not in state custody or at risk of state custody, we were unable to confirm its existence because TennCare would not provide it to us.

Discussions revealed that, according to TennCare's Children's Services' liaison, TennCare never received the listing of children who were in state custody. Even though there were still billing issues, TennCare continued to rely on Children's Services to bill correctly for the children in its care.

As a result, TennCare has continued to make payments to Children's Services for enhanced behavioral health services for children not in state custody during the dates of service. Using computer-assisted auditing techniques, auditors again performed a data match comparing payment data on the Bureau of TennCare's system to custody records from the Tennessee Kids Information Delivery System (TNKIDS). The results of the data match again indicated that TennCare had improperly paid \$193,266 to Children's Services for the year ended June 30, 2002, for children who were not in the state's custody during the dates of service billed to TennCare. Federal questioned costs totaled \$123,067. The remaining \$70,199 was state matching funds.

Recommendation

Note: This is the same basic recommendation for the remaining issues that has been noted in the previous three findings.

The Director of TennCare should ensure that monitoring techniques are implemented to detect and prevent payments to Children's Services for services that should be provided by the BHOs.

Management's Comment

We concur that the Department of Children's Services (DCS) should not bill for services that should be provided by a behavioral health organization (BHO). TennCare will analyze the billings submitted by DCS. Upon completion of the analysis, we will work with DCS to implement any additional procedures or controls that may be needed and will recoup any funds paid for inappropriate billings.

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

Finding

The previous five audits have reported that TennCare has not adequately monitored TennCare-funded activities of the Department of Children's Services (DCS). TennCare uses the services of the Department of Finance and Administration's Division of Resource Development and Support (RDS) to monitor DCS. The prior year's audit finding addressed two specific areas where RDS did not follow the requirements of its agreement with TennCare.

- RDS did not test the accuracy of DCS billing rates.
- RDS did not submit quarterly monitoring reports.

These areas were not corrected. Management concurred with the prior audit finding and stated that TennCare had discussed the testing of billing rates with RDS in a planning meeting and had determined that TennCare would be responsible for monitoring these rates. Management also stated that TennCare would select a sample of claims on a periodic basis, test the rates billed by DCS, and resolve any discrepancies with DCS. In addition, management also stated that TennCare would work with RDS to ensure that the quarterly reports are submitted. However, based upon discussions during fieldwork with the Assistant Commissioner of Delivery Systems, the Chief Financial Officer, an Assistant Commissioner with the Department of Finance and Administration, and TennCare's DCS liaison, none knew if any of these actions had occurred. Furthermore, testwork revealed that neither RDS nor TennCare has tested the accuracy of DCS billing rates. In addition, TennCare did not modify the contract with RDS to remove RDS' responsibility to test the rates. Discussions with management during fieldwork revealed that an Assistant Commissioner had discussion with RDS regarding this matter. However, the Assistant Commissioner did not ensure that the contract was modified.

Testwork also revealed that RDS did not submit a monitoring report to TennCare for the first quarter of the audit period, and the monitoring efforts for the fiscal year did not include all procedures requested by TennCare. For example, according to the agreement between TennCare and RDS, RDS is also responsible for the following:

- determining whether DCS has implemented procedures to identify incarcerated youth and prevent charges related to the care and treatment of the incarcerated youth to TennCare and to provide TennCare with notification of the date of admission and release of a youth to/from a locked facility;
- testing to ensure that the rates charged to TennCare are consistent with the documentation of expenditures;
- testing whether DCS adjusted billings to TennCare with any reimbursements/credits received from third-party providers for services previously billed to TennCare; and
- testing for the consistency of amount billed by provider and paid by DCS and the amount billed to TennCare by DCS.

Based on discussions with RDS personnel, none of the above were performed during the fiscal year.

In accordance with the agreement between DCS and TennCare, DCS 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. DCS pays these providers and bills TennCare for reimbursement. For the year ended June 30, 2002, TennCare paid approximately \$140 million to DCS in fee-for-service reimbursement claims.

Because of the inadequate monitoring of DCS, TennCare cannot ensure that the amounts billed are correct and allowable.

Recommendation

The Director of TennCare should ensure that RDS properly performs its responsibilities under the monitoring agreement and should require quarterly reports from RDS. The Director of TennCare should see that specific TennCare staff are assigned the duties of monitoring the DCS billing rates and that they fulfill that responsibility. The Director should ensure that staff are held accountable for actions promised in management's comments that do not occur.

Management's Comment

We partially concur. The new contract with RDS that went into effect October 1, 2002 will be revised to no longer require testing of the DCS rates.

Although the agreement with RDS stated the contractor would test rates billed by DCS, the Bureau agreed with RDS to test the rates internally. However, these tests were not performed during the audit period. Because of the process in place for establishing and loading DCS rates, the determination has been made that rates do not require testing. DCS residential treatment rates are reviewed in advance by the Comptroller's Office and the methodology is approved by the Centers for Medicare and Medicaid Services. Rates for targeted case management are reviewed by the Comptroller's Office. All rates are verified for accuracy when loaded onto the payment system. The system will identify and reject any billings that exceed the established rates. The new contract with RDS that went into effect October 1, 2002, was revised and no longer requires testing of the DCS rates.

RDS submitted quarterly monitoring reports for three quarters during state fiscal year 2002 and a memorandum report for the first quarter of the year. For the first quarter, monitoring of DCS residential providers was not performed; this information is clearly disclosed in the memorandum dated October 19, 2001. RDS performs the monitoring of these providers during the remaining three quarters of the year, thereby ensuring adequate monitoring.

Staff from the Bureau of TennCare worked with staff of DCS to develop a process to provide the Bureau a monthly report of children who are incarcerated (in youth development centers) and thus ineligible for TennCare services. Beginning in June 2002, DCS generated a monthly report of children in the centers. Reports submitted to the Bureau cover the last quarter of the fiscal year ending June 30, 2002. The Bureau has used these reports to send notices to DCS regarding inappropriate billings.

While a procedure to identify incarcerated youth has been implemented, currently the only procedure available to correct for these billings is to notify DCS and recover funds.

Accordingly, TennCare requested, in January 2003, that DCS develop new policies to both identify youth in the centers and prevent billings for these services to TennCare.

Rebuttal

This is the fifth consecutive year that the Bureau of TennCare has not ensured adequate monitoring of DCS. Management has concurred with the audit finding in each of the previous four audits.

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 for the State of Tennessee* for the period July 1, 2000, through June 30, 2001, HHS stated:

This is a material weakness and a repeat finding. We recommend procedures be strengthened to ensure billings from the Department of Children's Services are monitored to comply with grant requirements.

While RDS submitted quarterly monitoring reports for three quarters during the audit period, this monitoring did not include areas required by the agreement TennCare has with RDS which include

- determining whether DCS has implemented procedures to identify incarcerated youth and prevent charges related to the care and treatment of the incarcerated youth to TennCare and to provide TennCare with notification of the date of admission and release of a youth to/from a locked facility;
- testing to ensure that the rates charged to TennCare are consistent with the documentation of expenditures;
- testing whether DCS adjusted billings to TennCare with any reimbursements/credits received from third-party providers for services previously billed to TennCare; and
- testing for the consistency of amount billed by provider and paid by DCS and the amount billed to TennCare by DCS.

During fieldwork discussions with the Assistant Commissioner of Delivery Systems, the Chief Financial Officer, an Assistant Commissioner with the Department of Finance and Administration, and TennCare's DCS liaison, none knew if TennCare had selected a sample of claims on a periodic basis, tested the rates billed by DCS, and resolved any discrepancies with DCS as promised in the previous audit's management's comment.

It does not appear that "all rates are verified for accuracy when loaded onto the payment system" as described by management. During fieldwork we noted that one procedure code for a provider was incorrectly loaded as \$270.79 per day instead of \$275.79 per day. Further investigation with staff at Children's Services revealed that Children's Services had submitted a

request to TennCare to correct this problem. According to TennCare's system, the rate was updated on September 16, 2002. Since TennCare did not have adequate rate monitoring in place, it appears that if Children's Services had not notified TennCare of the rate discrepancy, the problem would have gone on much longer without detection.

Given the high probability of errors when loading the rates, TennCare should improve its rate monitoring effort. Also as stated in finding 13, TennCare has turned off third-party liability (TPL) edits for Children's Services claims. Monitoring of the rates could assist the Bureau in determining that TPL amounts are appropriately being deducted from payments to Children's Services.

Finally, management stated that "the determination has been made that rates do not require testing." However, management contradicts this statement in the "State of Tennessee Summary Schedule of Prior Audit Findings for Years 2001 and prior" required by the *Office of Management and Budget Circular A-133*. In the reporting of the status of corrective actions for the prior year audit findings as of June 30, 2002 management stated that "TennCare will select a sample of claims on a periodic basis and test the rates billed by DCS."

16. TennCare still does not adequately monitor the Medicaid Home and Community Based Services Waivers

Finding

As noted in the prior three audits, the Bureau of TennCare's monitoring of the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (HCBS MR/DD waiver) under Section 1915(c) of the Social Security Act is still inadequate to provide the federally required assurances of health and welfare and of financial accountability and to ensure fulfillment of TennCare's contract responsibilities.

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 prior audit finding identified eight specific weaknesses with TennCare's monitoring effort for the Medicaid Waiver for Home and Community Based Services for the Mentally Retarded and Developmentally Disabled. The following three issues from the prior year were not repeated:

- Policies regarding preparation of the HCFA 372 report were in draft stage. The policies have been finalized.

- TennCare's contract with the Division of Mental Retardation Services (DMRS) was not updated to reflect the new PAE (pre-admission evaluation) review responsibilities. (DMRS, which oversees the program for TennCare, is contractually required to monitor the HCBS MR/DD waiver's Medicaid service providers.) This weakness has been corrected.
- TennCare did not approve marketing plans as required by TennCare's contract with DMRS. This weakness could not be evaluated since the HCBS MR/DD waiver program had a moratorium in effect that limited entry into the waiver for the audit period. As a result, there was no marketing of the HCBS MR/DD waiver.

However, the other five issues remain. Four of five of the issues are repeated from the three previous audits. The other issue was reported for the first time in the previous audit.

No Formal Monitoring Plan to Ensure All Areas Are Monitored

TennCare still 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.

Management concurred with this portion of the prior audit finding and stated:

A meeting is scheduled for February 14, 2002 to develop an interim QM [quality monitoring] plan. A permanent QM plan will be developed upon hiring a QM manager.

Management also concurred in the report for the year ending June 30, 2000, and stated that TennCare was seeking additional positions for the TDLTC that will be moved into the Quality Monitoring Unit. Discussions with the Director of Long-Term Care revealed that, as a result of the February meeting, management developed a temporary QM plan to monitor the Arlington Mentally Retarded and Developmentally Disabled (MR/DD) Waiver. However, this interim plan did not include the larger HCBS MR/DD waiver. In addition, auditor inquiry revealed that attempts by TennCare to hire a QM manager have not been successful.

The HCBS MR/DD waiver that 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.

Required Assurances Not Reported Timely

TennCare has not reported the required assurances to the U.S. Department of Health and Human Services (HHS) in a timely manner. Section 1915(c)(2)(E) of the Social Security Act requires the state to provide the Secretary of HHS with an annual report, the Centers for Medicare and Medicaid Services (CMS) 372 report, which details the impact of the waiver on the type and amount of medical assistance provided under the state plan and on the health and

welfare of the recipients. The report should also include TennCare's assurances of financial accountability under the waiver.

TennCare once again did not submit the CMS 372 Report within 181 days after the last day of the waiver period as required by the CMS *State Medicaid Manual*, Section 2700.6 E., Submittal Procedures for Due Date. The CMS 372 report for the HCBS MR/DD waiver for fiscal year 2001 and the respective CMS 372 (S) report for fiscal year 2000 that should have been submitted by December 28, 2001, were submitted September 6, 2002. The Arlington MR/DD, and Shelby County Elderly and Disabled waivers' CMS 372 reports that should have been submitted by December 28, 2001, had not been submitted as of December 6, 2002. The CMS 372 report for the American Disabled for Attendant Programs Today (ADAPT) waiver (Davidson, Hamilton, and Knox counties) that should have been submitted by April 28, 2002, had not been submitted by December 6, 2002. The respective CMS 372 (S) reports have also not been submitted.

In a letter from the Centers for Medicare and Medicaid Services (CMS) dated October 25, 2001, regarding completion of a monitoring visit performed in October 2001, CMS stated,

Based on the deaths of three consumers since June 2001, and a review of the state's progress in implementing the activities identified in the State's response to the report, we find that Tennessee continues to not meet its obligations to assure the health and welfare of waiver participants, as required under 42 CFR 441.302(a).

Management concurred with this portion of the prior audit finding and stated that "[w]ith increased QM staff in the TDLTC [TennCare Division of Long-Term Care], reports should be timely from this point forward." However, according to the Director of Long-Term Care, staffing levels are still inadequate, and as a result, the reports have not been submitted timely.

Inadequate Staff to Perform the Monitoring Duties

Testwork revealed that TennCare still does not appear to have adequate personnel to perform the monitoring needed to support the federally required assurances. The Bureau of TennCare had only one permanent monitor, who is a registered nurse, for the approximately 4,300 recipients of waiver services, approximately 500 service providers, and DMRS during the year ended June 30, 2002. Management concurred with this portion of the prior audit finding and stated that "a QM Unit is being established with a number of new positions approved to staff the unit." According to discussions with the Director of Long-Term Care, no new employees have been hired because management has decided to out-source these functions. She stated that TennCare has been unable to find experienced individuals at the salary levels available in the State's civil service system.

No Monitoring of the Office of Program Accountability and Review (PAR)

Discussions with staff in the long-term care unit revealed that TennCare has not monitored PAR's work for the HCBS MR/DD waiver and the Arlington waiver during the audit

period. Therefore, management can not be sure that PAR has complied with the terms of its monitoring agreement with TennCare.

Contractually Required Monitoring for the HCBS MR/DD Waiver Program Not Performed

According to discussions with the director of TennCare's division of long-term care, TennCare did not perform its monitoring responsibilities outlined in TennCare's contract with DMRS. TennCare's contract with DMRS requires TennCare to perform these responsibilities:

1. TennCare is to monitor the plans of care for persons receiving waiver services by reviewing a sample of the plans of care for individuals in the program during the annual state assessment or more frequently, if needed.
2. TennCare is to monitor and approve DMRS's policies and procedures for implementation and coordination of the waiver services approved by CMS.
3. TennCare is to provide quality assurance monitoring to evaluate performance of DMRS and its providers.
4. TennCare is to conduct periodic reviews to ensure the health, safety and welfare of waiver enrollees, compliance with Medicaid requirements, and to ensure contractual compliance of DMRS.

Testwork revealed that DMRS continues to implement policy without the approval of TennCare which is further evidence of a lack of general oversight, control, and coordination at the governor level.

Management concurred with this issue in a previous audit finding and stated:

Regarding DMRS monitoring tools, policies and procedures, TDLTC has reviewed the Quality Monitoring section of the DMRS Operating Guidelines. QE [quality enhancement] tools are undergoing further revision and TDLTC is participating in this process. The DLTC Regional Monitoring Nurse participated in testing the current QE tool for Home Health providers and provided recommendations for revision to the form and process during the testing period.

However, testwork revealed that DMRS continued to issue policies that were not approved by TennCare. The 12 pages of rates that DMRS used to pay waiver providers were generated by DMRS but were not approved by TennCare. The *Operations Manual for Community Providers* was not approved by TennCare, and only four sections of the *Operating Guidelines* that replaced a portion of the outdated *Operations Manual for Community Providers* were reviewed and approved by TennCare. DMRS also issued new policy for service plans and cost plans and QE guidelines without TennCare's approval. Testwork also revealed that TennCare has not approved all monitoring tools used by DMRS to monitor the waiver's providers.

During fieldwork, the Director of Long-Term Care stated that CMS conducted a review of the HCBS MR/DD waiver and that this review satisfied these monitoring requirements

outlined in the contract. When we examined the documentation of the monitoring TennCare performed in conjunction with CMS, we determined that this monitoring included monitoring for the contract requirements. However, TennCare has not monitored DMRS for these areas of the contract since the review by CMS in November 2000 and focus reviews conducted in February and March of 2001.

In a related prior-year finding, it was noted that alternative providers such as nutritionists, therapists, and dentists were not monitored. In response to the prior audit finding management concurred and stated:

. . . TDLTC is establishing a Quality Monitoring Unit. Staff in this unit will evaluate the DMRS QE system and provide recommendations for improving the process and correcting deficiencies as is appropriate. A major focus will be on ensuring follow-through sufficient to assure timely correction of deficiencies noted.

Discussions with management revealed that TennCare did not complete the actions indicated in the prior year management's comments to ensure monitoring and has not ensured monitoring of the waiver's alternative providers including nutritionists, therapists, and dentists, and TennCare did not ensure monitoring of vision service providers for the Arlington Mentally Retarded and Developmentally Disabled (MR/DD) Waiver.

Because critical monitoring responsibilities have not been fulfilled, TennCare cannot support the required federal assurances for health and welfare and for financial accountability. Also, TennCare's inadequate monitoring increases the risk that other federal requirements are not met.

Recommendation

Note: This is the same basic recommendation for the remaining issues as the last three audits.

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 CMS. The Director should ensure that the HCFA 372 reports and contractually required reports are submitted in a timely manner. The Director should ensure sufficient monitoring of the process to ensure adequate assurances of health and welfare and of financial accountability are made to CMS. The Director should ensure that an adequate number of appropriately trained staff are available to perform monitoring. In addition, the Director should ensure that the monitoring performed by PAR is reviewed to ensure that the monitoring performed is adequate. The Director should ensure that all providers are monitored and that all contractual monitoring responsibilities are satisfied, including monitoring of DMRS policies and procedures.

Management's Comments

Formal Monitoring Plan

We concur. TennCare Division of Long Term Care (TDLTC) has had difficulties recruiting and retaining adequate numbers of qualified and trained Quality Monitoring (QM) staff, but continues to work toward filling all vacant positions, including the QM Manager position.

TennCare is working with CMS technical consultants, the Division of Mental Retardation Services (DMRS) and other stakeholders to develop a formal Quality Monitoring Plan for the MR waiver that will include outcomes, indicators, evaluation tools, and responsible parties. Regular meetings have been held to work on this project. A technical assistance contract has been implemented and a draft initial report has been issued, inclusive of a work plan. The Quality Monitoring plan for the (mental retardation) MR waiver is expected to be available by July 1, 2003.

TDLTC will also develop a Quality Monitoring plan for elderly/disabled waiver programs. This plan is expected to be available by January 1, 2004. TDLTC staff are currently working with Tennessee Commission on Aging and Disability (TCAD) staff to develop quality assessment processes for the new State Wide Waiver and are beginning review of quality assessment procedures for existing programs.

372 Reports

TDLTC continues to work toward preparing timely 372 reports. Requests for generation of the reports are submitted to Information Systems timely, generally in the month following the beginning month of the new waiver year. This is the earliest the report can be requested with assurance of claims submission for the reporting period. This allows approximately 5 months for production of the report. Timeliness of production of the initial reports has improved; however, errors in the data reported have necessitated TDLTC to work with IS staff to try to identify the cause of the error(s) for the reports to be generated again, sometimes multiple times. Although errors in the report may be corrected, in subsequent reports, new errors may be noted. Report errors can result in delay of the final report. Another issue related to timely submission of 372 reports has been adequate staff to provide QM reports. A summary of QM activities is to be included with the 372 report.

TDLTC will continue to work with IS staff to ensure timely production of 372 reports and timely correction of errors. It is anticipated that the new TCMIS system (to be implemented fully in October 2003) will result in timely reports with more accurate data. TDLTC will continue to work toward hiring and retaining adequate QM staff to perform required QM functions, including timely reports of QM findings and 372 summary reports.

Inadequate Staff to Perform Monitoring Duties

At this point, outsourcing quality assurance functions is uncertain. TDLTC continues to try to fill vacant positions and is working with CMS technical assistants to develop an effective monitoring process given the staff and other resources available. TDLTC currently has 3 Regional Nurse Monitors (1 per region), 2 MR Program Specialists, and a Managed Care Program Specialist (for data base management) within the QM unit. Two additional MR Program Specialists have accepted positions, one to be on April 1, 2003 and the other on July 1, 2003. Three additional positions are being sought for the unit. Until a QM Manager is appointed, the TDLTC Medical Director will manage the QM Unit staff and functions.

No Monitoring of Office of Program and Accountability Review (PAR)

TennCare does not contract with PAR for monitoring of the MR waiver programs. PAR does have a contract with DMRS. DMRS has monitored the effectiveness of PAR.

Contractually Required Monitoring not Performed

TDLTC is currently drafting a policy for review and approval of DMRS policies. Current DMRS management understands that TDLTC must approve policies prior to issuance. Procedures have recently been implemented for sign-off as indicated by the TDLTC Director's dated signature on all policies issued after March 2003. TennCare has not retroactively approved all DMRS policies, manuals, and tools in use prior to the CMS audit report. DMRS policies and procedures in existence prior to the CMS audit will be reviewed as issues come up pertaining to specific policies. There is insufficient staff within TDLTC to retroactively approve the volume of policy-related documents currently in existence. TennCare is currently working with DMRS and other stakeholders to revise TennCare Home and Community Based rules, revise waiver definitions, and draft a new Operations Manual. These rules and policies will be promulgated to replace current rules and policies. TennCare and DMRS are also working together with CMS technical consultants and other stakeholders to review and revise current quality assurance tools, policies and procedures. CMS consultants are also assisting with improving case management/support coordination and incident management policies, tools, practices and procedures.

Regarding monitoring activities, TennCare was exempted from monitoring the (Mental Retardation/Developmentally Disabled (MR/DD) waiver according to the first Corrective Plan until October 2002. TennCare staff did do follow-up monitoring regarding the individual issues noted in the CMS report. DMRS reported their follow-up efforts to TennCare for review. Sufficient staff has not been available to perform a full-scale review of the MR/DD waiver. Focused reviews have been done to resolve complaint issues. An audit of the Arlington Waiver was conducted in Spring 2002. This report was initially intended to be reviewed by a contracted external quality assurance entity. A contractor was identified; however, the status of contracting with an external entity is now uncertain. Consequently, the report of this audit is still in draft form, but is being finalized by the TDLTC Medical Director and TDLTC Director.

Auditor's Comment

This finding points out the numerous deficiencies of TennCare's monitoring of the HCBS MR/DD waiver. Management at DMRS has chosen to engage the PAR unit to assist in the monitoring of the HCBS MR/DD waiver. TennCare has a duty to ensure that all waiver monitoring is performed and is adequate.

Management states "TennCare was exempted from monitoring the Mental Retardation/Developmentally Disabled (MR/DD) waiver according to the first Corrective Plan until October 2002." Upon receiving this response we asked management to provide written documentation from CMS that would indicate that CMS did not expect TennCare to monitor the waiver until October 2002. However, management stated that CMS sent no written approval other than oral approval to implement the corrective action plan mentioned in management's comment.

17. TennCare is still not paying claims for services provided to the mentally retarded and developmentally disabled in accordance with the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled

Finding

As noted in the prior three audits, TennCare has contracted with and paid Medicaid providers in violation of the terms of the Medicaid Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (HCBS MR/DD waiver). The *Code of Federal Regulations* (CFR), Title 42, Part 431, Section 10(e)(3), allows other state and local agencies or offices to perform services for the Medicaid agency. As a result, the Bureau of TennCare has contracted with the Division of Mental Retardation Services (DMRS) (both the Bureau and DMRS are within the Department of Finance and Administration) to oversee the HCBS MR/DD waiver program. However, DMRS continues to not comply with HCBS MR/DD waiver requirements regarding claims for services.

The prior finding noted the following:

- TennCare did not contract directly with providers but allowed DMRS to contract directly with these providers. Furthermore, DMRS did not obtain written approval from TennCare before entering into contracts with providers, nor did it submit copies of provider contracts to TennCare before their execution.
- TennCare did not make direct payments to providers of services covered by the waiver and allowed claims to be processed on a system not approved as a Medicaid Management Information System.

- TennCare allowed DMRS to pay waiver claims outside the prescribed waiver arrangement.
- TennCare allowed DMRS to combine services without waiver approval.

Management concurred with the prior audit findings concerning DMRS contracting directly with providers and corrected the situation by changing the contracts to three-way contracts between the provider, TennCare, and DMRS. However, the remaining issues continue to be problems, even though management concurred with these prior audit findings three previous times.

Testwork revealed that TennCare has continued to inappropriately pay DMRS as a Medicaid provider. DMRS in turn has continued to treat the actual Medicaid service providers as DMRS vendors. According to Medicaid principles, as described in the *Provider Reimbursement Manual*, Part I, Section 2402.1, DMRS is not a Medicaid provider because it does not perform actual Medicaid services.

Failure to Process and Pay Claims on Approved MMIS

Furthermore, the waiver agreement also requires provider claims to be processed on an approved Medicaid Management Information System (MMIS) and provider payments to be issued by TennCare. However, under the current arrangement, TennCare has allowed DMRS to process claims on its own system and make payments to providers through the State of Tennessee Accounting and Reporting System (STARS).

In response to the previous audit finding for year ending June 30, 2001, management stated:

Federal regulations allow providers to reassign payment to DMRS. Signed provider agreements include reassignment of payment to DMRS. However, we concur that the payments made by DMRS were not made via an approved MMIS system. TDLTC has had meetings with TennCare Information Systems staff, Fiscal staff and Provider Services staff to begin developing mechanisms for direct provider payment. . . .

In response to this issue in the audit finding for year ending June 30, 2000, management stated:

. . . 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. . . .

In response to this issue in the audit finding for year ending June 30, 1999, management stated:

. . . Provisions will be implemented that allow the provider voluntary reassignment of their service payment to a government agency, i.e., DMRS, with

the ability to cancel the arrangement should he choose to receive direct payment from the Medicaid agency. As a long-term goal, we will work toward the federal requirement that the Medicaid agency make payments directly to the provider of services. This effort will not be completed for several years due to computer system limitations.

While the HCBS MR/DD waiver allows voluntary reassignment of a provider's right to direct payment, the provider agreements in effect during the audit period required the provider to accept payment from DMRS. Contrary to management's prior-year comments, the "signed provider agreements" do not allow for voluntary reassignment since direct payments through the TennCare Management Information System (TCMIS) were not possible during the audit period. The Centers for Medicare and Medicaid Services (CMS) agree and have instructed TennCare to comply. A report dated July 27, 2001, on a compliance review conducted by CMS for the HCBS MR/DD waiver stated:

Section 1902(a)(32) requires that providers have the option of receiving payments directly from the State Medicaid Agency. The state should modify its payment system to comply with this requirement.

Claims Paid Outside the Waiver Agreement

Testwork revealed that DMRS has paid waiver claims outside the prescribed waiver arrangement. The waiver is designed to afford individuals who are eligible 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 billing and payment process is as follows:

1. Medicaid service providers perform services for waiver recipients.
2. Providers bill DMRS for services.
3. DMRS pays providers based on rates established by DMRS, not the rates in the waiver.
4. DMRS bills TennCare based on the waiver rates.
5. TennCare pays DMRS the TennCare rates using the TCMIS.

Also, regarding DMRS' paying waiver claims outside the prescribed waiver agreement, management stated:

We concur that DMRS has been paid in accordance with the rates in the waiver and that in most cases, the rates paid to providers by DMRS have been different. The rates in the approved waiver document are estimated average rates. It is

common for states to contract with providers for rates that are different than the average rates in the waiver to accommodate for differences in regional costs of living and staffing costs. The goal is for the rates paid to average what has been approved in the waiver application for FFP. The amount paid to DMRS in excess of what was paid providers was intended to provide reimbursement to DMRS for administrative costs of daily operations for the waiver program. The amounts realized via this mechanism do not, in fact, cover all the administrative costs incurred by DMRS; therefore, DMRS is not “profiting” from this arrangement. However, we intend to include in TennCare’s contract with DMRS a description of payment for administrative services in accordance with the cost allocation plan approved by CMS (verbal notification has been received approving the cost allocation plan and official notification is expected soon). The cost allocation plan includes a process to perform a year-end cost settlement.

This response was similar to the response for year ended June 30, 2000. TennCare included in their contract a section entitled “payment methodology” and described the payment of administrative costs through the cost allocation plan. While DMRS may not be recovering enough money through the claims reimbursement process to pay its providers and fund all administrative costs, it should be noted that administrative costs should be claimed using a cost allocation plan (see finding 19). Under the current arrangement with the Bureau, the profit (the excess of TennCare’s reimbursements to DMRS over DMRS’ payments to providers) from the reimbursement of treatment costs is inappropriately being used to pay administrative costs.

The federal government has also noted this inappropriate practice of using claims reimbursement to partially fund administrative costs in the CMS compliance review report dated July 27, 2001, in which CMS stated:

The State Medicaid Agency reimburses the DMRS for the services and DMRS reimburses the providers. It appears that, in some cases, the DMRS reimburses providers less than the payment received from the Bureau of TennCare. Governmental agencies may not profit by reassignment in any way, which is related to the amount of compensation furnished to the provider (e.g., the agencies may not deduct 10 percent of the payment to cover their administrative costs). To do so places the agency in the position of “factor” as defined in 42 CFR 447.10(b). Payment to “factors” is prohibited under 42 CFR 447.10(h).

Testwork specifically revealed that because TennCare has not ensured that DMRS complied with the waiver and federal regulations, TennCare paid DMRS more than DMRS had paid the providers in 53 of 60 claims examined (88%). TennCare paid DMRS less than DMRS paid the providers on the other 7 claims. For the 60 claims examined, TennCare paid \$91,428.95 to DMRS, and DMRS paid the providers \$83,613.83. As noted in finding 18, testwork on this same sample revealed that these claims were not adequately approved and/or documented. As a result, the questioned costs relating to the inadequate approval and/or documentation have been reported in finding 18. No additional questioned costs relating to the differences in payments will be reported in this finding.

Combined Services Without Approval

In the prior audit it was noted that DMRS contracted with providers who were providing a service described as community participation (CP) combo. CP combo services are provided to individuals in the HCBS MR/DD waiver. Chapter three of DMRS' *Operations Manual for Community Providers* permits CP combo services, which combine the following services: community participation, supported employment, and day habilitation (services to improve the recipient's social skills and adaptive skills) services. However, the HCBS MR/DD waiver does not allow any combination of services. Management stated in response to the prior-year audit finding

CMS has indicated that it is permissible to allow a combination of day services, as long as the provider is not paid for two day services that are billed during the same period of time. TDLTC will have further discussions with CMS and DMRS pertaining to the way DMRS has elected to pay for combination services. The system will be revised as necessary to comply with federal regulations and ensure appropriate payment for services rendered. TDLTC will monitor for overpayment via survey and post payment review.

In addition, a transmittal letter from HCFA (the Health Care Financing Administration, now known as CMS) dated January 23, 1995, states:

For a state that has HCFA approval to bundle waiver services, the state must continue to compute separately the costs and utilization of the component services to support final cost and utilization of the bundled service that will be used in the cost-neutrality formula.

During fieldwork, we asked management for documentation that CMS has approved this type of combo service. However, no such documentation of the alleged agreement was provided. By not receiving approval from the federal government, there is a chance that the services that were combined were not combined in accordance with the objectives of the program.

TennCare must comply with all federal regulations and waiver requirements to avoid losing federal contributions to the state's \$5 billion Medicaid/TennCare program.

Recommendation

Note: This is the same basic recommendation made in the prior three audits.

The Director of TennCare should take immediate action to comply with all federal requirements, including those in the waiver. The Director should also ensure that TennCare pays providers in accordance with the waiver. If TennCare maintains the current method of payment to providers through the DMRS system, it should ensure providers are given the option of receiving payment through TCMIS directly. For providers paid through the DMRS system, the

director should ensure that TennCare pays DMRS the same amount paid by DMRS to the providers. For providers who do not choose to reassign payments to DMRS, TennCare must pay providers directly through TCMIS. The Director should ensure that TennCare has CMS approval for all bundled services.

Management's Comment

We partially concur.

Provider Payment

We concur that the payments made by the Division of Mental Retardation Services (DMRS) were not made via an approved Medicaid Management Information System during the audit period. Direct provider payment has been discussed at meetings with the system contractor for inclusion in the design of the new system. Staff from DMRS and the TennCare Division of Long Term Care (TDLTC) have participated in TennCare Management Information System (TCMIS) planing sessions and have made it clear that the new system must be able to accommodate direct provider payment for mental retardation (MR) waiver providers. Implementation is scheduled for October 2003. In addition, direct payment of providers and a simplified rate structure have been included in the Infrastructure Development and Corrective Action plan for the MR waiver programs.

Meetings were held on January 15, 2002 and February 12, 2002 to discuss direct provider payment for the MR program. Participants in the first meeting were limited to TDLTC, Fiscal staff and DMRS staff. Participants in the second meeting included TDLTC, Fiscal and Information Systems staff as well as DMRS and MHDD Fiscal and Information Systems staff. Meeting participants concluded that given the fact that there are approximately 400 MR waiver providers and over 800 different service rates, enrollment of providers and development of a direct provider payment system would be a very complex and time consuming project with the current TCMIS.

DMRS attempted to implement a new rate system tied to a level of care assessment (NC SNAP) that would have simplified the rate structure by reducing the number of rates and providing consistency in the rates paid for different waiver services. However, implementation plans were delayed and eventually scrapped due to provider, advocacy and consumer/family groups opposition to use of the assessment instrument to determine rates. TDLTC staff continued to participate in DMRS meetings related to restructuring and simplifying MR waiver rates until the NC SNAP rate restructure project was terminated. Additional meetings to discuss alternative methods of restructuring rates were held November and December 2002 following termination of the NC SNAP project. Without simplification of the rate system, direct provider payment was believed to be unmanageable given the current demands on the TCMIS system. Consequently, it was determined that TDLTC would write business rules for implementation of direct provider payment for the newly approved Statewide Waiver for the Elderly and Disabled. Because the program is less complicated with fewer participants, fewer anticipated providers, a less extensive

service package and fewer rates, it was determined that this program would be a better testing ground for implementation of provider enrollment and direct provider payment procedures. Plans were made to implement direct provider payment for the MR programs following successful implementation for the Statewide Waiver.

For the Statewide waiver, business rules were written by TDLTC staff in collaboration with TennCare Fiscal staff and Tennessee Commission on Aging and Disability (TCAD) in May 2002 and submitted to TennCare Information Systems staff. Business rules were then reviewed, revised and finalized. Internal waiver coordination meetings among TDLTC staff, meetings with other divisions within TennCare, and technical assistance meetings with the TCAD staff have been held from late in 2001 through early 2003 to work toward implementation of the new waiver, including the direct provider payment system. Providers are currently being enrolled with assistance from the TennCare Provider Unit. Once sufficient numbers of providers are enrolled, the direct payment system will be tested and implemented. It is anticipated that testing will be completed by April 2003.

Payment of DMRS as a Provider

We concur that until approval of the cost allocation plan, DMRS administrative expenses were partially reimbursed by TennCare through a 7% add-on to waiver service rates. However, currently, the amount paid DMRS in total for all waiver services is utilized to reimburse providers for the cost of waiver services. The utilization figures and budgets for individual services, which were estimates to begin with, need to be revised to more accurately reflect current expenditures. This will be done with submission of a new waiver application, which is expected to be completed within the next 6 months. DMRS administrative costs are currently reimbursed via a Centers for Medicare and Medicaid Services (CMS) approved cost allocation plan.

CP Combo Rates

We concur that approval of “bundled services” has not been sought from CMS. Although combo rates existed during the time of the last CMS audit, CMS did not cite a deficiency for combo services. Combo services, as currently used by DMRS, were created to increase flexibility and reduce the volume of service requests required in the provision of day services. For instance, a person may have a part-time job that requires the person to work a variable schedule each week—for example, the person may work 20 hours one week and 10 hours the next week, depending on the needs of the employer and/or the waiver enrollee. The person’s Individual Service Plan (ISP) may require that the person receive community participation during the weeks where fewer hours are worked. In such a situation, the person would be authorized to receive up to 83 hours per month of a combo service, which allows both supported employment and community participation to be provided for different numbers of hours each week, as long as the monthly maximum is not exceeded. The provider would then be paid the supported employment rate for the number of hours of supported employment billed and the community participation rate for the number of hours of community participation billed.

If combo services were not authorized, there would be no flexibility—the person would be authorized for a set number of hours of each service and each time there was a need for the hours to change based on the person’s needs, a new service authorization would need to be submitted. Consequently, it would be contrary to the best interests of waiver enrollees and administratively burdensome at the state and provider level to reduce the amount of flexibility in the provision of day services. TDLTC and DMRS intend to remedy the issue regarding flexibility in the provision of day services through revision of waiver definitions for the waiver renewal application that will be completed within the next 6 months.

18. TennCare has still failed to ensure 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 three audits, TennCare has not ensured that the Division of Mental Retardation Services (DMRS) appropriately reviews and authorizes the eligibility of and the allowable services for recipients under the Medicaid Home and Community Based Services for the Mentally Retarded and Developmentally Disabled (HCBS MR/DD) Waiver and the Elderly and Disabled waivers. DMRS allowed providers to render services to recipients before proper eligibility preadmission evaluations (PAEs) were performed and documented and before services were reviewed and authorized. As a result, claims were paid for unallowable and/or unauthorized services, and the required service plan and cost plans were inconsistent.

Management concurred with the findings reported in the audit reports for fiscal years ended June 30, 1999, and June 30, 2000, and stated it would review and modify the service authorization process. The only apparent change to the process occurred in June 2000 when TennCare began approving PAEs. For the audit period ended June 30, 2001, management partially concurred and indicated that it would continue to review the deficiencies noted in the finding. It is not clear from management’s prior comments with which part of the finding it did not concur. Furthermore, as evidenced by the high percentage of errors, management apparently has not taken sufficient action to correct the numerous issues noted.

A sample of 60 claims from the HCBS MR/DD Waiver was selected. In the review of the 60 claims, testwork revealed that for 52 (87%) of the claims tested for the waiver recipients, deficiencies were noted. The deficiencies included the following:

- For 47 of the claims tested, the enrollee’s service plans were not signed timely or were missing from the regional office. The *Operations Manual for Community Providers*, Chapter 2, states that billing cannot be claimed for services furnished prior to the development and authorization of the Service Plan.
- The services provided on the enrollee’s service plan were not in agreement with the independent support plan (ISP) for two of the recipients tested.

- The enrollee's Freedom of Choice form was not completed properly or was missing for five of the claims tested. Chapter 1 of the *Operations Manual for Community Providers* requires the Freedom of Choice to be signed by the individual prior to enrollment, and the completed form should include the name of the individual considered for waiver services.
- Chapter 2 of the *Operations Manual for Community Providers* requires the service plan to be maintained for a minimum of three years by the organization funded to provide support coordination. However, for 10 of the 35 ISC (independent support coordination) claims in the sample, the service plans were either not approved by the regional office or were missing at the ISC agency.
- Proper supporting documentation was not retained by many of the vendors for the claims reviewed. In many instances, the support was inadequate because the hours or days recorded by the vendor differed from the hours or days paid by TennCare. In some cases, documentation could not be found, or the waiver recipient was absent from the provider on the day the claim was made.
- Testwork also revealed that in one case the services provided exceeded the levels approved in the service plans. For this claim, ten more hours of nursing were paid than were approved on the service plan. In another case, a service approved on a service plan was not provided to the enrollee.

The total amount of the 60 claims sampled was \$91,429. Costs associated with the errors noted above totaled \$27,967, of which \$17,809 is federal questioned costs. The remainder of \$10,158 is state matching funds. The total amount paid for HCBS MR/DD waiver claims was \$190,555,033.

A sample of 60 claims for the HCBS Elderly and Disabled waiver was selected. In a review of the claims for the elderly and disabled recipients, testwork revealed that for 57 of 60 claims tested (95%), the supporting documentation was not adequate. The following problems were noted:

- For 22 claims (37%), the supporting documentation for personal care obtained from the provider was not adequate for many of the claims examined because the hours paid did not agree with the hours the vendor recorded. Other differences occurred because office hours that should have been charged as administrative time were charged to personal care hours. Also, several discrepancies were noted between the meals provided and the meals paid. In some cases, vendors were paid for more units than the documentation showed. (See the questioned costs below.)
- For 55 claims (92%), the services were furnished pursuant to a written plan of care, and numerous individuals who should have been furnished two to four hours of personal care per the plan of care received less than two hours per day. Not following the written plan of care could result in enrollees not receiving services in accordance with their needs assessment.

The total amount of the 60 claims sampled was \$54,263. Costs associated with the overpayments noted above totaled \$417, of which \$266 is federal questioned costs. The remainder of \$151 is state matching funds. The total amount paid for HCBS Elderly and Disabled waiver claims was \$4,507,580. We believe likely questioned costs associated with this condition exceed \$10,000.

A sample of 25 PAEs from the HCBS waivers was selected from PAEs approved during the year ended June 30, 2002. TennCare uses PAEs to document the necessity of waiver services. Before enrollees obtain waiver services, TennCare requires an approved and completed PAE. In a review of the PAE approval process, testwork revealed that for 13 of 25 PAEs tested (52%) for the waiver recipients, the PAEs were not completed properly, or the supporting documentation was not adequate. Specifically, one or more of the following deficiencies were noted:

- For ten PAEs (24%), the supporting physical and/or psychological exams were not signed within the required time frame. Chapter 1 of the *Operations Manual for Community Providers* requires that the psychological and physical exams be performed within the preceding 12 months. If an exam was performed over 90 days but less than one year before the PAE date, the PAE must be updated.
- The regional office could not locate one of the approved PAEs selected for review.
- For three PAEs (24%), the Plan of Care on the PAE was not properly completed.

In addition, testwork noted that the TennCare Management Information System (TCMIS) does not have a system edit to prevent payment for duplicate services during the same time period for a person who receives services from more than one waiver. Although no duplicate payments were found, similar services could be provided to an enrollee through different waivers. Allowing individuals to receive services through multiple waivers could prevent others who need waiver services from obtaining access to the services because there are a limited number of slots available.

Since TennCare did not ensure that adequate processes were in place for the approval of recipient eligibility and for the review and payment of services under the Medicaid Home and Community Based Services Waiver, Medicaid providers of HCBS Waiver services were paid for recipients whose eligibility and services were not adequately documented. Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, requires that costs be adequately documented.

Recommendation

Note: This is the same basic recommendation made in the prior three audits.

The Director of TennCare should determine why the measures taken in the previous year were inadequate and should ensure that the eligibility criteria for all individuals are documented

on the PAE. The Deputy Commissioner over DMRS should ensure that review and approval of services under the HCBS Waiver is adequately documented. Freedom of Choice forms should be appropriately completed for all enrollees. The Director should ensure that provisions are made to ensure documentation is kept for providers that cease providing services. The Director of TennCare should ensure that only properly supported and completed PAEs are approved. Waiver claims without adequate documentation should be denied. The Director should ensure that ISC agencies maintain proper service plans. The Director of TennCare should ensure that recipients are approved for only one waiver so as not to limit access to services by others.

Management's Comment

We partially concur.

HCBS MR/DD Waiver Issues

We concur. Draft audit findings have been provided to Division of Mental Retardation Services (DMRS). The findings, as well as the auditor's documentation of these findings will be reviewed at the April TennCare/DMRS Steering Committee meeting. Potential corrective measures will be discussed as well. DMRS will be required to submit a corrective plan within 30 days and TennCare will review and approve the plan or make additional recommendations. TennCare Division of Long Term Care (TDLTC) will monitor implementation of the corrective actions.

TDLTC has hired a new staff member who will be responsible for tracking all corrective actions for programs under TDLTC's administrative oversight.

The Corrective Action and Infrastructure Development Plan created by TennCare and DMRS, with input from program stakeholders, includes measures intended to streamline the planning and service authorization process. Work plans with action steps will be developed for all areas of the Plan. All corrective actions identified in this plan will be tracked for completion by identified responsible parties at TennCare and DMRS. Some work plans have been developed with assistance from CMS technical assistance contractors. Development of remaining work plans will be discussed at the April TennCare/DMRS Steering Committee meeting.

Elderly and Disabled /Waiver

We concur with these findings. In fact, similar issues were identified during the last TennCare State Assessment of the ADAPT waiver. The report for the ADAPT State Assessment has been delayed due to staffing and workload issues; however, a summary of the findings has been compiled for review with Senior Services. A meeting will be scheduled to discuss findings with Senior Services management during the month of April, in advance of issuing the report of findings. The State Assessment Report will be issued by April 30, 2003. Senior Services will be required to submit a plan of correction that will be reviewed by TDLTC. Upon acceptance of the plan of correction, TDLTC will monitor for implementation of corrective actions.

Senior Services has previously been advised in correspondence from TDLTC that travel/administrative time may not be billed as administrative hours.

PAEs

We partially concur with these findings. Nurse reviewers who approve the PAE ensure that there is a physician's history and physical within 1 year of the physician's certification date on the PAE. If the H&P (History and Physician Certification) is more than 90 days old, an update is required. TDLTC policy is to consider the physician's signature on the PAE as an update to the H&P if "see attached" is written on the H&P section of the PAE. PAE nurse reviewers are aware of the policies for PAE reviews. Reviewers receive an average of 4-6 months training including follow-behind review by an experienced review nurse. However, approximately 32,000 PAEs are reviewed annually, and some human error is expected. TDLTC is in process of collecting and reviewing auditor documentation and will address any errors that are noted with the appropriate nurse reviewers.

In discussions with auditors, it was explained that while psychological dates may be after the date of the PAE certification and the H&P date, an individual may not be enrolled in the waiver until a PAE is approved. PAEs are not approved without an attached psychological. Consequently, payment for waiver services should not occur prior to the date of the documentation submitted with the PAE. Although TDLTC staff still do not fully agree with the auditors position, we have revised internal policies to hopefully avoid further audit findings related to this issue. Nurse reviewers who review MR waiver or ICF/MR PAEs were instructed to ensure that the date of the PAE certification and approval is on or after the date of the H&P and psychological prior to approval. Written TDLTC internal policies will be revised accordingly. We will follow this process point forward, but will not be able to make adjustments for PAEs approved in the past. Following meetings with auditors last fall, a conference call was held with DMRS intake staff to advise of potential audit findings. A formal memorandum will now be sent to DMRS Central Office and Regional Offices to outline changes in requirements for PAEs submitted. The memorandum will also advise of the importance maintaining required documentation in accordance with the contract between DMRS and TennCare, as well as TennCare rules.

We do not have sufficient information at this time to determine agreement or disagreement with findings related to Plans of Care. TDLTC staff will review auditor's documentation to determine what was improper about the Plan of Care on the PAE and address appropriately.

Systems Edit

We concur that there is no edit to prevent payment for services in 2 different waiver programs simultaneously. However, no duplicate payments were found. Because of previous audit findings, TDLTC explored the possibility of establishing such an edit, but were told that it was not possible at this time. Consequently, different avenues were explored to correct the

problem. All Support Coordination agencies were advised that clients were not to be enrolled in other waiver programs if enrolled in the MR waiver. Senior Services were advised of the audit finding as well. Although these may not have been the corrective actions originally intended, there is no evidence at this point that these measures were not effective.

19. The Bureau of TennCare has continued to operate without an approved cost allocation plan, which has prevented the collection of federal matching funds for indirect costs for the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled

Finding

As noted in the three previous audits, TennCare should 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/DD) program. Management concurred with the prior audit finding and stated,

Representatives from TennCare, the Department of Mental Health and Developmental Disabilities, and the Division of Mental Retardation Services have worked with CMS [Centers for Medicare and Medicaid Services] since submission of the plan to obtain approval. CMS has recently indicated verbal approval for the cost allocation plan submitted in 2000, but written approval has not yet been received. Approval of the plan will allow the State to claim federal matching funds at a 50% administrative rate.

In response to the prior audit finding, TennCare did not draw federal funds related to these costs during the current audit period. A cost allocation plan was submitted to CMS, but without approval from CMS, the costs cannot be claimed. Management stated that there have been ongoing discussions with CMS regarding this matter, and this was confirmed with a CMS auditor. The Department of Finance and Administration's Division of Mental Retardation Services (DMRS) has the responsibility for day-to-day management of the HCBS MR/DD waiver program. The audit of the Bureau of TennCare revealed that DMRS had indirect costs for the supervision of the HCBS MR/DD program totaling \$26,192,331 for the year ended June 30, 2002. Because TennCare did not have an approved cost allocation plan, the state was not able to recover \$16,678,622 in federal matching funds over the last three years ending June 30, 2002, according to TennCare's records.

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 Bureau of TennCare is not eligible to recover these costs from the federal grantor.

Recommendation

The Director of TennCare should follow up with the federal grantor as quickly as possible to obtain an approved cost allocation plan.

Management's Comment

We concur that the written approval of the cost allocation plan was not received during the previous fiscal year. Numerous ongoing contacts were made with CMS Atlanta Regional Office staff by TennCare and Office of Health Services staff in order to obtain written approval for the cost allocation plan. We have now received a written approval letter from CMS for the cost allocation plan which will allow collection of federal matching funds retroactively.

20. TennCare's monitoring of the pharmacy program payments still needs improvement

Finding

As noted in the prior year, TennCare's monitoring of the payments for the pharmacy program still needs improvement. TennCare contracts with Consultec, LLC (Consultec) to pay claims on a fee-for-service basis to providers for individuals who are both Medicare and Medicaid eligible as well as for behavioral health drugs for TennCare enrollees. Consultec pays the claims submitted by the pharmacy program providers, and then TennCare reimburses Consultec for the cost of the claims paid. TennCare reimbursed \$850,742,110 to Consultec for claims for the year ended June 30, 2002.

The prior audit finding discussed the following three specific problems:

- TennCare did not adequately monitor the payments for the pharmacy program,
- TennCare did not maintain all the weekly listings of claims submitted by Consultec, and
- TennCare could not locate the drug use review board annual report.

The last two issues have been corrected. However, the first and most critical issue remains.

In response to the prior finding, management stated:

We do concur with the need for monitoring procedures. The Bureau will coordinate efforts between the Fiscal Unit and the Pharmacy Unit to assure written policies and procedures are developed and followed to effectively monitor

the contract between TennCare and Consultec (ACS). The monitoring effort will include procedures that will assure claims are paid correctly for eligible members and that Consultec pays providers exactly as they invoice the TennCare Bureau.

Furthermore, during the current audit fieldwork, management stated that they planned for the Internal Audit Unit to perform payment monitoring of Consultec and that management has begun developing a monitoring process.

Based on discussions with management, testwork, and observation, we have determined that TennCare has not developed the written policies and has not ensured adequate monitoring of the payments to Consultec. Some examples of the deficiencies in TennCare's monitoring of the contract between TennCare and Consultec include the following:

- TennCare did not monitor to ensure the amount paid to the providers for the drugs was correct and based on the average wholesale prices of the drugs prescribed, and that third-party liabilities were appropriately deducted from the amount paid.
- TennCare did not adequately monitor to ensure that an individual provider claim was not reimbursed more than once.
- TennCare did not monitor to ensure that Consultec paid providers only for claims for TennCare eligibles who should be receiving benefits through Consultec.
- TennCare did not monitor to ensure that Consultec paid the providers the same amounts billed to TennCare.
- TennCare did not monitor for claims paid for deceased individuals or incarcerated individuals.

Inadequate monitoring could lead to duplicate paid claims, ineligible recipients receiving benefits, Consultec's not paying providers what is billed to TennCare, and/or the incorrect amount being paid for drugs. In addition, TennCare's inadequate monitoring of the payments for the pharmacy program has resulted in payments for deceased individuals. (See finding 23 for further details regarding this matter.)

Recommendation

Note: This is the same basic recommendation for the remaining issues that has been noted in the previous audit finding.

The Director of TennCare should ensure that staff perform adequate monitoring of pharmacy program contract payments and develop and implement written policies and procedures as necessary to effectively monitor the contract with Consultec. The monitoring effort should include procedures to ensure that claims are paid only for individuals who should be receiving benefits through Consultec, correct amounts are paid for drugs, third-party liabilities are appropriately deducted, no duplicate claims are paid, claims are paid only for living enrollees

who are not incarcerated, and that Consultec is paying providers the same amount billed to TennCare.

Management's Comment

TennCare Pharmacy Program

We concur. TennCare has worked extensively with our internal auditors over the last year to develop a sound monitoring process for the TennCare Pharmacy Program's contract with Consultec. Our last meeting with the auditors was held on February 20, 2003. The auditors had requested changes in the reports and other data submitted by the pharmacy contractor to allow the TennCare Pharmacy Unit and TennCare Fiscal Unit to adequately monitor the contract. We expect final written recommendations from the auditors in the near future. TennCare is currently using an independent contractor to collect third party liabilities as that is not a duty performed by Consultec.

The new monitoring process will include mechanisms that ensure, at a minimum:

- Providers are paid accurately and TennCare is invoiced accurately for those claims
- Providers claims are not paid twice (duplicate billings)
- All paid pharmacy claims are for eligible TennCare members
- Pharmacy claims are not paid for deceased members; or recognizing the lag between death notices and claims submissions, recoupment of prescriptions that were paid in error

21. TennCare's monitoring of the payments for TennCare Select needs improvement

Finding

TennCare's monitoring of the payments for TennCare Select enrollees needs improvement. TennCare contracts with Volunteer State Health Plan, Inc., for the administration of TennCare Select. According to the contract, the purpose of TennCare Select is to "(1) provide services to populations who are more difficult to serve because of their health care needs, their mobility, and/or their geographic location; and (2) to serve as a back-up in any area of the state where TennCare enrollees cannot be adequately served by other TennCare HMOs, either in the event of the unexpected exit of an existing risk HMO or a need for additional capacity." Volunteer State Health Plan pays the claims submitted by the providers for individuals enrolled in TennCare Select, and then TennCare reimburses Volunteer State Health Plan for the cost of the claims. The amount TennCare reimbursed Volunteer State Health Plan for TennCare Select claims was \$312,061,645 for the year ended June 30, 2002.

Discussions with management revealed that TennCare staff have not adequately monitored the payments to Volunteer State Health Plan for claims of the TennCare Select enrollees. Some examples of the deficiencies in TennCare's monitoring of the payments for TennCare Select include the following:

- TennCare did not monitor to ensure the amount paid to the providers for services provided to TennCare Select enrollees was correct and that third-party liabilities were appropriately deducted from the amount paid.
- TennCare did not adequately monitor to ensure that an individual provider claim was not reimbursed more than once.
- TennCare did not adequately monitor to ensure that Volunteer State Health Plan only billed TennCare for claims paid for eligible TennCare Select enrollees.
- TennCare did not monitor to ensure that Volunteer State Health Plan paid the providers the same amounts billed to TennCare.
- TennCare did not reconcile the amount TennCare reimbursed Volunteer State Health Plan to the TennCare Select claim encounter data received by the Division of Information Systems.

The inadequate monitoring could lead to duplicate paid claims, ineligible recipients receiving benefits, Volunteer State Health Plan not paying providers the same amounts it received from TennCare, and/or the incorrect amount being paid to providers.

Recommendation

The Director of TennCare should ensure that staff perform adequate monitoring of the TennCare Select payments. The monitoring effort should include procedures to ensure that the amount paid to the providers for services provided to TennCare Select enrollees is correct and that third-party liabilities are appropriately deducted from the amount paid, an individual provider claim is not reimbursed more than once, Volunteer State Health Plan only bills TennCare for claims paid for eligible TennCare Select enrollees, Volunteer State Health Plan pays the providers the same amounts received from TennCare, and TennCare reconciles the amount TennCare reimburses Volunteer State Health Plan to the TennCare Select claims.

Management's Comment

We concur. We will develop procedures to monitor for the items in the recommendation. We have begun reconciling payments to encounter data. We will have an audit performed of the amounts billed to the state for compliance with contract terms.

22. **For the second year, TennCare chose to go against the direction of the Centers for Medicare and Medicaid Services and inappropriately claimed federal matching funds for premium taxes related to the graduate medical education program and pool payments made to Meharry Medical College and essential provider hospitals**

Finding

As noted in the prior-year audit, against the direction of the Centers for Medicare and Medicaid Services (CMS), TennCare inappropriately claimed federal funds for premium taxes related to the graduate medical education program and a pool payment to Meharry Medical College for its dental program. In addition, during the current audit, it was found that TennCare also inappropriately claimed funds for premium taxes related to a pool payment to essential hospital providers. Management did not concur with the prior-year audit finding even though CMS specifically stated in both years' approval letters that TennCare could not claim federal financial participation for these taxes.

As noted in the prior finding, TennCare has contracted with four graduate medical schools to administer the graduate medical education program. For the years ended June 30, 2002, and June 30, 2001, these contracts with the schools totaled \$46 million for each year.

In addition to these four contracts, TennCare also contracted each year with Volunteer State Health Plan (VSHP), a managed care organization (MCO), to disburse the \$46 million to the four graduate medical schools. However, TennCare's payments to VSHP resulted in MCO premium taxes that were to be paid by VSHP back to the state. As a result, TennCare contracted with VSHP for a total of \$46,938,776 for each fiscal year to cover VSHP's premium tax cost. The approval letters from CMS to TennCare for the graduate medical education program specifically state,

. . . as we have already advised your staff, the State cannot claim Federal financial participation (FFP) for the \$938,776 that you intend to pay Volunteer State Health Plan for their cost of the MCO premium tax that will be paid back to the state.

An examination of TennCare's quarterly expenditure report revealed that TennCare again claimed federal financial participation for this premium tax. For the year ended June 30, 2002, the premium tax totaled \$938,776, of which \$597,437 is federal questioned costs. The remaining \$341,339 is state matching funds.

TennCare also contracted with Xantus Healthplan to make a pool payment to Meharry Medical College for Meharry's dental program. The total amount paid to Xantus was \$4,917,276 for the year ended June 30, 2002. A similar amount of \$4,909,168 was paid in the year ended June 30, 2001. The fiscal year 2002 payments consisted of \$4,817,950 to Meharry; a 2% MCO premium tax of \$98,326; and an administrative fee to Xantus of \$1,000.00. The CMS approval letters for these pool payments also prohibited TennCare's claiming the federal financial participation on the payments to Xantus for premium taxes. However, TennCare again claimed

\$62,575 in federal financial participation for the premium tax for the year ended June 30, 2002, which is federal questioned costs. The remaining \$35,751 is state matching funds.

In addition, TennCare contracted with VSHP to make a pool payment to essential provider hospitals. The total amount paid to VSHP was \$20,408,164, which consisted of the payment to the hospitals of \$20,000,001 and a 2% MCO premium tax of \$408,163. The CMS approval letter for this pool payment also prohibited TennCare's claiming the federal financial participation on the payment to VSHP for premium taxes. However, TennCare claimed \$259,755 in federal financial participation for the premium tax, which is federal questioned costs. The remaining \$148,408 is state matching funds.

In total, for the year ended June 30, 2002, TennCare claimed \$1,445,265 for premium taxes. A total of \$919,767 of federal questioned costs is associated with the conditions discussed in this finding. The remaining \$525,498 was state matching funds.

TennCare's continued failure to follow specific CMS guidance outlined in the approval documents has resulted in more federal questioned costs and could also jeopardize future federal funding.

Recommendation

The Director of TennCare should ensure that TennCare follows directives of the federal grantor in determining which costs can be funded with federal dollars.

Management's Comment

We do not concur. It is our opinion that these are allowable expenditures under Title XIX regulations. It is our responsibility to claim all expenditures eligible for federal funding. CMS officials are aware the state claimed the funding and we have not received any further correspondence from CMS on this issue.

Rebuttal

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, 2000, through June 30, 2001, HHS stated:

This is a material instance of noncompliance. We recommend (1) procedures be implemented to ensure Federal funds are not used to pay premium taxes and (2) the questioned costs be returned.

In addition, CMS continued to specifically state in the approval letters that TennCare cannot claim federal financial participation for these taxes. CMS, not TennCare, is ultimately the judge as to which costs are allowable and which costs are not. OMB Circular A-133 defines a questioned cost as a cost which “resulted from a violation or possible violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the use of Federal funds, including funds used to match Federal funds” [emphasis added].

- 23. For the fifth consecutive year, TennCare did not recover capitation payments made to managed care organizations for deceased individuals (who had been dead for more than a year), and for the second year, TennCare did not recover fee-for-service payments made for deceased enrollees; this has resulted in new federal questioned costs of \$207,499 and additional costs to the state of \$118,479**

Finding

As noted in the prior four audits, TennCare has continued to inappropriately use federal matching funds for capitation payments paid to managed care organizations for deceased individuals who have been dead for more than a year. In addition, as noted in last year’s audit, TennCare has not ensured that adequate controls are in place to recover fee-for-service payments that are made to providers for dates of service after an enrollee’s date of death.

The capitation payments are made to the MCOs on behalf of TennCare enrollees to cover medical 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 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.

When this issue was first discovered in the audit for the year ended June 30, 1998, TennCare’s procedures for identifying deceased enrollees were inadequate. As a result of that finding, management implemented new procedures utilizing on-line access to the Social Security Administration’s death records and recovered millions of dollars in capitation paid to the MCOs. Although improvements were made, the audit for the year ended June 30, 1999, disclosed that TennCare was not recovering capitation beyond twelve months from the date of death notification. In response to the finding for June 30, 1999, management stated that “Procedures will be established to allow recoveries for capitation payments that exceed the twelve-month reconciliation for identified deceased enrollees.” However, the audit for the year ended June 30, 2000, reported that TennCare still was not recovering capitation payments beyond twelve months from the date of death notification. In response to that finding, TennCare sought an opinion from the state’s Attorney General’s Office which agreed that recovery could not exceed the twelve month limitation. The audit for the year ended June 30, 2001, reported that TennCare did not recover fee-for-service claims paid to providers and used federal matching funds for capitation

payments paid to managed care organizations for deceased individuals including those who had been dead for more than a year. Management did not concur with that finding, but stated that it would review the process to ensure that procedures in place are effective.

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, because of a Temporary Restraining Order TennCare has not reverified the eligibility of enrollees timely (see the observations and comments section of this report for more details).

When an enrollee dies, TennCare receives notification of the death from various sources. It is reasonable to expect that TennCare would not receive the notice of death of an enrollee immediately. Because of this normal delay in the death notification process, TennCare has procedures in place to retroactively recover capitation payments made to the MCOs up to twelve months before the official date of death of an enrollee.

Although TennCare's contract with the MCOs prohibit the recovery of payments from the MCOs for these individuals, TennCare has continued to claim federal financial participation for individuals that have been deceased for more than 12 months. For costs to be allowable for federal financial participation, the costs must be paid for allowable services provided to living enrollees.

As in the past four audits, we performed a data match between capitation payments per TennCare's paid claims tapes and date-of-death information from the Office of Vital Records in the Department of Health. We found that TennCare paid \$920,868 to MCOs on behalf of deceased individuals reported by the Office of Vital Records. We selected a sample of 350 of these payments to the MCOs totaling \$43,606 to determine if these payments had been recovered. For 267 of 350 payments tested (76%) totaling \$40,498, TennCare had not recovered the payment to the MCO as of November 28, 2002. For all the 267 payments selected except two, the recovery had not occurred because the individual was either not identified as deceased in TennCare's system or had some other date of death that could not be substantiated. For the two, the recovery had not occurred apparently because the dates of death loaded in TCMIS were over a year before the capitation payment service dates. Federal questioned costs totaled \$25,713. The remaining \$14,785 was state matching funds.

Testwork also revealed that TennCare has not ensured that adequate controls are in place to recover fee-for-service payments that are made to providers for dates of service after an enrollee's date of death. 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 in TCMIS. Based on discussion with management, the fee-for-service payments were made because the date-of-death notification occurred after the date of the payment. According to 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. While there appears to be a legitimate reason for not recovering capitation payments occurring more than a year before notification of death, there does not appear to be a legitimate reason for not recovering such fee-for-service payments.

As in the past two years, we performed a data match between fee-for-service payments for nursing homes, the Home and Community Based Service Waiver for the Mentally Retarded and Developmentally Disabled, and Medicare cross-over services per TennCare's paid claims tapes and date-of-death information from the Office of Vital Records in the Department of Health. We found that TennCare paid \$110,089 to providers on behalf of deceased individuals reported by the Office of Vital Records. We selected a sample of 60 of these payments to the providers totaling \$11,144 to determine if these payments had been recovered. For 26 of 60 payments tested (43%) totaling \$5,343, TennCare had not recovered the payment to the provider as of November 28, 2002. Federal questioned costs totaled \$3,402. The remaining \$1,941 was state matching funds. We believe that likely federal questioned costs associated with this condition could exceed \$10,000.

In addition, we also found that TennCare made payments through Consultec, LLC (Consultec), for drugs for deceased individuals. A comparison of data from the Office of Vital Records and claim information received from TennCare revealed that TennCare paid \$265,903 for individuals with dates of death that occurred before the dates of service. Federal questioned costs totaled \$169,320. The remaining \$96,583 was state matching funds.

Also, we discovered fee-for-service payments for deceased individuals made to Volunteer State Health Plan, Inc. for enrollees in TennCare Select. A comparison of TennCare select claim information with the Office of Vital Records revealed that TennCare paid \$14,235 for individuals with dates of death that occurred before the date of service. Federal questioned costs totaled \$9,064. The remaining \$5,170 was state matching funds.

A total of \$207,499 of federal questioned costs is associated with the conditions discussed in this finding. The remaining \$118,479 was state matching funds.

Recommendation

The Director of TennCare should consider removing the 12-month limit on recoveries from the contracts with the MCOs. Nevertheless, the federal government should not share in the costs of unrecovered payments due to the 12-month limitation in the contracts. Furthermore, the Director should determine why the death notification process sometimes exceeds a reasonable period and should take corrective action as needed. In addition, the Director should ensure that all fee-for-service payments, including pharmacy and TennCare select claims, made on behalf of deceased recipients are recovered back to the date of death.

Management's Comment

TennCare Information Systems

We do not concur. TennCare Information Systems has processes in place to facilitate the recovery of both fee-for-service and capitation payments made on the behalf of deceased individuals. We process capitation payments on a monthly basis and process fee-for-service payments on a weekly basis. TennCare Information Systems staff works suspected dates of death. Other dates of death, which are obtained from the MCOs, are researched and, if verified, are manually updated to the TCMIS. We will work with Vital Records to attempt to correct any delays in reports of death.

In addition, TennCare purchased a subscription service to obtain date of death information directly from the Social Security Administration. We will work with the Program Integrity Unit to validate and react to potential matches.

TennCare Pharmacy Unit

The billing procedures for long term care pharmacy providers require them to dispense all medications in a nursing home setting in seven day supplies and in unit dose packaging. These individually wrapped drugs can legally be returned to the pharmacist's stock in the event the prescriber changes an order, there are unexpected side effects to a drug or if the drug prescribed is not effective. The pharmacy provider should bill TennCare "post-consumption" in order to properly credit all drugs sent to the nursing home that are not taken by the patient. Because these providers bill after the month has ended, the date of service on the claim is usually the end of the month or the first few days of the next month. If the patient had expired during the month and that information is loaded into TennCare's system (and that of Consultec-ACS) a month or two later, then the claim would appear to have been paid after the patient was deceased.

In a new procedure we are implementing for monitoring pharmacy claims, TennCare will review lists of deceased patients and verify if the dates of service for these patients fall into this situation with long term care providers or if another situation exists. In either event, claims paid erroneously will be discovered and recouped.

Rebuttal

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, 2000, through June 30, 2001, HHS stated:

This is a material instance of noncompliance and a repeat finding. We recommend 1) procedures be implemented to ensure payments are only made on

behalf of living enrollees, 2) payments made on behalf of deceased clients be recovered, and 3) the questioned costs be returned.

TennCare information systems staff in their comment state that “TennCare Information Systems has processes in place to facilitate the recovery of both fee-for-service and capitation payments made on the behalf of deceased individuals.” Regarding capitation payments, management’s comments do not address the \$25,713 of federal questioned costs that management’s controls failed to recover.

Management also did not address the part of the recommendation concerning the removal of the 12-month limit on recoveries from the contracts with the MCOs. Also, management did not address the incorrect billing of the federal government’s share of unrecovered payments. The recovery of TennCare select claims was also not addressed in management’s comment.

24. A Medicaid enrollee’s pre-admission evaluation was not on file, and medical necessity could not be substantiated

Finding

Because a long-term care provider did not maintain a pre-admission evaluation (PAE) for a Medicaid enrollee, TennCare could not provide the necessary documentation to substantiate the medical necessity of services provided to the enrollee.

Rules of the Tennessee Department of Finance and Administration Bureau of TennCare, Section 1200-13-1-.10(2)(f), states:

A PreAdmission Evaluation must include a recent history and physical signed by a physician who is licensed as a doctor of medicine or doctor of osteopathy. A history and physical performed within 365 calendar days of the PAE Request Date may be used if the patient’s condition has not significantly changed. Additional medical records (progress notes, office records, discharge summaries, etc.) may be used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed.

TennCare uses PAEs to document enrollees’ eligibility and need for nursing home services.

Testwork revealed that for one of 25 PAEs (4%), neither TennCare nor the long-term care provider could provide the complete PAE, which included the physician’s signature and documentation of medical necessity.

Per discussion with TennCare staff, TennCare issues “lost PAE” letters when a PAE cannot be located. However, TennCare did not realize the PAE was lost when the enrollee transferred from one provider to another.

Office of Management and Budget (OMB) Circular A-133 defines questioned costs as costs that:

. . . at the time of the audit, are not supported by adequate documentation.

The total amount paid for the individual who did not have an approved PAE was \$31,162. The total amount paid for the individuals sampled was \$402,732. TennCare paid \$1,026,215,550 for nursing home claims. Federal questioned costs totaled \$19,843. The remaining \$11,319 was state matching funds.

Recommendation

Since the PAEs are critical support for TennCare eligibility, the Director of TennCare should ensure that PAEs are properly maintained, and if a PAE is lost, that appropriate actions are taken to ensure that medical necessity can be substantiated through medical records or other evidence. To assist in the effort, the Director should ensure that TennCare complies with all utilization of care and services and suspected fraud requirements discussed in finding 36.

Management's Comment

We concur that a long-term care provider could not provide a Pre-admission Evaluation (PAE). There are approximately 350 nursing facilities in Tennessee with a total of around 39,000 beds. Occupancy rates average 90-91% and about 75% of the residents occupying these beds at any given time will be Medicaid eligible. Approximately 30,000-32,000 PAEs are approved yearly. It would stand to reason that given these numbers, an occasional PAE may be lost or misplaced due to clerical error or other circumstances, such as off-site storage of old records. The missing PAE related to this finding involved the transfer of a resident from one facility to another. TennCare rules allow transfer forms to be used instead of PAEs when transferring to the same level of care at a different facility. Page one of the approved PAE in use prior to the transfer is required to be sent with the transfer form to the new facility as proof of the original approval.

Because of the volume of records generated in the PAE process, missing PAEs have been anticipated. TennCare Division of Long Term Care (TDLTC) does not have sufficient storage space to maintain copies of all approved PAEs. Consequently, when a PAE is approved, a PAE work card is maintained on file and a PAE segment is entered on the TennCare Management Information System (TCMIS). The work card provides historical information regarding all PAE submissions for a person. This work card serves as proof that on a particular date a PAE was approved because the applicant met the level of care criteria for the requested reimbursement level. There is a process in place to generate "lost PAE" letters based on the information maintained by TDLTC when PAEs are lost.

TDLTC believes that providers are sufficiently informed that PAEs are to be kept on file as documentation of medical eligibility/level of care determination. Previous bulletins have been issued advising of this requirement. This information is also routinely provided at TennCare Nursing Facility Provider workshops presented by PAE and Claims Unit staff. Providers are also routinely advised of the process for requesting lost PAE letters.

Upon implementation of the new system, all PAEs and supporting documentation will be scanned into the system and stored for future reference. TennCare will then have the ability to provide a copy of the actual PAE to the facility upon request. In the meantime, TDLTC will issue a bulletin to nursing facility providers to remind them that PAEs must be maintained on file for Medicaid eligible residents. The bulletin will advise that the provider should contact TDLTC for lost PAE letters (or copies of approved PAEs when the new system is implemented) if PAEs are missing.

25. TennCare needs to improve policies and procedures and processing of Medicare cross-over claims

Finding

As noted in five prior audit findings, TennCare has not corrected control weaknesses in processing Medicare cross-over claims. The following issues were again noted in the current audit:

- TennCare's policies and procedures manual for pricing cross-over claims is inadequate; and
- TennCare's Management Information System (TCMIS) was not set up to appropriately deduct third-party liability (TPL) for psychologists and social workers.

Management corrected an issue reported last year regarding departmental rules. However, management did not concur with the other issues reported in the prior year finding. Regarding issues repeated in the current audit, management did not address our concerns about the inadequate cross-over claims policies and procedures manual not including certain pricing information about some types of professional cross-over claims.

Management also did not concur with the issue that TCMIS was not set up to appropriately deduct TPL for psychologists and social workers. However, management's comments did not address specifically how the system detects TPL on claims for psychologists and social workers.

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.

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). During fieldwork, we asked management precisely how TennCare identifies and deducts third-party resources (commonly referred to by TennCare as TPL, third-party liability) for psychologists and social workers. Discussions with the Director of Information Systems revealed that TennCare's system was not programmed to search the psychologists' and social workers' provider codes to identify TPL related to claims.

In addition, TennCare's policies and procedures related to professional cross-over claims and institutional cross-over do not contain adequate pricing guidelines. Testwork performed revealed that the following pricing methodologies were not mentioned in TennCare's policies and procedures manual for cross-over claims:

- For institutional cross-over claims with injection codes, the system automatically pays a \$2.00 administrative fee.
- For professional cross-over claims where there is not a type of service listed, TennCare pays the amount which is billed. After the audit period, TennCare developed a policy to deny claims where no type of service was listed on the claim and send the claims back to the provider.

Testwork also revealed that the payment methodology for the following types of providers was not discussed in TennCare's policies and procedures manual for cross-over claims:

- radiology,
- rural health,
- home health,
- rehabilitation services, or
- dialysis.

Not including all pricing methodologies and types of providers in the policies and procedures manual could lead to confusion among staff regarding pricing methodologies for cross-over claims.

Recommendation

Note: This is the same basic recommendation for the remaining issues that has been noted in five previous audit findings.

The Director of TennCare should ensure that TCMIS detects and deducts TPL when necessary for cross-over claims for psychologists and social workers. The cross-over claims policies and procedures manual should be updated to include all pricing methodologies.

Management's Comment

We partially concur with this finding. We concur that the system does not have the third-party liability (TPL) edits to identify psychologists and social workers' claims. A System Change Request (SCR) has been initiated to update the system for the TPL edit for these provider codes. Upon completion of the required system modifications, TennCare will reprocess cross-over claims adjudicated during the audit period ending June 30, 2002 and up until the time the SCR is made to identify any potential adjustments. In addition, we will continue to review institutional and professional cross-over programs to ensure all provider types are edited for TPL.

We concur that our policies and procedures manual for cross-over claims did not include the pricing methodologies for Rural Health Clinics and Radiology providers. The manual was updated December 5, 2002 to include methodologies for payments to these provider types. However, we do not concur that the policies and procedures manual did not contain methodologies for Dialysis Clinics, Home Health Services and Rehabilitation Centers. These provider types are included in the section that identifies all providers that are paid billed charges.

Auditor's Comment

Management's comments regarding pricing methodologies for Dialysis Clinics, Home Health Services, and Rehabilitation Centers refer to the pricing of professional cross-over claims. However, management's policies for the pricing of institutional cross-over claims do not address the pricing of claims for Dialysis Clinics, Home Health Services, and Rehabilitation Centers.

26. The Bureau of TennCare overstated the amount of Certified Public Expenditures

Finding

The Bureau of TennCare overstated the amount of Certified Public Expenditures (CPEs) for the fiscal year ended June 30, 2001, which was reported to the Centers for Medicare and Medicaid Services (CMS) during the fiscal year ended June 30, 2002. CPEs are actual unreimbursed expenditures incurred by public and private hospitals for TennCare enrollees who are eligible and individuals who are eligible but not enrolled in the TennCare program (the state does not pay any portion of the hospitals' expenditures directly). The CMS Special Terms and Conditions provides for CMS to reimburse the state at the applicable federal matching rate for these costs identified as CPEs.

TennCare contracts with the Medicaid/TennCare Section of the Comptroller's office to review the amount providers report for CPEs on the Hospitals' Joint Annual Reports. These reports are submitted by hospitals and include amounts expended for charity care. After each review of the annual reports, the Medicaid/TennCare Section generates and forwards to

TennCare a spreadsheet containing updates from the review of the annual reports, to be reported as CPEs.

Each month TennCare receives an estimated amount from the federal government for CPEs. Once TennCare receives the Final CPEs from the Medicaid/TennCare Section, TennCare makes an adjustment in the State of Tennessee Accounting and Reporting System (STARS) and adjusts subsequent draws from the federal government accordingly. Auditing procedures performed for the fiscal year ended June 30, 2002, revealed that TennCare's CPEs for the fiscal year ended June 30, 2001, were overstated by \$291,991. This overstatement resulted because TennCare did not properly adjust the CPEs drawn to agree with the spreadsheet received from the Medicaid/TennCare Section, dated April 25, 2002. Federal questioned costs totaled \$185,757. Since no state funds were expended for CPEs, there are no state matching funds associated with this condition.

Recommendation

The Chief Financial Officer should ensure that Certified Public Expenditures are reconciled to the Medicaid/TennCare Section's reports and reported accurately and in compliance with federal laws and regulations. Draws of federal funds should be adjusted for the difference between estimated and actual CPEs.

Management's Comment

We concur. The funds referenced in the finding were returned to the Centers for Medicare and Medicaid Services (CMS) on January 3, 2003 and were adjusted in the December 31, 2002 CMS 64 report. Management will ensure that a reconciliation to the final approved report from the Comptroller's Office will be completed and adjustments reported in a timely manner.

27. TennCare's providers did not substantiate the medical costs associated with fee-for-services claims or provide evidence that the service was actually provided

Finding

TennCare could not provide documentation to substantiate medical costs associated with fee-for-service claims. For claims to be allowable, Medicaid costs for medical services must be for an allowable service rendered which includes being supported by medical records or other evidence indicating that the service was provided and consistent with the enrollee's medical diagnosis.

Although the state is operating under a waiver from the federal Centers for Medicare and Medicaid Services (CMS) to implement a managed care demonstration project, more and more services are being paid on a fee-for-service basis. This is occurring because the state has decided

to shift the burden of high cost/high risk groups from the managed care organizations to the state. Services provided on a fee-for-service basis include: services provided in the long-term care facilities, services provided to children in the state's custody, services provided under the Medicaid Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled, services provided to enrollees who are both TennCare and Medicare recipients (Medicare cross-over claims), services provided to TennCare Select enrollees, and pharmacy claims for individuals that are recipients of TennCare and Medicare as well as behavioral health drugs for all TennCare enrollees.

We tested a sample of claims for children in state custody, claims for services provided under the Medicaid Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled, claims for services provided to TennCare Select enrollees, and pharmacy claims, to determine the adequacy of documentation supporting the medical costs associated with these claims for service. Specifically, testwork revealed that TennCare's providers could not provide documentation to support the need for the medical service, including pharmaceutical services, or that the service was actually provided for 13 of 65 claims (20%). The documentation for these claims could not be obtained for the following reasons:

- For one pharmacy claim, TennCare personnel indicated that a provider located in Florida prescribed the medication to the individual. When the provider was contacted, the provider stated that they had never seen the individual. This issue has been referred to the Special Investigations section of the Comptroller's Office and to the Bureau of TennCare's Office of Program Integrity for further investigation.
- For two pharmacy claims, the provider that prescribed the drug could not be located.
- For two pharmacy claims, the documentation received from the doctors that prescribed the drugs did not support the need for the drugs.
- For one of Children's Services' claims, the documentation could not be obtained because the medical records according to the provider had been destroyed in a fire.
- For one of Children's Services' claims, there was no documentation that the child was located in the facility for 6 days of the 28 days billed. There was an additional two days, where the child was allowed a leave of absence from the facility.
- For five of the HCBS claims, there was not adequate documentation that the services billed were provided.
- For one of the Children's Services' claims, the documentation received from the facility did not support the services billed.

The total amount of the errors noted above was \$7,281, out of a total of \$45,797 tested. Federal questioned costs totaled \$4,636. The remaining \$2,645 was state matching funds. TennCare paid \$1,524,319,677 in fee-for-service claims for the types of claims sampled. We believe likely questioned costs exceed \$10,000.

Without having adequate documentation that medical services, including pharmaceutical services, are provided and are consistent with the medical diagnosis, TennCare may be paying for and billing the federal government for unallowable medical costs.

Recommendation

The Director of TennCare should ensure that providers maintain the required documentation to support costs charged to the program. In addition, TennCare should perform its own post-payment reviews to ensure providers are billing for appropriate, allowable medical costs.

Management's Comment

TennCare Division of Long Term Care

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

Pharmacy

We concur. On July 1, 2002 the use of a standardized prescriber identification system for all pharmacy claims (MCO and carve-outs) was implemented. The use of DEA numbers has improved encounter data and pharmacy utilization management. In the future, when asked similar pharmacy questions by state auditors, TennCare staff will not only provide prescriber identification information, but also research the specific claims by contacting the dispensing pharmacy to assure the claims correctly identified the prescriber. In one of the cases above, the pharmacist had incorrectly entered the prescriber identification number for a physician that happened to live in Florida.

TennCare is currently implementing an audit procedure for the pharmacy carve-out programs, based in large measure on the input and recommendations from TennCare Internal Audit. These new monitoring efforts of Consultec's (ACS) billings and data will assure that the payments to Consultec are correct. TennCare cannot audit pharmacy claims for dually eligible members to determine medical necessity because these patients are not typically seen by TennCare participating providers.

Children's Services Claims

We concur that providers should maintain adequate support for services provided. The Bureau of TennCare contracts with the Department of Finance and Administration, Office of Program Accountability Review (PAR) to monitor the Department of Children's Services (DCS) residential treatment providers. Regarding the provider's records that were destroyed in a fire, there is no possible way that TennCare can ensure that these incidents do not occur. For the two remaining issues, TennCare will coordinate with DCS to determine the cause of the issues and make appropriate billing adjustments, if such are indicated.

28. **TennCare inappropriately paid \$32,247 for administrative leave for the former Director and a former Assistant Commissioner who terminated employment**

Finding

TennCare inappropriately paid for administrative leave for employees who terminated employment.

Department of Personnel Policy, Chapter 3, states:

Discretionary leave may be for reasons or situations where an employee is removed from normal duties with approval of the appointing authority or other authorized supervisor for a period of (30) calendar days or less when considered necessary for proper operation of the agency or welfare of the employee. Periods of discretionary leave with pay that exceed thirty (30) calendar days must be approved by the Commissioner of the Department of Personnel. . . .

Testwork revealed that for the period July 1, 2002, through July 30, 2002, TennCare paid the former Director of TennCare, \$15,913 for 30 days of administrative leave with pay after he resigned his employment with the state. The Director had no accrued annual leave at the time of his termination. However, as a result of the extra 30 days of pay, he was also paid for one day of annual leave, which was accrued during the period he was not working, but was receiving his salary. The former director's annual salary was \$190,956. Although TennCare had a letter signed by the Commissioner of the Department of Finance and Administration granting approval of this paid leave, this leave does not appear to be necessary for proper operation of the Bureau of TennCare or for the welfare of the employee, as required by this policy.

Testwork also revealed TennCare paid the former Assistant Commissioner of Delivery Systems \$16,334 from September 3, 2002, through October 31, 2002, for 60 days of administrative leave after his employment was terminated by the Director of TennCare. At the time he stopped working, he had accrued 52.5 hours of annual leave. He was paid for these hours as well as for two more days of annual leave he accrued during the 60 days he was not working, but was receiving his salary. His annual salary was \$98,004. Although TennCare also

had a letter signed by the Commissioner of the Department of Finance and Administration granting approval of paid leave for 60 days, the Commissioner of the Department of Finance and Administration does not have the authority to grant discretionary leave with pay for periods exceeding 30 days. Again, according to Department of Personnel Policy, leave in excess of 30 days must be approved by the Commissioner of the Department of Personnel. Furthermore, this employee's paid leave does not appear to be necessary for proper operation of the Bureau of TennCare or welfare of the employee, as required by this policy.

The total amount paid for administrative leave, after termination of employment, to the former Director of TennCare and the former Assistant Commissioner for Delivery Systems was \$32,247. Federal questioned costs totaled \$16,124. The remaining \$16,123 was state matching funds.

The approval of administrative leave for former employees, without a justifiable business reason as outlined in the guidelines of the Department of Personnel's policies and procedures, has resulted in unnecessary costs to the state and federal governments.

Recommendation

The Commissioner of the Department of Finance and Administration and the Director of TennCare should ensure that only reasonable and necessary administrative leave is approved.

Management's Comment

We do not concur with the auditor's conclusion that the decisions on administrative leave were not necessary for the proper operation of the Bureau of TennCare. TennCare management and the Commissioner of Finance and Administration made decisions regarding the referenced employment situations based on their knowledge of circumstances and understanding of the impact these circumstances were having on TennCare staff and operations. They took actions believed to be in the best interests of the TennCare program.

We do concur that we failed to obtain the Commissioner of the Department of Personnel's approval for the administrative leave in excess of 30 days for the Assistant Commissioner of Delivery Systems. This was an oversight and every effort will be made to ensure that any such future transactions contain all appropriate approvals.

Rebuttal

As stated in the finding, the payment of administrative leave for these former employees does not appear to be necessary for the proper operation of the Bureau of TennCare.

29. For the third consecutive year, TennCare did not pay provider claims in a timely manner

Finding

As noted in the prior two audits, the Bureau of TennCare did not pay Medicare crossover provider claims within 6 months after receiving the Medicare claim as required by federal regulations. In addition, the Bureau paid the Department of Children’s Services (Children’s Services), Home and Community Based Waiver (HCBS), and long term care claims over 12 months after receiving the claim. In the audit for the year ended June 30, 2000 management stated:

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.

Management concurred with the audit finding for the year ended June 30, 2001, stating that they “are reviewing the controls over cross-over claims and will implement necessary changes to ensure compliance with regulations.” However, testwork revealed that the problems still exist.

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, 2000, through June 30, 2001, HHS stated:

This is a repeat finding. We recommend 1) procedures be implemented to ensure Medicaid claims are submitted and paid within the time limits contained in Federal regulations and 2) the questioned costs be returned.

The *Code of Federal Regulations*, 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 (2) The agency must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt. (3) The agency must pay 99 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt. (4) The agency must pay all other claims within 12 months of the date of receipt, except in the following circumstances: (i) This time limitation does not apply to retroactive adjustments paid to providers who are reimbursed under a retrospective payment system. . . . (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. (iii) The time limitation does not apply to claims from providers under investigation for fraud or abuse. (iv) The agency may make payments at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, correction action, or other court order to others in the same situation as those directly affected by it.

The Bureau of TennCare pays long-term care, skilled nursing facilities, and Medicare crossover providers directly. The Division of Mental Retardation Services (DMRS) within the Department of Finance and Administration pays providers under the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (HCBS-MR) waiver. Children's Services providers are paid directly by Children's Services. After paying their providers, DMRS and Children's Services submit their provider claims to the Bureau for reimbursement.

Testwork revealed TennCare paid \$70,796 in claims to crossover providers that were not paid within 6 months of receipt of the claim. In addition, TennCare paid claims more than 12 months after receipt of the claim: \$16,666 in claims to providers for long-term care and \$38 for other fee-for-service claims. Although federal regulations allow certain exceptions beyond the 12-month or 6-month requirement, the claims in question do not fall within the exceptions listed in the CFR.

A total of \$87,500 was paid for claims that were not in compliance with the CFR. Federal questioned costs totaled \$55,718. The remainder of \$31,782 is state matching funds.

Recommendation

The Director of TennCare should ensure that the claims are paid within 12 months of the date of receipt and that Medicare crossover provider claims are paid within 6 months after receiving notice of the disposition of the Medicare claim.

Management's Comment

We concur. We will review our claims editing and payment process and make necessary changes to ensure compliance with federal requirements.

30. TennCare did not comply with purchasing guidelines, used incorrect vendor authorization forms, and used a delegated purchase authority to circumvent the competitive bid process for purchases for legal services

Finding

As noted in the prior-period audit, TennCare made purchases from vendors that did not comply with federal and state regulations. Specifically, these purchases of legal services for agency matters and court actions were not in compliance with the Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*; OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*; Department of Finance and Administration Policy 6, “Payments Under Contract After Closing or Purging of Contract From STARS;” or with the Delegated Purchase Authority (DPA).

Management concurred with the prior audit finding and stated accounts payable staff require vendor authorization forms to be completed and submitted with billings. Also management said that the payment limits in the DPA contracts are being increased. Although management concurred, the issues noted in the prior audit remain.

For the purchases for year ended June 30, 2002, TennCare increased the payment limits. However, as stated below there was a purchase that did not have an authorization to vendor form.

Procurements questioned in this finding were made using DPAs. DPAs are granted to departments by the Commissioner of the Department of Finance and Administration when purchases are small in nature and frequent in occurrence and it is not practical to determine in advance their volume, delivery, or exact costs. DPAs assist departments in expediting the purchasing process. The DPA in effect during the year ended June 30, 2001, was renewed for the year ended June 30, 2002.

Circular A-87 basic guidelines require that purchases “conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items” and “be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.” These basic guidelines also require that all costs “be adequately documented.”

Testwork revealed the following conditions:

Noncompliance With Basic Purchasing Guidelines

In a sample of 41 purchases, 34 (83%) did not comply with one or more of the A-87 basic guidelines because the purchases did not comply with state purchasing procedures. Section 6, “Service Provider Selection,” of the DPA states that the “Bureau of TennCare shall retain records to show the basis of each purchase. . . .” Furthermore, Section 12, “Authorization To Vendor,” of

the DPA states, “All purchases made pursuant to this authority shall be made by the use of the attached Authorization to Vendor. . . .” All purchases made under the DPA should be sufficiently and adequately supported. The following issues were noted:

Thirty-one of the 41 purchases (76%) were not adequately documented. Specifically, one or more of the following deficiencies were noted:

- No “authorization to vendor” form could be found.
- The “authorization to vendor” form was not signed by a state employee.
- The time sheets of the vendors were not attached, making it impossible to determine compliance with the DPA limits.
- The hours on the vendor’s invoice did not agree with the hours on the vendor’s time sheets.
- It appeared in some cases that there was a possibility that vendor employees could have been billing TennCare for hours the vendor employee was at lunch. A review of the sample items revealed that some vendor employees deducted hours taken for lunch while others did not report any lunch taken.

Two of the 41 purchases (5%) did not conform to all limitations required by the DPA which TennCare used to make these purchases. For example, the total for one purchase exceeded the \$5,000 limit required by the DPA. Another purchase included charges for one or more of the vendor’s employees, which exceeded the \$250-per-day limit required by the DPA.

In addition, the same two purchases were not approved by all appropriate state officials who were party to the original contract agreement as required by Policy 6 of the Department of Finance and Administration, “Levels of Approval Requirements.”

Lack of Current Vendor Authorization Forms

Testwork also revealed that when the DPA was renewed, a new “Authorization to Vendor” form was created, containing new terms of authorization. Terms of authorization are essential in this purchaser-vendor relationship because they represent the binding terms of agreement between the vendor performing the services and the State paying for them. However, for 37 of 39 current year payments (95%), the prior year’s “Authorization to Vendor” form was used for purchases authorized under the DPA in effect for the year ended June 30, 2002.

Lack of Evidence of Competitive Bid Process

Section 6.b. of the DPA states,

Each purchase pursuant to this Delegated Purchase Authority will be made, where practicable, on a competitive basis, taking into consideration price, delivery, availability, quality of work, and experience.

The auditors inquired several times about the methodology or approach used to ensure that purchases from vendors are initiated and compensated on a competitive basis; however, the General Counsel did not provide any evidence that the vendors were obtained on a competitive bid basis.

Inappropriate Use of Delegated Purchase Authority

Testwork revealed that the Bureau of TennCare did not comply with the terms under Section 3 of the DPA, “Justification,” which states,

This Delegated Purchase Authority shall be used to obtain the services of and to compensate witnesses, expert advisors, paralegal and legal associates, sheriffs and constables, court clerks, security personnel, and court reporters for services rendered in conjunction with Bureau of TennCare programs. The services purchased are episodic, uniquely transactional, or emergent and it is not possible to determine in advance their volume, delivery, or exact costs. . . .

However, because TennCare compensated several individuals who performed legal services for more than 12 months and up to 36 months, it appears that these services are not episodic, uniquely transactional, or emergent as required under the DPA.

According to OMB Circular A-133, costs that “are not supported by adequate documentation” are questioned costs. The total of the purchases in question above is \$57,850. Of the \$57,850 paid, federal questioned costs are \$28,925. An additional \$28,925 of state matching funds was related to the federal questioned costs. The total amount paid for the sample of 41 purchases was \$185,192. According to data from the State of Tennessee Accounting and Reporting System (STARS), the total amount paid pursuant to the noted DPA was \$2,854,910.

Recommendation

Note: Except for the new issues noted, this is the same basic recommendation that was made in the previous audit.

The Director of TennCare should ensure the Chief Financial Officer (CFO) complies with the recommendations noted in this finding. If the CFO does not comply with the recommendations, the Director should find out why. The CFO should ensure that all costs are in compliance with Circular A-87 guidelines and with the terms of the DPA. The CFO should ensure that adequate procedures to detect payments not in compliance with OMB Circular A-87 guidelines are performed during the payment review and approval process. The CFO should ensure TennCare is in compliance with Policy 6 of the Department of Finance and Administration. The CFO should ensure that vendors are informed, and that the DPA includes specific terms stating, that lunch-hour costs should not be billed to TennCare. The CFO should ensure that TennCare uses the correct “Authorization to Vendor” forms. The CFO should use

DPA's only for services that are purchased on an episodic, uniquely transactional, or emergent basis. Any other services should be obtained through the state's competitive procurement process. Documentation of the state's competitive procurement process should be maintained and provided to us.

Management's Comment

Office of General Counsel

TennCare concurs that all costs should be in compliance with Circular A-87 guidelines. TennCare will ensure that adequate procedures are in place to detect payments not in compliance with OMB Circular A-87 guidelines when performing payment review and approval processes.

Legal Assistants were originally hired in the Office of General Counsel from the DPA because of the sudden increase in work resulting from the *Grier* Revised Consent Decree. Although it was originally the belief of management that the workload as a result of *Grier* would eventually taper off and that DPA staff would no longer be necessary but that has not been the case. The number of cases processed through the Office of General Counsel has increased steadily for two years, resulting in the need for ever increasing staff. *Grier* appeals have increased more than 400% over the last two years. Additionally, as a result of the *Rosen v. Tennessee Commissioner of Finance and Administration* case, workload in the eligibility unit of the Office of General Counsel has increased by at least 400% in appeal volume this year over last and is still climbing due to appeals in the recertification process.

As the need for additional staff has arisen, the Bureau has hired under the DPA for the short term and then tried to work with the Department of Personnel to create positions in which to transition DPA vendors. In the past six months the Office of General Counsel has replaced 21 DPA vendors with full-time state employees. On February 25, 2003, the Office of General Counsel was notified that 20 additional full-time state employee Legal Assistant positions had been approved. The Office of General Counsel is working the state register to fill the 20 positions as soon as possible thus replacing 20 additional contract positions with 20 state employee positions. It is anticipated that all Legal Assistant contract positions in the Office of General Counsel will be eliminated by May 1, 2003.

In the last six months a meeting was held with all DPA vendors to once again explain billing procedures (several meetings/trainings have been held over the past two years). Vendors were informed that "authorization to vendor" forms must be signed by one of three managing attorneys, time sheets must be attached to the vendor forms, the hours on the vendor invoices must be exactly the same as the hours on each time sheet, and that lunch breaks would now be mandatory and all lunch breaks must be reflected as non-paid. At this meeting, procedures for using the OGC time clock, which was instituted in July 2001, were reiterated. On January 23, 2003, an OGC Policy and Procedure, entitled Attendance Policy for On-site Vendors, was revised. This policy was originally drafted on October 1, 2001 and revised March 26, 2002.

On January 21, 2003, the Office of General Counsel was notified by the TennCare Bureau that the authorization to vendor form for this fiscal year had been changed. Upon notification OGC immediately began using the correct forms.

The General Counsel exchanged emails and phone calls with the auditor from October to December 2002, but from the conversations was not aware that the auditor was seeking evidence that legal assistants were hired under a competitive basis. If this had been understood, it would have been explained that it was not practical to go through a competitive process for these services. However, we paid an hourly rate to each legal assistant, taking into consideration price, delivery, availability, quality of work and experience.

The Bureau of TennCare is committed to compliance with all state and federal laws and has worked through the state process to establish permanent positions. With the approval of the additional positions within the various divisions of TennCare, it is expected that the use of the DPA will substantially decrease.

TennCare Solutions Unit

The TennCare Solutions Unit (TSU), the Medical Appeals Unit within TennCare also hired staff from the DPA because of the sudden increase in work resulting from the Grier Revised Consent Decree. Since 2001 the number of DPA staff have been reduced from in excess of forty to the current level of ten DPA staff. The reduction has been facilitated by the establishment and hiring of state positions within the TSU to process the medical appeals that continue to date.

The TSU DPA staff always use a time card, complete a weekly time sheet and an Authorization to Vendor form each week. Each DPA staff person is assigned to a full-time state employee for the purposes of supervision. The supervisor is also responsible for signing the DPA employee's time sheet. Copies of the time card, weekly time sheet and Authorization to Vendor forms are retained in the TSU personnel files. There is a designated state employee working under the direction of the Director of the TSU, who is assigned the task of processing these documents for TennCare's Fiscal Services office and maintaining a copy in the TSU files. This same person is also responsible for keying time for the state staff in the TSU. These documents require a supervisory signature for approval prior to submission. In addition, training has been held with all DPA staff and their supervisors to ensure that the documents are completed accurately and completely. Staff working through the DPA contract are required to take a minimum thirty minute lunch break anytime they work six or more continuous hours and all lunch breaks are required to be reflected on the time sheets. DPA staff is not permitted to work in excess of forty hours weekly. Any discrepancies in time are reported to the Director and fully resolved prior to submission of the documents.

Member Services

The managers of Member Services and Administrative Appeals documented all contract personnel time. Contract personnel were only paid for time worked and no overtime was

allowed. Copies of timesheets are signed by the manager and are kept for our records. Any discrepancies are brought back to the employee to correct. After corrections are made the Authorization to Vendor forms and timesheets are attached and are signed by the employee and manager to be forwarded to OGC for payment.

Administrative Services

Administrative Services is now monitoring the DPA payments on a weekly basis to ensure that they are properly signed, persons have taken off time for lunch, and that the Divisions are proceeding with replacing contracted legal assistants with State employees.

31. TennCare did not require all contractors and providers to make necessary disclosures concerning suspension and debarment

Finding

As noted in the prior two audits, the Bureau of TennCare has not required all providers of goods and services, and all others involved in nonprocurement transactions with contracts equal to or in excess of \$100,000, to certify their organization and its principals have not been suspended or debarred from a government 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 regarding the Single Audit of the State of Tennessee for the period July 1, 2000, through June 30, 2001, HHS stated:

This is a repeat finding. We recommend procedures be implemented to ensure suspension and debarment requirements are met.

In response to the prior audit finding, management amended purchasing and HCBS waiver contracts to contain the required certifications. However, testwork revealed that the providers enrolled through TennCare's Provider Enrollment Unit (PEU) were not required to supply suspension and debarment certifications during the audit period.

According to the Office of Management and Budget "A-133 Compliance Supplement," which references the *Code of Federal Regulations* (CFR), 45 CFR 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 and 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.

The Division of Mental Retardation Services (DMRS) in the Department of Finance and Administration enrolls providers in the Medicaid Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled. However, neither the PEU nor DMRS has policies in place that include federal suspension and debarment requirements. Also, the Bureau's purchasing manual does not include the federal requirements concerning suspension and debarment.

Management concurred in part with the prior audit finding and stated in response that

TennCare's *Purchasing Policy and Procedures* manual contains *The Department of General Services' Agency Purchasing Procedures Manual*, which includes a section on suspension and debarment. Furthermore, the TennCare manual has been amended to add a section on vendor debarment.

In our comment to their response we noted, the referenced section of the *Department of General Services' Agency Purchasing Manual* did not include federal suspension or debarment requirements; it contained requirements pertaining to the state's Qualified Vendor List. Vendors who are on the state's Qualified Vendor List may be suspended or debarred by the federal government. The Tennessee Department of General Services is not responsible for compliance with federal suspension and debarment requirements. Instead, each department must ensure compliance.

The A-133 Compliance Supplement encourages states to have

Official written policy for suspension and debarments that: Contains or references the Federal requirements; prohibits the award of a subaward, covered contract, or any other covered agreement for program administration, goods, services, or any other program purpose with any suspended or debarred party; and requires staff to obtain certifications from entities receiving subawards (contract and subcontract) over \$100,000, certifying that the organization and its principals are not suspended or debarred.

Since the Bureau does not require providers enrolled through the PEU to certify that their organization and its principals have not been suspended or debarred, the Bureau would be less likely to know if it had contracted with suspended or debarred parties. Not having policies that contain all federal requirements increases the chance that federal suspension and debarment requirements are not met.

Recommendation

The Director of TennCare should ensure that providers enrolled through the PEU certify that their organization and its principals have not been suspended or debarred from a government program. TennCare's purchasing manual and the PEU unit's policies and procedures should be

amended to include the federal requirements. The Director of TennCare should ensure that DMRS develops policies which include federal requirements.

Management's Comment

We concur. The Bureau attempted to comply with the prior year finding recommendation by requiring contractors certify to us that they were not debarred or suspended. However, a policy was not developed until the current year. The suspension and debarment policy is currently under review and will become effective once approved. Policies for the Provider Enrollment Unit and the Purchasing Manual will be revised to reference or include the approved policy.

The Bureau will work with the Division of Mental Retardation Services to ensure that they also implement a policy to comply with the federal regulations over debarment and suspension procurement practices.

32. TennCare still needs to improve enrollee premium reporting

Finding

As noted in findings in three previous audits, the "Case file premiums by month" report contained a problem that compromised the reliability of this report. The TennCare Bureau prepares this report each month to track the total premiums billed to enrollees, the total amount remitted by enrollees, and the total amount due from enrollees. Management uses this report to develop premium estimates for financial reporting purposes.

The prior audit finding noted that the column that summarizes "total overdue" from enrollees included balances that management had written off.

Management concurred in part with the prior-year audit finding and took corrective action that resulted in all other issues contained in the prior-year finding not being repeated. Management's previous comments did not address the issue of write offs being included in the "total overdue" amount.

According to TennCare legal staff and review of a court order dated September 8, 1999:

. . . effective October 27, 1998, the TennCare Bureau forgave all unpaid premium balances that accrued between January 1, 1994, and September 30, 1995, for individuals enrolled as uninsured or uninsurable. . . .

Although discussions with TennCare's legal counsel confirmed that TennCare should not have any enrollee premium balances for the period January 1, 1994, through September 30, 1995, and although this issue has been noted in previous audits, the report that totals premiums by

month again contained outstanding balances for these months. Management still does not have an explanation for the discrepancy in the report. In prior years, management stated that these differences resulted from computer programming errors.

In the current year, management could not give a more definite explanation for these balances. However, the Director of Information Systems stated that he believed that TennCare was not billing enrollees for premiums for the time period January 1, 1994, through September 30, 1995. Although management provided examples of individuals who had premiums written off and were not billed by TennCare, management could not demonstrate that these examples were included in the amounts on the premium reports. Furthermore, management could not explain by the end of fieldwork which enrollees made up the balances on the report for the months in question.

While these balances on the report from January 1994 through September 1995 are not material to the TennCare program or for financial reporting purposes, there is a possibility that TennCare is incorrectly billing enrollees for premiums that should have been written off.

Recommendation

The Director of TennCare should assign specific staff responsibility to determine why there are balances on the premium report for January 1994 through September 1995 and take appropriate action. The Director should ensure that reports used for financial reporting purposes are accurate and do not include amounts for premiums that have been written off. Furthermore, the Director should ensure that enrollees are not billed for premiums that have been written off.

Management's Comment

We concur. Management has requested that Internal Audit perform a review of certain financial reports for accuracy, which will include reports generated for enrollee premiums. This review is underway. Once completed, corrective actions recommended made by the auditors will be implemented to ensure the premium reports are reliable and accurate.

33. TennCare did not comply with the Department of Finance and Administration's Policy 22, Subrecipient Monitoring

Finding

As noted in the previous audit, the bureau did not identify and report its subrecipients to the Department of Finance and Administration (F&A) as required by Policy 22. Policy 22 establishes guidelines for uniform monitoring of subrecipients that receive state and/or federal funds from state departments, agencies, and commissions. The policy requires TennCare to submit an annual monitoring plan to the Division of Resource Development and Support (RDS)

in the Department of Finance and Administration for review, comment, and approval by September 30 of each year. This plan should identify all subrecipients to be monitored, describe the risk criteria utilized to select subrecipients for monitoring purposes, identify full-time equivalents dedicated to monitoring activities, and include a sample monitoring guide. TennCare has not prepared and submitted the required plan to identify its subrecipients and document other plan requirements for the audit period.

In addition, TennCare is required to submit an annual report summarizing its monitoring activities to the RDS by October 31 of each year. Per TennCare management, the report was not submitted to the division. Management could not give a reason as to why this report had not been submitted.

Management concurred with the prior-year audit finding and stated that they had assigned an individual the responsibility for coordinating contract monitoring and implemented a process to evaluate each contract to determine those that are subrecipient contracts. During fieldwork, we asked management if they had assigned a person to perform this monitoring. Management indicated that a person had been assigned to perform this task; however, this task was not completed.

Management also stated they would do the following:

- Assign each subrecipient to an appropriate individual for monitoring.
- Submit to the Department of Finance and Administration by February 28, 2002, the monitoring plan with all relevant information.
- Submit the annual report of monitoring activities by October 31 of each year.

However, based on discussion with the Assistant Commissioner of Finance and Administration, none of the above proposed actions have been completed.

Not submitting the required monitoring plan and annual report resulted in inadequate monitoring of subrecipients.

Recommendation

The Director of TennCare should ensure that the required annual monitoring plan is submitted by September 30 of each year and that the plan includes all the required information. Also, the Director should ensure that the annual report summarizing TennCare's monitoring activities is submitted by October 31 of each year. The Director should determine why actions proposed in last year's management's comments have not been completed and take appropriate action.

Management's Comment

We concur. For fiscal year 2002, the monitoring plan was not completed and submitted. However, TennCare did request that Finance and Administration monitor Department of Children's Services contracts for residential treatment, which are funded in part by TennCare, and Graduate Medical Education contracts. Each contract entered into by TennCare, including those identified as subrecipients, is assigned to an individual for monitoring. These individuals are responsible for ensuring that services performed under each contract are done in accordance with contract terms.

The monitoring plan for 2003 was submitted by the September 30, 2002 deadline. In addition, the annual summary of monitoring activities was submitted to Finance and Administration by October 31, 2002.

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

Finding

As noted in the prior three audits, the Bureau of TennCare has not complied with all of the TennCare waiver's Special Terms and Conditions (STCs). There are a total of 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 Centers for Medicare and Medicaid Services (CMS) describe in detail the nature, character, and extent of anticipated federal involvement in the TennCare waiver. CMS'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 indicated that some areas still need improvement.

The STC coordinator did not adequately monitor the STCs of the TennCare waiver. An internal quarterly STC status report prepared by the STC coordinator and used during the prior audit was discontinued for the current year. When we asked management why the quarterly status reports were not continued, management indicated that a number of STCs are monitored through preparation of the Quarterly Progress Reports sent to CMS. Our analysis of the CMS Quarterly Progress Reports revealed that the Bureau included in the report progress relating to the following STCs: 2, 3, 4, 5, 9, 14, 23, 24, and 35. However, there are other applicable STCs that are not reported in the Quarterly Progress Report. New procedures implemented during the audit period included the distribution of a progress file from the STC coordinator to management. A review of the progress file revealed that the status of five STCs was either unknown or not identified by the STC coordinator. The STCs were 7, 11, 12, 29, and 36.

Testwork revealed instances of noncompliance for 3 of 24 applicable STCs. Problems related to STCs 12, 23, and 24 are repeated from the previous audits. Previously reported

compliance issues with STCs 1, 3, 9, 19, 20, and 30 were resolved during the audit period. The three STCs that require improvement are as follows:

- STC 12 – *CMS will provide FFP at the applicable federal matching rate 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 TennCare has not requested information on actual expenditures from the BHOs and continues to use estimated expenditures rather than actual to draw funds. Management concurred with this portion of the prior-year audit finding and stated, “We have reviewed this finding and have directed the BHO to develop a quarterly report listing TennCare members having an institutional confinement/episode of more than 30 days, and/or those meeting or exceeding an aggregate annual limit of 60 days. When the report is developed, it will be run for calendar years of 2000 to date. These reports are due by March 1, 2002. When received, the reports will be used to calculate the correct amounts referenced in the audit findings. This procedure will be used to calculate the correct figures each quarter henceforth.” During fieldwork we asked the Chief Financial Officer, an Assistant Commissioner for the Department of Finance and Administration, the Director of TennCare Partners, and fiscal/budget staff if the reports were being received. However, none of these employees knew if the reports had been requested as stated in the prior year audit finding. Based upon this response it appears that TennCare did not request this information from the BHO as stated in the prior year audit response. The Director of TennCare Partners stated that he would request this information from the BHO.
- STC 23 – *The state must continue to ensure that an adequate MIS is in place and provide evidence of such to CMS upon request. One feature of the system must be to report current enrollment by plan.* Management did not concur with this portion of the prior-year audit finding but stated that “advances in technology have rendered the current TCMIS [TennCare Management Information System] in need of updating and further replacement. . . . TennCare is in the process of releasing an RFP [request for proposal] which will ultimately lead to the replacement of the current TCMIS with a state of the art system. . . . The new TCMIS will replace the current system and will include features that will provide extensive and enhanced reports on enrollment by plan to CMS. We desire improvement; however, proper redesign, procurement, and implementation of a replacement system takes a significant amount of time. Delivery in 2003 is appropriate.” According to the Director of Information Systems, the RFP was released on April 22, 2002. According to Information Systems (IS) staff, a new TCMIS to be implemented in 2003 is a top project for the Bureau of TennCare.
- STC 24 – *The State must continue to assure that its eligibility determinations are accurate.* Management concurred with the prior audit finding and stated, “The Bureau of TennCare began the Reverification process by mailing out initial reverification notices to approximately 10,000 enrollees. . . . By March 2002, the Bureau expects to be mailing out approximately 40,000 initial notices per month.”

However, implementation of management's plan was delayed. TennCare began the reverification process in December 2001, and mailed 10,000 reverification notices. However, in March 2002, only 25,000 reverification notices were mailed. No other reverification notices were issued during the audit period. However, significant progress did occur after the audit period. According to TennCare records, during the months of July, August, September, and October of 2002, TennCare mailed over 372,000 reverification notices, which included over 577,000 TennCare uninsured and uninsurable enrollees. As of October 19, 2002, TennCare had terminated 35,150 individuals found to be ineligible for the TennCare program through the reverification process. Furthermore, as of November 2, 2002, the Bureau has terminated almost 87,000 enrollees for not responding to the reverification requests. In addition, there were other internal control weaknesses with TennCare eligibility. (See finding 10.)

Recommendation

The Director of TennCare should ensure overall compliance with the Special Terms and Conditions of the TennCare waiver. The STC coordinator should include the status of all STCs in the progress file that is sent to management. The Director should continue to communicate with the STC coordinator and other designated monitoring officials to guarantee compliance with the Special Terms and Conditions.

The Director should ensure that the requested reports are received from the BHOs and used to determine actual expenditures for services to enrollees residing in an IMD. The Director should ensure timely development of the new TCMIS. The Director should ensure that all TennCare enrollee's eligibility is reverified every 12 months and that internal control over eligibility is adequate.

Management's Comment

We concur. The responsibility for coordination of the Special Terms and Conditions (STC) was reassigned in October 2002. The Bureau had attempted to incorporate STC reporting into the quarterly report submitted to CMS. However, the internal quarterly status report on STCs alone has been reinstated effective for the January-March 2003 quarter.

In addition, we want to point out that we operated under two sets of STCs in state fiscal year 2002. From July through the end of January, we were under the "old" STCs. Beginning in February, we began a one-year extension of the TennCare waiver, which was sometimes referred to as "TennCare II." The STCs were slightly different. Beginning in July 2003, we started a new TennCare waiver, which involved another set of STCs.

STC 12 – We concur. TennCare is currently reviewing reports of enrollees in Institutions of Mental Disease that were prepared by the Department of Mental Health and Developmental Disabilities (DMHDD). DMHDD worked with the Behavioral Health Organizations to develop

the report format and recently submitted reports for 1997-2001 to the Bureau for analysis. Another report for the first 6 months of 2002 is in progress and will be submitted to TennCare in February 2003. Once the Bureau's analysis is complete, appropriate adjustments will be made to expenditures and federal draw amounts. In addition, DMHDD will run the report quarterly and will submit it to the Bureau at least 6 months past the end of each quarter. This timeframe will ensure the reliability of the data contained in the report.

STC 23 – We concur. TennCare has awarded a contract for development, implementation, and maintenance of an efficient and modern management information system. The new system has been designed and is actively in development. Initial testing is to begin by or before April 2003 and full implementation is to take place by October 2003. The new system is expected to rectify system-related issues specified in past audit findings and will allow for vastly improved processing, reporting, and fraud detection.

STC 24 – We concur that the mailing of reverification notices stopped in April 2002. The reason for this change in the reverification process was that a transition from the Department of Health to the Department of Human Services (DHS) was taking place during this time. Effective July 1, 2002, eligibility determination functions were moved to DHS with the exception of presumptive eligibility for pregnant women and women with breast or cervical cancer; these eligibility functions remained in the health department. The number of reverification notices mailed after July 1, 2002, was considerable, as the auditor's report indicates.

35. For the fourth consecutive year, internal control over provider eligibility and enrollment was not adequate to ensure compliance with Medicaid provider regulations

Finding

As noted in the three previous audits, the TennCare program still did not have adequate internal control for provider eligibility and enrollment to ensure compliance with Medicaid provider regulations. Management partially concurred with the prior audit finding and corrected three issues concerning the following:

- TennCare's contract with the Department of Children's Services (Children's Services) requiring Children's Services to comply with Medicaid provider rules and regulations;
- TennCare's providing the Division of Mental Retardation Services (DMRS) with the Medicaid provider rules and regulations that DMRS should follow; and
- TennCare's maintaining documentation that the providers for all long-term care facilities (LTCF) met the prescribed health and safety standards.

However, the current audit revealed that TennCare still had the following internal control weaknesses and noncompliance issues that were noted in the previous audit:

- the licensure status of Medicare crossover, managed care organization (MCO), and behavioral health organization (BHO) providers was not reverified after the providers were enrolled;
- TennCare did not monitor the enrollment of Medicaid providers at Children's Services and DMRS;
- provider agreements did not comply with all applicable federal requirements;
- departmental rules were not followed; and
- not all providers had a provider agreement, as required.

Responsibility for TennCare provider eligibility and enrollment is divided among the Provider Enrollment Unit in the Division of Provider Services and the Pharmacy Program in the Division of Pharmacy, both in the Bureau of TennCare; the Division of Resource Management in Children's Services; and the East, Middle, and West Tennessee regional offices in DMRS.

The Provider Enrollment Unit is responsible for enrolling MCO and BHO providers; Medicare crossover 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. The Pharmacy Program is responsible for the eligibility of the providers that provide drugs to individuals who are both Medicare and Medicaid eligible and that provide behavioral health drugs to TennCare enrollees.

Children's Services is responsible for the eligibility of the providers it pays to provide Medicaid-covered services to eligible children. DMRS 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 and Developmentally Disabled program. (DMRS is responsible for the daily operations of this Medicaid program.) TennCare reimburses Children's Services and DMRS for payments to these providers.

Provider Licensure Not Reverified

In response to the prior-year finding, management stated, "The Provider Enrollment unit has developed procedures for reverifying the licensure renewal for providers participating in the Medicaid Program. The implementation of this new program will ensure providers participating in the program maintain a valid license. However, the implementation of the license reverification program is pending for mainframe system modifications and the hiring of three new staff members." Although the system modifications were made and the procedures developed, new staff positions have not been obtained; therefore, the positions cannot be filled. Testwork revealed that for 38 of 50 crossover providers tested (76%), there was no evidence in the TennCare Management Information System that the provider's license had been reverified. This appears to have occurred because, without the needed staff, the reverification process has not been fully implemented or performed on a continuous basis.

Testwork also revealed that the Pharmacy Program does not perform an initial verification or a reverification of pharmacy provider licenses. Although the Department of Commerce and Insurance has a Web site available to verify that a pharmacy has a license, the TennCare Pharmacy Program staff does not use the site for verification.

Because of the lack of reverification of providers, the Provider Enrollment Unit and the Pharmacy Program cannot ensure that only licensed providers are enrolled in the TennCare program as required. The *Rules of the Tennessee Department of Finance and Administration*, 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."

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

Testwork revealed TennCare did not monitor the enrollment of Medicaid providers at Children's Services. On behalf of TennCare, the Division of Resource Development and Support (RDS) in the Department of Finance and Administration (F&A) performed fiscal monitoring procedures at Children's Services during the year ended June 30, 2002. At that time, RDS verified that providers had a current license. However, TennCare did not require RDS to examine Children's Services' provider agreements to ensure compliance with the Medicaid regulations discussed below.

Testwork revealed that Children's Services and DMRS did not always comply with Medicaid provider rules and regulations governing requirements of the provider agreements. Children's Services and DMRS did not comply with criteria (3) of the *Code of Federal Regulations* (CFR), Title 42 Part 431 Section 107, "Required Provider Agreement," and Children's Services did not comply with criteria 4 and DMRS did not comply with criteria 4 and 6 of the *Rules of the Tennessee Department of Finance and Administration*, 1200-13-1-.05, "Providers."

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." Also, 42 CFR 431.107 (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.

The *Rules of the Tennessee Department of Finance and Administration*, Section 1200-13-1-05 (1)(a), “Providers,” 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 Medicaid 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.

Provider Agreements Not Adequate

In response to the prior finding, management stated, “The Provider Enrollment unit developed and implemented the use of a new Provider Participation Agreement form and revised the current Provider Enrollment application to comply with the requirements of 42 CFR 431.107. We implemented the use of these new forms in October 2001. Each provider must complete these forms to enroll and participate in the Medicaid Program.” However, these forms are only completed for new enrollees enrolling with the Provider Enrollment Unit after September 31, 2001. Therefore, the Children’s Services, DMRS, and Pharmacy Program provider agreements did not comply with federal requirements. Testwork performed on the Children’s Services, DMRS, and Pharmacy Program provider agreements noted that these agreements did not disclose ownership and control information and information on a provider’s owners and other persons convicted of criminal offenses against Medicare or Medicaid, as required by 42 CFR 455 subpart B.

In addition, TennCare’s agreements for individual crossover, MCO, and BHO providers enrolled prior to October 1, 2001, did not require providers to

- keep any records necessary to disclose the extent of services the provider furnishes to recipients;
- furnish to the Medicaid agency, the secretary, or the state Medicaid fraud control unit information required in 42 CFR 431.107; and
- disclose ownership and control information and information on a provider’s owners and other persons convicted of criminal offenses against Medicare or Medicaid.

Furthermore, TennCare’s agreements with group crossover providers enrolled prior to October 1, 2001, did not require providers to

- keep any records necessary to disclose the extent of services the provider furnishes to recipients; and
- furnish to the Medicaid agency, the secretary, or the state Medicaid fraud control unit information required in 42 CFR 431.107.

Departmental Rules Not Followed

The TennCare Provider Enrollment Unit, Children’s Services, DMRS, and the Pharmacy Program did not limit participation to providers that complied with the *Rules of the Tennessee Department of Finance and Administration*, Section 1200-13-1-.05 (1)(a), “Providers.”

Testwork revealed that the TennCare Provider Enrollment Unit did not require Medicare crossover, MCO, and BHO providers that enrolled prior to October 1, 2001, to

- accept, as payment in full, the amounts paid by Medicaid or paid in lieu of Medicaid by a third party;
- not be under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs;
- maintain and provide Medicaid and/or its agency access to all Medicaid recipient medical records for five years from the date of service or upon written authorization from Medicaid following an audit, whichever is shorter;
- provide medical assistance at or above recognized standards of practice; and
- comply with all contractual terms and Medicaid policies as outlined in federal and state rules and regulations and Medicaid provider manuals and bulletins.

Children’s Services did not require providers to

- maintain and provide Medicaid and/or its agency access to all Medicaid recipient medical records for five years from the date of service or upon written authorization from Medicaid following an audit, whichever is shorter.

DMRS did not require providers to

- maintain and provide Medicaid and/or its agency access to all Medicaid recipient medical records for five years from the date of service or upon written authorization from Medicaid following an audit, whichever is shorter; and
- comply with all contractual terms and Medicaid policies as outlined in federal and state rules and regulations and Medicaid provider manuals and bulletins.

The Pharmacy Program did not require providers to

- not be under a federal DEA restriction of their prescribing and/or dispensing certification for scheduled drugs; and

- provide medical assistance at or above recognized standards of practice.

TennCare Did Not Have Documentation That All Providers Had an Agreement

In response to the prior finding, management stated, “To ensure all intermediate care and skilled nursing facilities’ provider files contain the appropriate forms and agreements, the reviewer must complete an enrollment checklist. We currently depend on HCF [Health Care Facilities in the Department of Health] to notify our office of nursing home facilities needing new contracts. However, we are currently working with the IS [Information Systems] unit on system modifications to track all LTCF recertification due dates and to generate monthly reports to alert staff of upcoming contract termination dates.” Although the system modifications have been made, the Provider Enrollment Unit is not receiving the monthly reports. Also, even though the use of an enrollment checklist has been implemented, not all providers had an agreement in their file.

A sample of payments to intermediate care facilities and skilled nursing facilities was 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. Intermediate care facilities and skilled nursing 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, and TennCare issues a new provider agreement to the long-term care provider for the certification period. As mentioned above, the State Plan and 42 CFR 431.107 require that providers have a provider agreement.

For one of 60 payments to intermediate care facilities tested (2%), TennCare did not have a provider agreement. The total amount of errors noted above was \$2,612. Federal questioned costs totaled \$1,663. An additional \$949 of state matching funds was related to the federal questioned costs. We believe that likely questioned costs would exceed \$10,000. For one of 60 payments to skilled nursing facilities tested (2%), TennCare did not have a provider agreement. The total amount of errors noted above was \$908. Federal questioned costs totaled \$578. An additional \$330 of state matching funds was related to the federal questioned costs. We believe that likely questioned costs would exceed \$10,000. However, after testwork was performed, the provider agreements were negotiated with the providers to correct the errors. TennCare paid approximately \$923 million to intermediate care facilities and \$104 million to skilled nursing facilities for the year ended June 30, 2002.

TennCare contracts with Consultec, LLC (Consultec), to pay claims on a fee-for-service basis to providers for individuals who are both Medicare and Medicaid eligible as well as for behavioral health drugs for TennCare enrollees. Consultec pays the claims submitted by the Pharmacy Program providers, and then TennCare reimburses Consultec for the cost of the claims paid. A sample of payments to Consultec was tested to determine if the pharmacy was licensed and that a provider agreement was on file for the dates of services for which each payment was made. Testwork revealed that 25 of 25 agreements tested (100%), were signed by the providers, but not by the Bureau of TennCare. The Pharmacy Participation Agreement, Section 9.5, “Application of Pharmacy,” states, “This signing of this Agreement by Pharmacy shall constitute an offer only, unless and until it is executed by TennCare in the State of Tennessee.” The

agreements are not considered executed without containing all proper signatures. TennCare reimbursed approximately \$851 million to Consultec for claims for the year ended June 30, 2002.

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.

Recommendation

Note: This is the same basic recommendation, for the remaining uncorrected issues, that has been made in the prior three audits.

The Director of TennCare should ensure that adequate internal control exists for determining and maintaining provider eligibility. The Director should ensure that procedures are implemented to reverify licensure and to prevent future payments to non-licensed providers.

The Director should ensure that a knowledgeable staff monitors the enrollment of Medicaid providers at Children's Services and DMRS. Management and staff should ensure the Bureau of TennCare, Children's Services, and DMRS comply with all Medicaid federal and state provider rules and regulations. The provider agreements should be revised to comply with the State Plan and the *Code of Federal Regulations*. Participation should be limited to providers that meet the requirements of the departmental rules. Management should ensure that all Medicaid/TennCare providers have a provider agreement, the agreement is signed by the appropriate parties, and providers are otherwise properly enrolled before they are allowed to participate in the program.

Management's Comment

Provider Licensure Not Reverified

Provider Enrollment Unit

We partially concur. As stated in the finding above, the Provider Enrollment Unit (PEU) verifies the license on all new providers enrolling in the TennCare program. In addition, in early 2002, the PEU implemented procedures to reverify licenses of active TennCare providers, which are those currently billing TennCare for crossover claims. During 2002, PEU reverified the license renewals of over 6,000 (90%) providers currently participating in the TennCare program. Active TennCare providers were determined by using the 2001 provider payment report and/or the IRS 1099 reports. During this reverification effort, only one provider was identified that had not renewed his license; this issue was subsequently resolved as the provider was in the process of renewing it.

Because provider licenses are renewed biennially, PEU will reverify license renewal for active providers every other year. During 2003, the reports mentioned above will again be used to identify active providers. With the current staffing levels and the huge number of registered providers, it is not possible to implement a full reverification program for all providers in the system. We believe that reverification of the active providers fulfills the requirement of the Rules since these are the providers participating in the program.

TennCare Pharmacy Unit

We concur. The TennCare Pharmacy Unit will begin a process of reviewing all pharmacy provider agreements to assure the pharmacy providers' licenses are current. For all new providers, this review is performed before their participation is approved.

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

Children's Services issues

We concur. TennCare will immediately request monitoring of Children's Services provider agreements by the Program Accountability Review section of the Department of Finance and Administration. We will request that the monitors confirm compliance with the required Medicaid provider rules and regulations regarding provider agreements.

TennCare Division of Long Term Care (TDLTC)- DMRS issues

We do concur that DMRS was not compliant with all Medicaid Provider rules and regulations. Following last year's audit, DMRS was advised of their responsibility to maintain compliance with all state and federal Medicaid rules, regulations and policies related to providers. A suspension/debarment policy has been drafted. The draft policy has been forwarded to DMRS management staff with instructions to prepare for implementation of the policy. The final policy will be forwarded when available. Specific language related to suspension/debarment was included in the FY 2002 and FY 2003 contracts between TennCare and DMRS at D.5.d.

The contract between DMRS and TennCare was revised for FY 2002 and FY 2003 to be inclusive of specific requirements for maintenance of records. The contract contains language requiring DMRS to comply with state and federal rules and regulations and TennCare policies and procedures as well. TennCare and DMRS continue to work together to ensure compliance with the contract and with State and Federal requirements for the waiver program. Throughout the past year, numerous meetings were held between TennCare and DMRS to work through compliance issues. Weekly meetings between DMRS, TennCare and the Commissioner of Finance and Administration were initiated in February 2003. Monthly steering committee meetings between TennCare and DMRS central office staff were initiated in March 2003 for the purpose of monitoring the progress of corrective actions and discussing compliance and other programmatic issues.

Provider Agreements Not Adequate
Departmental Rules Not Followed

Provider Enrollment Unit

The Provider Enrollment Unit developed and implemented the use of a new Provider Participation Agreement form and revised the current Provider Enrollment application to comply with the requirements of CFR-431.107. PEU implemented the use of these new forms in October 2001 and effective with the implementation date all providers enrolling in TennCare Medicaid must complete the new forms. With respect to providers enrolled before October 2001, PEU will use the 2002 provider payment report and/or the IRS 1099 report to identify providers that are actively participating in the TennCare program. All providers identified as currently participating in the TennCare program and enrolled before October 2001 will be notified and requested to complete the new agreement.

With the current staffing limitations and the huge number of providers registered, it is not possible to obtain new agreements on both active and inactive providers. We believe that obtaining new agreements on active providers fulfills the requirements of the Rules since these are the providers participating in the TennCare program.

TDLTC

We concur for the audit period; however, the finding has been corrected. The FY 2002 DMRS provider agreements were revised to add suspension/debarment language. The FY 2003 provider agreements were revised to add disclosure of ownership and control.

TennCare Pharmacy Unit

We concur. TennCare's Pharmacy Unit will soon be issuing amendments to the current Pharmacy Participation Agreement that will include requirements for compliance with the Tennessee state plan, 42 CFR 431.107, 42 CFR 455 subpart B and Section 1200-13-1-.05(1)(a), as appropriate. The new amendments of the agreement will also change the language in Section 9.5 to be more consistent with other TennCare provider agreements in that it will not require signature by the state, only the provider.

The TennCare Pharmacy Unit will begin a process of reviewing all pharmacy provider agreements to assure the pharmacy providers' licenses are in order. All new providers will have this review performed before their participation is approved.

Children's Services

We concur. We will work with Children's Services to revise the current provider agreements to ensure that all federal requirements are included. Also, as stated above, we will

request that the monitors confirm compliance with the required Medicaid provider rules and regulations regarding provider agreements.

TennCare Did Not Have Documentation That All Providers Had Agreements

Provider Enrollment Unit

We concur. The provider agreement referenced in the finding was obtained and on file for the new owners; however, due to the facility's change of ownership, the effective date of the new ownership was not clearly communicated to TennCare PEU. We contacted Health Care Facilities regarding the error on the Certification and Transmittal (C&T) Form and requested a corrected copy. The facility received and signed a new agreement.

To ensure all intermediate care skilled nursing facilities provider files contain the appropriate forms and agreements; the reviewer must complete a checklist and verify the C&T effective dates. In addition, all provider agreement contracts will be reviewed to verify any lapses in coverage dates.

TennCare Pharmacy Unit

See comments above regarding pharmacy provider agreements.

36. For the fourth consecutive year, 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 three audits, the Bureau of TennCare still 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 prior-year finding and stated,

. . . Significant steps have been taken toward implementing a Post-payment review process for LTC [long-term care] waiver programs. . . . Two nurse auditors from the Comptroller's office have been reassigned to TDLTC [the TennCare Division of Long-Term Care] and are being trained to review records for HCBS [Home and Community Based Services] Waiver programs. . . . These nurses began formal record reviews in November 2001. A process for post-payment reviews for the MR [Mentally Retarded] Waiver program is being developed first, due to the need to develop such process for compliance with the MR Waiver Corrective Plan. The process developed will then be modified and implemented for other LTC waiver programs.

The nurses performed one limited post-payment review, consisting of a sample size of 40, on the HCBS Waiver for the Mentally Retarded and Developmentally Disabled. Per discussion with the Director of Long-Term Care, no other reviews were performed on the HCBS Waiver claims or LTC facility claims. She also stated that because TennCare has been unable to hire staff to perform post payment reviews, it plans to contract with an outside vendor to perform these reviews. However, TennCare did not use an outside vendor during the audit period, nor did TennCare have other procedures in place for the ongoing post-payment reviews for the HCBS Waiver or LTC services. The Director of Long-Term Care was not aware of any formal cost/benefit analysis performed to arrive at the outsourcing decision.

In addition in its comments from the prior audit, management stated,

With respect to fraud and abuse, a new process will require the respective programs and the TennCare Quality Oversight and Program Fraud organizations to work together to assure the finding is addressed. The Bureau will develop a plan to address this issue in collaboration with Program Fraud organizations.

For the past three audits, management's comments have basically remained the same stating that they would address changes in the program and develop a plan to address utilization of care and suspected fraud in the areas of the program that were still on a fee-for-service basis. In the audit report for the year ended June 30, 2001, we reported that TennCare had begun developing, but did not complete a comprehensive plan to address these requirements.

Finally, during the audit for the year ended June 30, 2002, discussions with management revealed that a new committee called PRIQ, consisting of members from the Provider Network, Provider Relations, Program Integrity, and Quality Oversight, was formed to address issues of fraud, abuse, complaints, and audit findings. The committee conducted its first formal meeting in February 2002 and now meets monthly. The group focuses primarily on providers for which complaints have been received. Formal written procedures were developed in October 2002, after the end of the audit period.

Although the state is operating under a waiver from the federal Centers for Medicare and Medicaid Services (CMS) to implement a managed care demonstration project, more and more services are being paid on a fee-for-service basis. This is occurring because the state has decided to shift the burden of high cost/high risk groups from the managed care organizations to the state. Services provided on a fee-for-service basis include: services provided in the long-term care facilities, services provided to children in the state's custody, services provided under the Medicaid Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled, services provided to enrollees who are both TennCare and Medicare recipients (Medicare cross-over claims), services provided to TennCare Select enrollees, and pharmacy claims for individuals that are recipients of TennCare and Medicare. Discussions with key TennCare management during the current audit and in the previous audits 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,” except for the one post-payment review performed for the HCBS waiver during the audit period; 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.

These same conditions existed during the three preceding audits.

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, in 1992 the State Medicaid Agency told the federal grantor in the Tennessee Medicaid State Plan,

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 that during the audit period, there was no statewide program of surveillance and utilization control. This condition has existed during the previous three audit periods.

An example of an area needing utilization review is TennCare’s pharmacy program. During testwork we noted an enrollee who averaged more than 40 prescriptions a month and two enrollees for whom TennCare paid over \$100,000 each for drugs for the year ended June 30, 2002. While all or some portion of these billings may be appropriate, the lack of procedures to identify enrollees with possible excessive use and investigate these billings could cause TennCare to be incurring costs for drugs that are not needed by the enrollee.

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

Note: This is the same basic recommendation we have made for the three consecutive prior audits.

The Director of TennCare should ensure development of the comprehensive plan for utilization control and identification of fraud for all areas of the program that are fee-for-service based. When the plan is completed, the Director should ensure that it is implemented promptly. The Director should ensure that procedures are performed to identify and investigate enrollees who might be receiving excessive prescriptions.

Management's Comment

Program Integrity Unit and PRIQ Group

We concur. As stated in the finding, the PRIQ team meetings began in February 2002 and continue on a bi-monthly basis. This group focuses on complying with federal regulations and the state plan regarding unnecessary utilization of care and services and suspected fraud for fee-for-service areas of the program by providing opportunities to discuss trends identified in provider behavior which appear outside the norm. These meetings have resulted in some case referrals to the Program Integrity Unit (PIU), which performs investigations as indicated by circumstances of each case. Referrals are also received by the PIU from other sources, including mail, fax, hotline calls and the Fraud and Abuse web-site. A representative from the Long Term Care Division has been asked to join the PRIQ group at the next meeting in March 2003.

PIU also meets with representatives of Health Related Boards (HRB) and the Tennessee Bureau of Investigation (TBI) Medicaid Fraud Unit on a regular basis regarding allegations of potential provider abuse of the TennCare program. These meetings have resulted in referrals to the PIU for validation of allegations. If an allegation is validated, the case is referred to TBI and/or HRB for further action on licensure or prosecution.

The PIU has actively participated in the development of the Fraud and Abuse program in the replacement TCMIS, which is being designed. This program will allow the PIU to perform statistical analysis and peer review reports and identify outliers (both enrollees and providers) in addition to other fraud and abuse monitoring activities. Both on-demand reports and targeted queries have been developed for the new system, which will assist Program Integrity in initiating

investigations in a timely manner and will allow for movement towards more proactive investigations.

TennCare Division of Long-Term Care

We partially concur. The TennCare Division of Long Term Care (TDLTC) has had difficulties recruiting and retaining staff in the Quality Monitoring (QM) Unit. Resources were stretched in training new QM staff, given the fact that there was only one existing staff member with QM experience. TDLTC did get two nurse auditors on loan from the Comptroller's Office to assist with QM functions. However, one of these nurses has since retired and the position has been abolished. TDLTC continues to attempt to fill vacant positions within the QM Unit. Although outsourcing had been planned for this unit because of the inability to adequately staff it, the current fiscal environment may not allow this flexibility.

A tool was developed for the two nurses to review approximately 40 records. The review process took longer than anticipated due to the training needs of the reviewers, the complexity of the program, the volume of records involved, and the need for the reviewers to assist the Comptroller's Office with some special audits. The reviews are now completed and draft handwritten findings have been submitted to the TDLTC director. There have been insufficient staff (given the volume of work) available within TDLTC to compile these findings into an acceptable report.

TDLTC and the Division of Mental Retardation Services (DMRS) are currently working with the Centers for Medicare and Medicaid Services (CMS) technical assistance consultants to develop a comprehensive quality assurance system. Staff from TDLTC and DMRS is meeting regularly with and without representatives from the CMS consultant group to complete this project. A technical assistance contract has been developed, a draft initial report has been issued, and a work plan with time frames has been developed. Utilization review will be a part of the comprehensive quality assurance program. Utilization Review is noted in the Infrastructure Development and Corrective Action Plan.

In addition, DMRS is currently testing a Utilization Review tool for select services. The tool is being tested in reviewing randomly selected files of 25 individuals receiving behavior services and 25 individuals receiving therapy or nutrition services through the Arlington Waiver. The results will be available in late March 2003. This tool/process will be evaluated for use in both waiver programs.

Pharmacy

We concur. TennCare has developed a Request for Proposal (RFP) to secure the services of a vendor that could perform fraud, waste and abuse audits of pharmacy claims data. This vendor would be required to perform computer audits, desk audits and onsite audits of every pharmacy provider every year. This audit process will identify waste, fraud and abuse in both the provider community (pharmacists and physicians) and among enrollees. This contractor would work closely with TennCare, the TBI and the TennCare Program Integrity Unit to share and

integrate information regarding overuse or abuse of the pharmacy program. If the funds become available, this RFP will be released, evaluated and a contract awarded this calendar year. TennCare has announced its intention to develop a single statewide drug formulary and the fraud/abuse contractor will be able to more easily monitor all of TennCare's pharmacy expenditures when that occurs.

Auditor's Comment

Regarding the comments by the TennCare Division of Long-Term Care, it is not clear from management's comments with which part(s) of the finding management does not concur.

37. The TennCare Management Information System lacks the necessary flexibility and internal control

Finding

As noted in four previous 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 \$6.2 billion federal/state health care reform program effectively and efficiently. Management partially concurred with the prior finding and indicated it has begun preparations for implementing a new TennCare Management Information System. Management also stated that the "current work schedule calls for the RFP to be released on February 28, 2002." According to the Director of Information Systems, the RFP was released on April 22, 2002. According to Information Systems (IS) staff, the implementation of a new TCMIS is to occur in 2003 and is a top project for the Bureau of TennCare.

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 organization, 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.

Recommendation

The Director of TennCare should continue to 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 internal control to prevent or recover erroneous payments. TennCare should ensure that an updated system is implemented timely that more effectively supports TennCare's operations.

Management's Comment

We concur. TennCare Information Systems contracted with EDS to design, test, implement, and maintain a modern, efficient replacement TennCare Management Information System (TCMIS). The new TCMIS, which is scheduled to become fully operational by October 2003, will be a highly sophisticated, feature-rich system centered on a strong, Medicaid-specific relational data model which divides the application into components so that they process on different networked computers, leveraging the true power of client/server architecture.

The new TennCare system will employ modern graphic capabilities and native Windows-based features that only a true graphical user interface (GUI) can provide. Features such as pull-down menus, tabs, and buttons will be programmed for users in each individual application. These features will simplify the windows' uses and reduce the learning curve for new users, which is a significant concern in the new system.

The new TCMIS will be based on a true client/server design utilizing industry-leading Sun servers. The applications will take advantage of the client/server platform capabilities that yield such benefits as concurrent processing and load balancing in a readily scalable environment.

Preliminary testing on the new system indicates that it will effectively solve the shortcomings evident in the current system. The new system will provide for all current functionality plus additional enhanced reporting, tracking, and fraud detection capabilities. This new system will have a vastly superior database as a foundation, which will allow for more expeditious access to any necessary information.

Access to information will be one of the strengths of the new TCMIS. The new system will employ a standard Structured Query Language (SQL) data access methodology. The online application will allow users to query key information using multiple parameters, which will bring extensive flexibility from online information access to users.

The new TCMIS will feature Sun Microsystems servers running Sun Solaris UNIX with server applications coded in ANSI Standard C. Other functions and servers that support the various TCMIS functions will connect off this solid foundation.

In the interim, TennCare has implemented various financial ad-hoc monitoring reports for both the fiscal and program integrity units.

38. Management has misrepresented the corrective action taken regarding controls over access to the TennCare Management Information System

Finding

As noted in the four previous 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 ensuring, 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.

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 are critical to the integrity and performance of the TennCare program. Good security controls provide access to data and transaction screens on 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

The lack of authorization forms was first reported in an audit finding for the year ended June 30, 1998. Management then responded that a new security authorization form was being developed. However, in the audit report for the year ended June 30, 1999, we reported that system users still did not have authorization forms. In response to that finding management responded that action had been taken in July 1999 to resolve the issue. However, in the 2000 audit report our finding stated that while authorization forms were being completed by new users beginning in July 1999, no forms had been obtained from existing users. At that time TennCare’s security administrator stated that forms were not obtained for all existing users because she was not instructed to obtain these forms. In response to that finding, management stated that they would continue their efforts to ensure that proper access forms are obtained for all TennCare and other users who require interaction with the TennCare system. However, in the 2001 audit report we indicated that authorization forms still had not been obtained for all existing users outside the Bureau of TennCare.

Management concurred with this portion of the audit finding for year ended June 30, 2001, and stated that staff was “currently obtaining justification from users in the Department of Human Services (DHS).” However, once again TennCare has misrepresented the corrective action which has been taken. In fact, our testwork revealed that justification forms have not been obtained for any of the more than 1600 DHS employees who have access to TCMIS.

Access to TCMIS is controlled by Resource Access Control Facility (RACF) software, which prohibits unauthorized access to confidential information and system transactions. The TennCare security administrator in the Division of Information Systems is responsible for implementing RACF, as well as other, system security procedures; for assigning a “username” (“RACF User ID”); and establishing at least one “user group” for all TennCare Bureau and TCMIS contractor users. RACF controls access by allowing each member of a user group to access a set of transaction screens. Not requiring users outside the Bureau of TennCare to sign justification 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

In the audit report for the year ended June 30, 1998, we reported that users in the default group had access to at least 44 TCMIS transaction screens, some of which were not necessary for the performance of each user’s job duties. Management responded that a review was being done of the user groups to verify that the types of transactions for all groups were as needed and that changes would be made as needed.

In the audit report for the year ended June 30, 1999, it appeared that the previous problem had been corrected, but that users in the default group had the ability to update at least two screens. Management sent a work request to the contractor in August 1999 to make corrections. An audit finding in the 2000 report indicated that the problems had still not been corrected. Management’s response indicated they were still awaiting corrective action by the contractor.

In the 2001 audit report we indicated that unauthorized access to one screen was still permitted.

Management concurred with this portion of that audit finding and requested Electronic Data Systems (EDS) (the contractor hired to operate and maintain the TCMIS) to restrict unnecessary access to TCMIS. However, during the audit period, there was still a problem with access to one screen. User access testwork revealed that auditors and users in TennCare’s default group could obtain unauthorized access and inappropriately add or change information regarding an enrollee’s application for the TennCare/Medicaid program. Thus, it appears that management has not ensured that transactions are protected against unauthorized users making changes. Management did correct this problem after we brought it to their attention.

Security Administration Not Centralized

In the audit report for the year ended June 30, 1998, it was first reported that security administration was not centralized. Both security administrators at the Department of Health and at the Bureau of TennCare could give users access to TCMIS. In response to the finding management agreed that it was necessary for the Security Administrator to be centralized. The audit report for the year ended June 30, 1999, indicated that the Security Administrator for the Department of Health was still giving access independent of TennCare’s Security Administrator. Management responded that “effective immediately, only the TennCare Security Administrator

can now authorize access to TCMIS.” However, the 2000 audit indicated that management’s response to the prior audit finding was incorrect and that the situation remained the same. Management then responded that “Centralization of TCMIS security under TennCare Information Systems’ security administrator was implemented as of November 3, 2000.” The 2001 audit indicated that an attempt had been made to correct the situation by removing the TCMIS transactions from the Department of Health’s default group. However, the removal interrupted the ability of users in the Department of Health to perform their TennCare responsibilities. As a result, the transaction screens were added to the default group once again and no other attempt to correct the problem had been made.

Management partially concurred with this portion of the audit finding for the year ended June 30, 2001, and stated that TennCare, the Department of Health, and the Department of Human Services (DHS) were currently in negotiations “to develop a no-cost inter-departmental contract that will include enhanced procedures to control access to the TCMIS.” TennCare corrected the problem with the Department of Health Security Administrator granting access. However, as of December 17, 2002, the contract has not been developed, and the security administrator for DHS continues to have the ability to add users to TennCare user groups without notifying TennCare’s security administrator. Furthermore, as noted earlier in the finding, neither TennCare nor the DHS security administrator obtained justification forms for users added to these groups. In addition, TennCare did not monitor the activities of the DHS security administrator as they relate to TennCare. When access to TCMIS is decentralized, it is more difficult to monitor and control.

Dataset Modifications Not Monitored and Access not Documented (This portion of the finding has not been reported in previous years.)

Auditor inquiry determined that TennCare does not monitor EDS programmers with TCMIS access to production datasets. Production datasets are computer files used by TCMIS that contain critical information about enrollees. When making system changes, sometimes it is necessary for an EDS programmer to change information in a production dataset. TennCare, however, does not monitor the changes made by the programmers to ensure changes are made correctly and are authorized.

Testwork also revealed that TennCare has not maintained documentation of state employees who have access to TCMIS datasets. Management stated that the Director or a manager in the Division of Information Systems must first approve a request for access to a dataset before access is granted; however, testwork revealed that this approval is not documented. The failure to require signed security authorization forms with proper supervisory approval makes it more difficult to monitor 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.

Recommendation

Note: This is the same basic recommendation we have made for the four previous audits.

The Director of TennCare and the TennCare security administrator should ensure that the authorization forms are obtained for all current and future users who have access to TCMIS, including users who have dataset access. Access levels for all TCMIS 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. Formal monitoring procedures should be developed to monitor all TCMIS dataset activity and the DHS security administrator's activity as it relates to any TCMIS security issues.

Management's Comment

We do not concur. TennCare Information Systems has worked with the Department of Human Services to ensure that signed agreements are obtained for all users. However, the agreement between the agencies has not been signed. We will continue to work with DHS to get the contract in place and/or obtain copies of all signed agreements that DHS currently possesses.

Rebuttal

Despite management's refusal to acknowledge the problem, significant deficiencies existed in controls over access to TCMIS during the audit period. Indeed, because management has continuously failed to fully acknowledge these deficiencies and to take appropriate corrective actions, this finding is being repeated for the fifth consecutive year. As stated in the finding, our testwork revealed that justification forms have not been obtained for any of the more than 1600 DHS employees who have access to TCMIS.

Management's comments did not address the following recommendations:

- Access levels for all TCMIS 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.
- Formal monitoring procedures should be developed to monitor all TCMIS dataset activity and the DHS security administrator's activity as it relates to any TCMIS security issues.

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

Finding

As noted in the preceding five 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). The prior audit addressed two specific areas where TennCare did not comply with the federal regulations related to ADP risk analysis and system security review:

- TennCare's policies and procedures did not address all the areas required by the Office of Management and Budget (OMB) Circular A-133 and the *Code of Federal Regulations* (CFR), Title 45, Subtitle A, Part 95, Section 621.
- TennCare did not conduct the required system security reviews on a biennial basis.

Management concurred in part with the prior audit finding and stated that "TennCare management has made a written request to CMS [Centers for Medicare and Medicaid Services] for written verification that the current TennCare Business Continuity and Contingency Plan (BCCP) meets all federal requirements and guidelines for security." Management prepared a written request dated February 11, 2002, but as of June 26, 2002, CMS has not responded to the request. Management also stated that a TennCare Security Procedures manual was "currently under development" and that "TennCare management is currently in the process of developing an ADP risk analysis document and matrix." In addition, management drafted an "Information Systems Internal Security Manual" and an "Information Systems Security Handbook." However, as of June 26, 2002, neither of the documents have been approved and placed in operation.

The Bureau has relied on the Department of Finance and Administration's Office of Information Resources (OIR) for security of TCMIS. According to OIR's policy number one, agency management is to "provide for an agency administrative review of security standards, procedures and guidelines in light of technical, environmental, procedural, or statutory changes which may occur." However, the Bureau has not complied with all federal regulations, which require establishing a comprehensive program for ADP risk analysis and system security review.

According to 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 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."

Furthermore, “The State agency shall maintain reports of their biennial ADP system security reviews, together with pertinent supporting documentation, for HHS on-site review.” However, testwork revealed that TennCare did not conduct the required system security reviews on a biennial basis.

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
- 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

The prior audit noted four specific areas the existing policies did not address:

- Physical security
- Equipment security
- Telecommunications security
- Personnel security

Management has a draft of new policies and procedures that address these requirements. However, these policies have not been implemented.

Recommendation

The Director of TennCare should ensure that the Director of Information Systems promptly implements the newly drafted procedures for 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. In addition, the Director should ensure that TennCare performs the required system security reviews on a biennial basis. Otherwise, the Director of TennCare should obtain, and provide to us, documentation of

concurrence by CMS of TennCare's actions as a valid ADP risk analysis and system security review.

Management's Comment

We concur. Although we believed that the BCCP (Business Contingency Continuity Plan) fulfilled all federal requirements, CMS has not replied to our request for clarification of this issue. Therefore, TennCare Information Systems developed a comprehensive ADP security audit plan document, which was provided to the Comptroller's auditors in October 2002. This plan covers all aspects of ADP security audits according to federal requirements and has been reviewed and approved by TennCare Information Systems management. The on-site security inspection and audit check is scheduled to begin April 4, 2003.

In addition, the Information Systems Security Handbook was completed and distributed in July 2002. This handbook addresses policies over physical, equipment, telecommunications and personnel security as discussed in the audit finding, as well as other requirements.

STATEWIDE SUBRECIPIENT MONITORING

Our objectives were to determine whether

- the Division of Resource Development and Support (RDS) was performing its duties as the lead agency for the statewide monitoring system required by Finance and Administration Policy 22, "Subrecipient Monitoring" by properly monitoring subrecipients in accordance with the Single Audit Act; and
- RDS was properly billing departments and divisions which used RDS to monitor subrecipients.

We interviewed key personnel and reviewed the procedures that were being used by RDS. To determine if subrecipients were adequately monitored in accordance with the Single Audit Act and Policy 22, we tested a nonstatistical sample of subrecipients to determine if RDS monitors' work covered all core areas and if the monitoring reports were 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.

Testwork revealed that RDS was performing its duties as required by Policy 22 by adequately monitoring subrecipients. Also, RDS billings were appropriate and adequately supported.

BUDGETING

Our objectives were to determine whether

- the 2001-2002 approved appropriation bill reconciles to the original budget recorded on the State of Tennessee Accounting and Reporting System (STARS);
- the revisions to the original budget were adequately supported and authorized;
- the budget document contained the information required in Section 9-4-5106, *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 calendar 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, 2002, 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 2001-2002 and reconciled, for a nonstatistical sample of budget entries, the approved appropriation bill amounts to the original budget recorded on STARS. We also selected a nonstatistical sample of budget revisions and reviewed the support and authority for any revisions made by the department to the original budget. We reviewed the budget document to determine whether it 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, 2002. 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 calendar year.

Based on the testwork performed, we determined that the budget document and appropriation bill reconciled to the original budget 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

calendar year. However, the overage was approved by the legislature in Senate Bill 3167. 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*.

DIVISION OF ACCOUNTS

Our objectives were to determine whether

- the controls for expenditures are in place and operating effectively;
- the expenditures are allocated in accordance with the cost allocation map, the cost allocation is reasonable, and costs are related to the division; and
- the amounts billed to other agencies for Accounts' services and equipment are based on the cost allocation map and did not exceed expenses.

We interviewed key personnel about controls and procedures used to allocate expenditures and observed the controls in operation. We tested a nonstatistical sample of expenditures to determine if they were allocated according to the allocation map, the cost allocation was reasonable, and the costs were related to the division. We tested a nonstatistical sample of STARS billings to verify that the correct amount was billed based on the cost allocation. In addition, we reviewed total revenues and expenditures for each cost center to determine if revenue exceeded expenses.

Based on testwork performed, we determined that controls over expenses were in place and operating effectively. Cost allocations were reasonable and allocated correctly, and the costs were related to the division of accounts. Revenues did not significantly exceed expenses, overcollections from the prior year were refunded, and appropriate amounts were billed.

CAPITAL PROJECTS AND REAL PROPERTY 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, construction, accumulation, and disposal 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 documented and approved and properly classified in the project accounting system and the State of Tennessee Accounting and Reporting System (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 and donations 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. Also, real property purchases were appraised, and disposals were supported. However, we determined that controls to ensure complete and accurate inventories of real property are maintained need improvement.

40. Control over the recording of land in the Land Inventory System needs improvement

Finding

Due to a lack of a review system, land maintained on the Land Inventory System (LIS) was not always properly valued, and the number of acres did not calculate correctly. The Division of Capital Projects and Real Property Management (CP/RPM) uses the LIS to maintain records of state-owned land for each site in the state's 95 counties. For each site, there are one or

more activity records that include the information regarding acquisition or disposal transactions of property and the associated value for each activity related to that site. These transactions are initiated by the agents and entered into the system by the administrative assistant without any supervisory review to ensure that the amount entered into the system is the correct amount based on the information in the paper file. The values for each activity in LIS are used to generate reports—such as the Land Value Report (LVR), the Land Inventory Report (LIR), and an Adjustments Report at the end of each fiscal year—which are used in determining the amount of land to be included in the financial statements. The audit revealed that the land values were not recorded at the proper amount on the LVR and certain disposal transactions were not valued correctly. Also, land transfers from one department to another within the state did not transfer at the correct amount, and there was not adequate documentation to support the value of land listed on the LVR. The numbers of acres for the land sites per the LIR are not accurate, and the numbers of acres for land activities do not match the number of acres on the deed. Furthermore, it was noted that adequate documentation was not maintained for access to LIS.

Three of 30 land acquisitions for the year (10%) were not valued at the proper amount on the LVR, resulting in an overstatement of \$3,919,965. One of the three errors involved incorrectly including the value of the buildings with the value of the land in the LVR. Land and building amounts should be shown separately on the state's financial statements. The value of the remaining two items were just determined incorrectly.

Six of 86 transactions involving a zero or nominal amount (7%) were not correctly valued on the LVR, resulting in an overstatement for those parcels of \$252,924. The six disposal transactions should have reduced the value of the land by larger amounts.

Four of 13 land transfers tested (31%) did not transfer correctly. Two land transfers did not transfer from one department to another at the same amount, resulting in an overstatement of \$58,107. The items were removed from one department at the original amount, but they were added to the other department at a different amount. The state as a whole was not disposing or acquiring any new parcels of land so the LVR should not indicate any changes in value for land transfers. The third erroneous land transfer was not removed at the same amount that was originally recorded in the system, resulting in an overstatement of \$269, and the documentation was not present to support the amount of the fourth transfer as discussed in the following paragraph.

Two of 86 land items examined (2%) did not have proper documentation to support the value on the LVR. According to the notes in LIS, 1.16 acres were disposed of and .19 acres were transferred out, both at \$23 per acre. Currently, the average costs/value per acre are \$322 for the 1.16 acres and \$40 for the .19 acres. There is no documentation to support that the average costs/value per acre at the time of the transactions were in fact \$23. When only a portion of land is disposed or transferred to another jurisdiction, as opposed to the entire site, the average cost or value is used to determine the amount to be removed from the LVR. The original cost or value for each site should be used, but since that is not always easily determined for portions of land, the best option is the average cost or value, which is constantly changing with the sizes and prices of the parcels associated with each site.

The correct value to remove from LVR could not be determined for 2 of 13 land transfers tested (15%) and one of the 6 items over \$5 million (17%) because the number of acres for each site is incorrect. The acres listed individually on the LIR for each activity for each site in all of the counties were added and subtracted by the auditor to calculate the total number of acres for the site. These calculations did not correspond to the total acres for the site on the LIR. If the LIR is not correctly calculating the number of acres, the average cost/value for each site in the LIS will not be accurate. If the average is incorrect, the total value of land could be affected.

For 3 of 42 land activities tested (7%), the number of acres in LIS was not the same number that was listed on the deed. In addition, a data extract was obtained directly from the LIS. This extract was used to recalculate the amount of acres that should have been reported on LIR for each site. However, for 4 of 42 sites (10%), the amount recalculated did not match the amount reported on the LIR. Three of the problems were created because several transaction codes were included in the LIR calculation that should have no effect on the number of acres. The cause for the other error is unknown. If the wrong number of acres is being used to calculate an average, this could also affect the average cost/value.

With regard to computer security for LIS, 9 of 11 users of LIS (82%) did not have adequate system request documentation, and all 11 (100%) lacked proper documentation of supervisor approval. A few years ago, CP/RPM began using the Computer System Action Sheet, an on-line form, to document requests and approvals for access. Employees who had been granted access prior to the use of those forms have no documentation regarding approved access. Also, since the form is on-line, the division head is to send an e-mail to F&A Security in place of his signature, but these e-mails are not filed with the form. Currently a complete list of LIS users is not easily determinable.

Recommendation

CP/RPM management should implement a review system to ensure the value entered into LIS equals the cost or the appraisal amount, changes to land are valued correctly, and the original cost or value of land transferred between departments does not change. CP/RPM should maintain documentation to support the amount removed from a site in LIS. The formula used in the system to calculate acres should be reviewed and revised to include only items that affect the LIR. Before the information is keyed into LIS, the land files should be monitored and reviewed. Once information is on LIS, system information should be compared to the source documents and files to ensure accuracy. CP/RPM should update the files for everyone with access to LIS to indicate proper request and approval, and new employees should have a properly completed file to document access request and approval. If approval is granted through e-mail, either the approval should be maintained within the system, where it is accessible, or the e-mail should be printed documenting the approval and maintained within the paper file. The LIS administrator should maintain a list of all users with access to LIS and what type of access they have.

Management's Comment

We concur with the finding and recommendation. Most of the errors uncovered in this audit are simply mistakes that should have been uncovered with an adequate review system. On September 27, 2002, Real Estate Management instituted a new policy and procedures for closing land transactions and posting data to the Land Inventory System (LIS). The procedures include two levels of review before the transaction file is closed and the data input is deemed accurate. These reviews will ensure that land values and acreages match legal documents pertaining to the transaction and that transfers of property between agencies reflect the original cost and value when that property was first acquired.

We are acutely aware that the current LIS is outmoded, subject to error, and needs to be replaced. The department's Information System Plan (ISP) includes a project for the system replacement. Significant work has been done on system needs analysis. The project will continue upon completion of higher priority projects.

The system does not allow for proper documentation of land values when transferring land between agencies if the parcel is only a portion of the site and the value is based on average cost and value. The system only retains the current average cost and value and those can vary greatly with the acquisition or disposal of several large or costly parcels. Our process for posting land transactions now includes getting a screen print of the site totals on the LIS site screen before the transaction is posted and placing that screen print in the paper file for documentation.

A more serious system error was uncovered in this audit that affects total acreage for each site and acreage totals in the Land Inventory Report (LIR). Site acreage totals should only reflect acreage added or subtracted to the site by fee acquisitions, fee disposals, or transfers of jurisdiction. It was determined that adjustments to activities other than these types of transactions also cause changes to acreage totals. This obviously was a design flaw by the developer, MSE Corporation, that was never exposed in the testing process. A help desk request (Incident #111236) has been initiated to determine a fix for this.

Access to the Land Inventory System application and data files was granted to most LIS users years ago before the new system for requesting and granting access was initiated. Apparently old records of access requests no longer exist. It simply never occurred to anyone that we should make new requests for users who already have access rights to system applications. New requests for all LIS users have been initiated and the LIS administrator will maintain a list of all users and what type of access they have been granted.

DEVELOPMENTAL CENTER OPERATIONS

The objectives of our procedures at Greene Valley, 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
- adequate controls were in place over any developmental center areas reviewed by internal audit.

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 the State of Tennessee Accounting and Reporting System (STARS), and handled in accordance with state purchasing rules and regulations. We tested a nonstatistical sample of cash receipts to determine if the amount was deposited properly and recorded correctly. Furthermore, we reviewed internal audit reports related to the developmental centers.

Testwork revealed that internal control over trust funds and resident payroll was adequate. However, problems were noted by internal audit concerning contents of personnel files and improper contracting of employees. Also, internal controls over inventories, expenditures, and cash receipts need improvement. In addition, controls over equipment were weak; thus, equipment was recorded inaccurately.

41. Personnel files of the West Tennessee Regional Office were incomplete

Finding

As noted in the Office of Health Services Division of Audit and Investigations report dated June 18, 2002, a review of West Tennessee Regional Office personnel files revealed that current and complete personnel files were not maintained. The personnel files for the office are kept at the Arlington Developmental Center. Personnel files did not have current applications for the position held or proof of education documented. Personal references, prior job references, or background checks were not documented. Current job plans and evaluations were not found. In addition, IRS I-9 forms, internet agreement forms, drug-free workplace statements, and verification of professional licenses were not on file.

The Audit and Investigations Division of the Office of Health Services randomly selected 25 employees' personnel files for review to ensure that the proper records were being maintained. Of the 25 employees' personnel files selected, the Audit and Investigations Division found that three files did not contain a current state application. Seven employees' prior jobs were not documented. Five employees' personnel files did not have personal references documented in their personnel files. Background checks for 14 employees were not documented. Three files did not contain a copy of the high school diploma, college degree, or college transcript documenting that the employees were qualified for the positions held. Also, we found that 25 files did not contain a current job plan. Twenty files did not contain annual performance evaluations. Twenty personnel files did not contain the interim evaluations. Four did not contain an IRS I-9 form. Seven files did not contain a drug-free workplace statement. Six employees' personnel files did not contain a signed internet agreement form.

The State of Tennessee Department of Personnel requires the personnel division of all facilities to have a current application for position held, copies of proof of education, a current job plan, a current annual evaluation, and interim evaluations. These items are required to ensure that an employee is qualified for the position and is capable of performing the duties the position requires.

The State of Tennessee Department of Personnel requires an internet agreement to be on file for every employee who has access to the internet. In order to ensure that employees know the rules and regulations concerning what is acceptable, employees are required to sign a statement stating they fully understand the internet usage policy of the State of Tennessee.

The Department of Personnel requires a drug-free workplace agreement to be on file for every employee. A signed statement from employees is required to ensure that they understand the drug-free workplace policy of the State of Tennessee.

The State of Tennessee Department of Mental Health and Developmental Disabilities requires prior job references to be checked, personal references to be checked, and background checks of all personnel whose positions would include direct contact with or direct responsibility for any persons with mental illness or developmental disabilities, regardless of whether they are an employee or volunteer. The Department of Mental Health and Developmental Disabilities is required to perform these procedures to ensure the safety of the consumer.

The Immigration Reform and Control Act of 1986 requires the completion of the I-9 form. In order to verify the identity and the eligibility of an employee to work in the United States, an I-9 form must be completed and on file. This is a federal requirement for employment in the United States.

Recommendation

WTRO management and the fiscal director of Arlington Developmental Center should ensure that personnel staff adheres to the written guidelines established by the Department of

Personnel and the Department of Mental Health and Developmental Disabilities in maintaining employees' personnel files and all required documentation.

Management's Comment

We concur in part. All files should contain each of the items listed in the report except for documents required for the Job Performance Planning and Evaluation System. The documents required for support of the Job Performance Planning and Evaluation System, job plans and interim reviews should not be in the Personnel file, only the final evaluation form.

The Personnel Office serving the West Tennessee Regional Office will assure that all state employees have applications related to their current classifications; upon employment and subsequent promotions, a completed State of Tennessee application will be submitted and maintained in the personnel record at ADC. The Personnel Office will assure that previous employment reference letters are sent and that I-9 documentation is complete.

All managers are currently working to ensure the performance evaluation system is being properly used. This includes job plans, interim evaluations, and final performance evaluations. The Regional Director's office is now tracking due dates via spreadsheet and working with managers to ensure timely evaluations are completed and submitted through proper channels.

Drug-free workplace forms will be circulated to all employees (checklist will be used) for completion to ensure that records are complete. WTRO Training staff will ensure that all new employees complete this form upon their orientation to their new job. Copies will be maintained in the personnel file and at WTRO.

Internet Agreement forms will also be circulated to all employees for updating and completion to ensure all files are accurate and up-to-date. WTRO Training staff will ensure that all new employees complete this form upon their orientation to their new job. These forms will be maintained in the personnel file and at WTRO.

A spreadsheet has been created to track license expiration dates of all active professionals employed by WTRO. Copies of all required licenses are now on file and a copy will also be shared with the ADC Personnel office.

42. West Tennessee Regional Office has established improper employer-employee relationships

Finding

As noted in the Office of Health Services Audit and Investigations report dated June 18, 2002, a review of personnel files found that the West Tennessee Regional Office (WTRO) has established improper employer-employee relationships. The WTRO directs and supports the

Arlington Developmental Center and also has regional monitoring, training, abuse investigation, and intake coordination duties for home- and community-based services in west Tennessee. WTRO management has entered into contracts with agencies to provide individuals that are directly supervised by state employees. At the time of the audit, WTRO had 33 contract personnel working in state positions. Two of the 33 contract positions at WTRO are considered supervisory positions. A contract employee who is contracted through an agency as an Occupational Therapist holds the Deputy Regional Director position. Also, the Physical and Nutritional Management Coordinator is a contracted employee in a supervisory position. The practice of allowing employees of non-state entities to report directly to department officials/employees in carrying out what can be construed as state programs raises serious policy and legal issues.

The Department of Finance and Administration's policy "Personal Service, Professional Service and Consultation Service Contracts" states that contracts which create employer-employee relationships between the department and these employees are prohibited. The employer-employee relationship can be determined by but is not limited to the following factors: state employees and contracted employees being used interchangeably to perform the same function; contract employees performing day-to-day tasks and not specific projects; contracted employees using state equipment, space, and supplies; and state employees providing supervision for the contracted employees.

Recommendation

The Chief Administrative Officer of the Division of Mental Retardation should establish policies for the regional offices to follow to avoid establishing employer-employee relationships with individuals who are, in effect, performing state services. These individuals should be placed on the state payroll system through the proper hiring procedures established by the Department of Finance and Administration.

Management's Comment

We concur in part: We recognize that the situation of contracting for staff and having contract staff as supervisors is not optimal. However, with the requirements placed upon this region by the Federal Courts we have not been able to create and fill the number and types of positions required for compliance. Fines for non-compliance have been levied on the State in the past at \$1,000.00 per day.

The specialty staff requirement in the remedial court order deals with not only numbers of staff, but qualifications. For example, we must have Speech Pathologists that have specialty training in swallowing and serve as swallowing therapists; Physicians, Nurses, Behavioral Analysts and Therapists such as PT and OT, with specific training and experience working with the MR or DD population, etc. DOP qualification requirements do not address these additional

qualifications for this specialty population. There is not an established position series for Behavioral Analysts.

A few years ago a proposal was made to create the numbers and types of positions required and that proposal was rejected by F & A because it was too costly and would have to be done statewide, not just for this region.

Requests for Proposals (RFP) for each of these contracted services are in Nashville awaiting approval.

Auditor's Comment

Chapter 0620-3-3-.07(12) of the *Rules of the Department of Finance and Administration* requires that "State employees shall be hired through the merit system of the Department of Personnel." Section 8-30-201 (a), *Tennessee Code Annotated*, establishes "a system of personnel administration based on merit principles and scientific methods. That system shall govern the appointment, promotion, transfer, layoff, removal and discipline of employees, and other incidents of state employment." Section 8-30-201 (b), *Tennessee Code Annotated*, gives the Department of Personnel the responsibility of administering and improving this system. By entering into these contracts, the department in effect circumvented the state's employment process for obtaining staff.

43. Recordkeeping for equipment at the developmental centers is inadequate

Finding

As noted in the prior audit, Greene Valley Developmental Center (GVDC) in Greenville did not maintain accurate property records. The current audit revealed that Arlington Developmental Center (ADC) did not record the locations of equipment correctly. Also, Clover Bottom Developmental Center (CBDC) has not established internal control over the removal of equipment from property records. In addition, as a result of the lack of control over equipment at GVDC and ADC, an excessive amount of property was reported as lost, stolen, or destroyed during the audit period.

In response to the prior audit finding, management concurred and stated that a new property officer had been hired at GVDC to replace the property officer that had been on extended sick leave. They also stated that they were in the process of taking a complete inventory of the facility to ensure the proper transition to the new property officer. Although the inventory was not completed until June, these corrective action steps were taken. However, many problems were still noted in the current audit.

Internal control at each facility was reviewed. Equipment was verified by selecting 25 items each from GVDC, ADC, and CBDC from an equipment listing on the Property of the State of Tennessee (POST) system. The results of our examination were

GVDC

- Five of 25 property items selected (20%) from the POST property listing could not be located. The cost of the missing equipment was \$33,119.12.
- Two of 25 property items selected (8%) had incorrect serial numbers in POST.
- Seven of 10 property items listed as not found in the prior audit (70%) still could not be located or were not reported in POST as lost, stolen, or destroyed.

ADC

- Three of 25 property items selected (12%) had incorrect location codes in POST.

CBDC

- The removal of equipment from the property records is approved by the property officer and is not subjected to an independent review, such as from the superintendent.

An equipment inventory reconciliation received from the Tennessee Department of Mental Health and Developmental Disabilities shows an excessive amount of property lost, stolen, or destroyed.

- GVDC reported a book value of \$10,717.32 in lost, stolen, or destroyed items. The original cost of the items was \$108,560.62. Four of the five equipment items that could not be located were not included on this list.
- ADC reported a book value of \$66,237.98 in lost, stolen, or destroyed items. The original cost of the items was \$191,469.75.

If management does not maintain an accurate, up-to-date equipment inventory system that holds individuals accountable for state property, that property may be misused or misappropriated. This could result in jobs not being performed because of the lack of needed equipment or an increase in costs to the state to replace lost or stolen equipment.

Recommendation

The fiscal directors at GVDC and ADC should ensure that records are updated as necessary for loss, recordkeeping errors, and location changes. They should also increase the individual accountability for equipment. The fiscal director at CBDC should establish controls over the removal of equipment from the property records, including a formal approval process.

Management's Comment

Arlington Response: We concur: A complete inventory of all property items has been conducted and updated in the POST data base in April and May of 2002. Property officer will update the system as moves occur.

Clover Bottom Response: We concur. Clover Bottom Developmental Center's process for removing property from inventory has been modified to require the review and Chief Officer's signature before removal transactions are entered into P.O.S.T.

Greene Valley Response: We concur. GVDC's Property Officer reported as lost or stolen items that had not been found as of the required closeout date for the inventory. At that time we were unaware of the extent to which discrepancies were inaccurate and the extent to which that was impeding our search for missing items. We have since found a number of items that we are asking to have reinstated on POST. We have also noted that a part of the problem with locating the items was a result of not having a description that properly identified the items. This resulted from descriptions not properly transferring from the old ACAMI System to POST and all corrections not having been made at that time.

Items are not moved by the GVDC Property Office without the proper facility forms being completed by the area requesting the move except in the case of emergency (broken or damaged equipment that poses an immediate safety risk). Descriptions of the items are in the process of being updated to the extent possible on POST where errors were detected during the inventory. Cost center managers are being given quarterly listings of property assigned to them to account for.

Problems with GVDC property records began when errors were never corrected when the transition was made from the property records being maintained on the TMHDD ACAMI System to the State's POST system. Exceptions that were requested and approved for the ACAMI System, such as using a single room number in each unit that did not exist to denote items which are mobile and must be moved from room to room hourly in the unit to care for the individuals we serve, were not requested and approved on POST. Over a period of time since then, for reasons noted in the previous audit, the records of the property at GVDC have not been properly updated with items moved, items lost or stolen, or items destroyed, in part due to our failure to prepare the necessary paperwork, but in part due to the fact that transactions initiated and processed by GVDC were not updated on the POST system. This also may have represented a failure on our part to follow through to be sure the transactions had been received by General Services and processed. It should be noted that items of equipment which were recently written off were not misappropriated but rather were disposed of properly, but without transactions being properly recorded, for reasons stated above, in the POST system.

A review of the list of items written off clearly shows that many of the items were obsolete and would have been well beyond any reasonable, useful life expectancy and obviously would have been discarded or otherwise disposed of or are items such as handicapped accessible

tubs, large lifts, etc., which are somewhat stationary in nature and would not have disappeared but may have been cannibalized or altered in such a way that the identity of the item may have been compromised and now cannot be reconstructed.

As recommended, we will ensure that GVDC property records on POST will be updated as necessary to accurately reflect the status of GVDC's property inventory. Individual cost center managers are being given higher standards for accountability for property under their control. We will also be continuing our efforts to locate property which had to be shown as missing at the point in time for inventory close-out and these items will be reinstated as they are located.

44. Controls over drug and supplies inventories at the developmental centers need improvement

Finding

The audit revealed that controls over inventories at Clover Bottom Developmental Center (CBDC), Arlington Developmental Center (ADC), and Greene Valley Developmental Center (GVDC) need improvement. Inventory records at CBDC are not accurate, and the pharmacists share the same password. At ADC, there is improper safeguarding of the inventory. At GVDC, inventory records are not accurate.

CBDC, ADC, and GVDC have various inventories, including drugs, dietary products, medical supplies, and maintenance supplies. The developmental centers maintain perpetual inventory systems and make physical counts of inventory at the end of each fiscal year. Our review of the controls over inventory revealed several internal control weaknesses.

CBDC

- Eighteen of 50 items physically counted by the auditor (36%) did not agree with the inventory records. The misstatement of inventory related to these sample errors was \$1,159.64 in inventory missing and \$719.14 in inventory that was not included in the perpetual records.
- Three pharmacists use the same log-in information and password to access the inventory system. Therefore, accountability for entries to the perpetual system is lost.

GVDC

- Eight of 50 inventory items physically counted by the auditor (16%) did not agree with the inventory records. The misstatement of inventory related to these sample errors was \$139.63 in inventory missing and \$170.67 in inventory that was not included in the perpetual records.

ADC

- Eleven of 23 employees have a key to the building where the inventory is stored. Out of the 11 with keys, 7 have the code to disarm the alarm system. Also, one former employee still has the alarm code.

It is not known what caused the discrepancies between the perpetual records and the physical counts. The discrepancies could have been caused by any or all of the following:

- inaccurate physical counts at year-end,
- issuing inventory without recording the transaction in the system,
- not recording the receipt of inventory into the system,
- not updating the system for returned inventory, or
- theft.

If inventory is not accounted for properly, it becomes increasingly difficult for the developmental centers to know if inventory is being misappropriated. The lack of controls over inventory access and over accounting for inventory makes items more susceptible to theft without detection from management. Also, if the computer system does not have individual passwords, accountability would not be established even if inappropriate transactions were detected.

Recommendation

The fiscal director should ensure that year-end inventory counts are correct and that spot checks are done periodically throughout the year to ensure that the perpetual system is accurate. When inventory is received, it should be immediately entered into the system. Inventory should only be issued through a properly prepared requisition and entered into the system upon issuance. Also, all inventory returned to stock should be updated in the inventory records. Separate passwords should be established for each pharmacist, and access to the inventory storage should be minimized. As employees with access to the alarm code terminate their employment with ADC, a new code should be established.

Management's Comment

Arlington Response: We concur. The Procurement/Warehouse area is protected by restricted key access and an alarm that sounds in PBX. Since the audit, the number of keys has been reduced to 5 and the alarm access code has been changed.

Clover Bottom Response: We concur. Even with the immense number of drugs purchased, maintained and dispensed at Clover Bottom Developmental Center, inventory discrepancies are

virtually insignificant. For the pharmacy supply inventory conducted June 2002, the variance percentage was 0.04%. It is believed that the discrepancies are as likely to be inventory miscounts as maintenance controls deficiencies or dispensing errors.

The pharmacy inventory system has been modified to provide that each pharmacist and pharmacy technician must use a unique log-in and password to access the inventory system.

Greene Valley Response: We concur in part. In addition to the causes for discrepancies noted in the finding, additional possible contributing factors to inventory variances are pills or tablets being destroyed during shipping or while being transferred from bulk containers into unit dose packaging. This occurs when the packaging machine crushes the tablets or pills and the crushed units are not issued and sometimes not detected.

GVDC does spot checks on inventory periodically throughout the year on a random basis. During the annual inventory, we go back to recount items when the variance on the count warrants. We also have some Fiscal Services individuals check counts on the inventory both before and after the counts are done to confirm that counts are correct.

We review the dollar amount of the variance and look at the variance amount as percentages of total dollars issued and total inventory value to determine that the variance is less than what reasonably should be expected from a materiality standpoint. GVDC will continue to do periodic spot checks and to insure that all issues to and receipts from inventory are accurately recorded in order to safeguard State of Tennessee assets.

45. Developmental center disbursements were not handled appropriately

Finding

As in the prior audit, a review of controls and procedures related to disbursements at the Clover Bottom Developmental Center (CBDC) and the Greene Valley Developmental Center (GVDC) revealed weaknesses in internal control and noncompliance with policies and procedures. Bids were not obtained when necessary, conflict of interest statements were not prepared, and disbursements were not coded to the appropriate object codes.

In the prior audit, management partially concurred with the recommendations related to obtaining bids and stated that the CBDC split invoices were not intentionally split and that GVDC would “initiate a system that will review vouchers for characteristics of split invoices and follow up on any transactions that are suspicious.” This system was implemented and appears to be functioning at GVDC, but invoice splitting still occurred at CBDC. According to the *Department of General Services Purchasing Procedures Manual*, purchases over \$400 require three phone bids. At CBDC, we obtained a list of invoices that, based on dates and vendors, had characteristics of split invoices. A split invoice occurs when an employee avoids bid requirements on higher dollar items by splitting the invoice up into several smaller invoices. The

employee is then able to make a purchase without obtaining three phone bids. Splitting invoices is a method used to circumvent controls and can lead to irresponsible spending.

From the listing obtained, we examined a sample of 28 sets of the questionable invoices. At CBDC, 2 of the 28 questionable sets (7%) appeared to be split invoices. The sets involved invoices for the same day and the same vendor, and accumulated in amounts over \$400.

Also, CBDC and GVDC do not require potential conflicts of interest to be documented by employees for whom conflicts of interest could influence or give the appearance of influencing their decisions. Without such a requirement, purchases to a vendor for which a conflict of interest exists could go unnoticed.

In addition, CBDC did not use appropriate object codes. Management partially concurred in relation to this issue in the prior audit and stated that when incorrect codes are used, they are typically corrected later in the disbursement process and that “in the future, when an error is corrected, the invoice or other original document will have any corrections recorded on it.” However, 4 of 25 invoices tested (16%) were not coded correctly, and evidence of correction was not present on the invoices. This is considered noncompliance with the procedures for recording expenditures and could result in a misclassification of expenditures in internal financial reports.

Recommendation

The fiscal director of CBDC should review vouchers for characteristics of split invoices and follow up on suspicious transactions. The director of each center should adopt a conflict of interest policy and require disclosure of potential conflicts of interest. In addition, employees should be trained to assign appropriate object codes. The performance of the employees who are responsible for purchasing and the employees who are responsible for recording transactions should be monitored and, when necessary, disciplinary action should be taken.

Management’s Comment

Clover Bottom Response: We do not concur.

➤ Split invoices

Clover Bottom Developmental Center has not been supplied information as to which particular transactions appear to auditors to have “had characteristics of split invoices” based on dates and vendors. We will emphatically respond that we do not split invoices to avoid bid requirements. Because Clover Bottom Developmental Center makes many discrete purchase transactions of a similar nature, many on the same day from the same vendor, it is not surprising that these attract attention at first glance. For example, clothing clerks, or others, may purchase separate clothing items for different people (residents of CBDC) on the same day from the same retail establishment. Despite the appearance of splitting one large bulk purchase, the transactions

are, in fact, separate and distinct, individual purchases made in accordance with state purchasing rules and policies.

➤ Object Code Errors

Occasional object code errors are made, due in part to the vast variety of purchases and the volume of transactions. These initial errors are corrected by our cost accountant and annotated on the invoice or other original document.

➤ Conflict of interest

Clover Bottom will adopt a conflict of interest policy and will require disclosure of potential conflicts of interests.

Greene Valley Response:

➤ Conflict of interest

We concur. The DMHDD did not have a departmental conflict of interest policy when the Division of Mental Retardation Services was included in that Department. The Division of Mental Retardation Services has also not issued a policy since it was moved to the Department of Finance and Administration. GVDC has obtained copies of the documents used by the Department of General Services to comply with the State of Tennessee conflict of interest executive order and will follow their policy with all individuals who are involved in the purchasing process until a Divisional policy is issued.

Auditor's Rebuttal

Clover Bottom split invoices:

Management was supplied information regarding this issue, along with a draft copy of the finding, three months prior to the end of fieldwork. The first transaction questioned included three vinyl glider rockers for \$345 each, same commodity code, same day, separate purchase orders. The second transaction questioned included three battery maxilifts for \$237 each, same commodity code, same day, separate purchase orders. The center has again been supplied with this information after transmittal of the management response.

46. Internal control over cash receipts at the Clover Bottom Developmental Center needs improvement

Finding

As noted in the prior audit, Clover Bottom Developmental Center (CBDC) does not have control over cash receipts. Receipting duties are not adequately segregated, and comparisons are not made between the mail log, cash receipt book, and deposits.

The reimbursement officer opens the mail, prepares a mail log, restrictively endorses the checks for deposit only, and passes the cash or check received to the accountant to write the cash receipt. However, no comparison is made between the mail log, cash receipt book, and/or deposit by someone independent of those functions. In addition, the accountant that prepares the cash receipt also performs the bank reconciliation. As such, the accountant has access to the cash, has the ability to write receipts from which posting will occur, and could cover up any discrepancies through the bank reconciliation. This situation is an invitation for fraud involving large sums of money that could occur and go undetected for a long period of time.

In response to the prior audit finding, management concurred and stated that the payroll clerk would take over the writing of cash receipts. However, the accountant continues to perform this function. An adequate segregation of duties is a primary component of internal control. Segregation of duties is essential to fraud detection and aids in prevention of possible errors and misappropriation of funds.

Recommendation

The fiscal director of CBDC should immediately designate an employee without receipting or depositing duties to compare the mail log, cash receipt book, and deposits.

Management's Comment

Clover Bottom Developmental Center concurs. Changes have been made to segregate duties and provide for comparisons between the mail log, cash receipt books, and deposits.

Checks received will be restrictively endorsed by the Reimbursement Officer, then forwarded to the Accounting Office for the Payroll Clerk to write receipts and prepare bank deposits. Someone other than the Payroll Clerk or Reimbursement Officer will deliver the deposit to the bank. After the deposit, the Cost Accountant will enter the transaction into STARS. An Accountant will prepare the bank reconciliation in the Accounting Office.

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, 2002, responsibility letter was filed in compliance with Section 9-18-104, *Tennessee Code Annotated*, and to follow

up on a prior-year audit finding concerning financial integrity act reports that were due on December 31, 1999, not including the Bureau of TennCare.

We reviewed the June 30, 2002, responsibility letter submitted to the Comptroller of the Treasury and to the Department of Finance and Administration to determine adherence to the submission deadline, and we determined that the Financial Integrity Act responsibility letter was submitted on time.

We determined that the Bureau of TennCare did not submit the Financial Integrity Act internal accounting and administrative control report that was due on December 31, 1999, until August 13, 2002 (see finding 47).

47. The Department of Finance and Administration did not evaluate and report on the internal control of the Bureau of TennCare in accordance with the Financial Integrity Act

Finding

As noted in the two prior audits, the Department of Finance and Administration did not include the Bureau of TennCare in the required Financial Integrity Act internal control evaluation report that was due December 31, 1999. Management concurred with the prior audit finding and stated,

While the evaluation has been performed, the final report is still in progress. The required report will be submitted to the Commissioner and Comptroller by February 28, 2002.

However, management did not submit the required report until August 13, 2002.

Section 9-18-102, *Tennessee Code Annotated*, 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, Section 9-18-104, *Tennessee Code Annotated*, states,

(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 Section 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, the Commissioner of Finance and Administration has not publicly acknowledged his responsibility for internal control over the program, nor has he reported a plan and schedule for correcting weaknesses as required by law.

Recommendation

The Commissioner of Finance and Administration should ensure that the internal control evaluation reports are submitted by the required deadlines. The commissioner should also ensure that all material weaknesses are identified and corrective action is taken regarding those weaknesses.

Management's Comment

We concur. The Bureau of TennCare performed an evaluation of internal controls and submitted its Financial Integrity Act report in August 2002. The report identified all significant weaknesses and the corrective actions being taken to correct the weaknesses. Every effort will be made to meet the deadlines for future reports.

TITLE IX OF THE EDUCATION AMENDMENTS OF 1972 AND TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

Section 4-4-123, *Tennessee Code Annotated*, 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.

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.

Section 4-21-901, *Tennessee Code Annotated*, 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 each June 30.

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. 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.

Our objectives were to determine whether the department submitted the annual Title IX compliance report and implementation plan and the annual Title VI compliance report and implementation plan by the deadlines and to determine whether the Title IX plan included TennCare.

We reviewed the submission dates of the Title VI and Title IX compliance reports and implementation plans to determine adherence to the submission deadline. In addition, we interviewed key personnel to determine if the scope of the Title IX report included TennCare.

The Department of Finance and Administration did not include TennCare in the Title IX implementation plan, and neither the Title IX nor the Title VI implementation were submitted by June 30 as noted in finding 48.

48. The Department of Finance and Administration's Title IX implementation plan did not include TennCare, and Title IX and Title VI plans were not submitted in a timely manner

Finding

Section 4-4-123, *Tennessee Code Annotated* (TCA), requires each entity of state government subject to Title IX of the federal Education Amendments Act of 1972 to develop an annual Title IX compliance report and implementation plan. As noted in the prior-year audit, the Department of Finance and Administration's Title IX compliance report and implementation plan did not include the Bureau of TennCare. In addition, the Department of Finance and Administration did not submit the Title IX and the Title VI implementation plans in a timely manner.

Management concurred with the prior audit finding and stated:

. . . To ensure compliance with Title IX and TCA, the Bureau of TennCare will coordinate activities with Finance and Administration. An implementation plan and subsequent plan updates will be prepared and submitted and annual compliance reviews will be performed and submitted.

However, as of October 23, 2002, management of the Bureau of TennCare has not submitted the required compliance report and implementation plan. During fieldwork, management indicated that TennCare planned to submit its own Title IX compliance report and implementation plan for this year, but it had not been completed.

Section 4-4-123, *Tennessee Code Annotated*, states:

Each entity of state government that is subject to the amendments of Title IX of the Education Amendments act of 1972, (20 USC 1681 et seq.), and regulations promulgated pursuant thereto, shall develop a Title IX implementation plan with participation by protected beneficiaries as may be required by such law or regulations. To the extent applicable, such plan shall include Title IX implementation plans of any subrecipients of federal funds through the state entity. Each such entity of state government shall submit annual Title IX compliance reports and implementation plan updates to the Department of Audit by June 30, 1999, and each June 30 thereafter.

Title IX, 20 USC 1681, states:

(a) No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance, . . .

The Department's plan states that Title IX is "applicable to all of the programs, activities, and operations of the department and the Subrecipient entities with which the department contracts for education activities utilizing federal funds." However, the plan did not include the activities of the Graduate Medical Education program administered by TennCare, and TennCare has not separately submitted a plan. The Graduate Medical Education program helps to provide training for residents who agree to serve TennCare enrollees in a "Health Resource Shortage Area" of Tennessee.

In addition, the Department of Finance and Administration's Title IX plan that was submitted was not received until August 21, 2002, despite the June 30 deadlines.

Testwork also revealed that the Bureau of TennCare and the Department of Finance and Administration did not submit the Title VI compliance report timely.

Section 4-4-123, *Tennessee Code Annotated*, states:

Each state governmental entity subject to the requirements of Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d et seq., and regulations promulgated pursuant thereto, shall develop a Title VI implementation plan with participation by protected beneficiaries as may be required by such law or regulations. To the extent applicable, such plan shall include Title VI implementation plans of any subrecipients of federal funds through the state entity. Each such state governmental entity shall submit annual Title VI compliance reports and implementation plan updates to the department of audit by June 30, 1994, and each June 30 thereafter.

However, TennCare did not submit its report until August 22, 2002, and the Department of Finance and Administration did not submit its report until August 21, 2002.

The late filing or absence of Title IX and Title VI compliance reports and implementation plans, annual compliance reviews, and plan updates could indicate inadequate attention is given to preventing discrimination on the basis of race, color, origin, or gender.

Recommendation

The Director of TennCare should ensure that a Title IX implementation plan is submitted which includes all areas of TennCare receiving federal funds for education programs and activities. The plan should include the activities of the Graduate Medical Education program administered by the Bureau of TennCare. In addition, the Commissioner of the Department of Finance and Administration and the Director of TennCare should ensure that the Title VI and Title IX compliance reports and implementation plans are submitted timely.

Management's Comment

Finance and Administration Title VI and IX

We concur. The Department of Finance and Administration's 2002 Title VI and Title IX implementation plans were submitted after June 30, 2002, in order to include in the report pertinent data relative to grant subrecipients for the fiscal year ending June 30, 2002, that was not available until late July and early August. The Department will not include this complete information in next year's report, thereby allowing it to be submitted before June 30, 2003.

TennCare Title IX

We concur. The TennCare Bureau is committed to compliance with Section 4-4-123, *Tennessee Code Annotated* (TCA). The report for June 30, 2002, was submitted to State Audit on November 26, 2002. In order to ensure the timely submission of the TennCare Title IX Plan, as required by state law, the Bureau's Non-Discrimination Compliance Coordinator has worked proactively with the Bureau's Graduate Medical Education (GME) staff in order to make

revisions in the GME contract incorporating the following requirements:

- Name and sex of residents/students receiving GME funding for Title IX purposes by medical program;
- Overview of the GME program and any revisions in program activities;
- Each medical school's/higher education institution's Title IX notification procedures for house residents and staff;
- Notification of the filing of complaint procedures and documentation under Title IX and staff contact information, including House Resident Handbook;
- Quarterly reporting of any Title IX complaints, actions taken to resolve Title IX complaints, and pending complaints by each institution receiving GME funding to the TennCare Bureau's Non-Discrimination Coordinator;
- Provision of technical assistance by the TennCare Bureau GME staff in conjunction with the Bureau's Non-Discrimination Compliance Coordinator to institutions receiving any funding subject to Title IX in order to keep them abreast of federal and state law requirements;
- Required notification to the TennCare GME staff and to the Bureau's Non-Discrimination Compliance Coordinator within 15 business days of any changes in the administration and/or staffing of the GME Program in terms of Title IX Compliance and/or responsibilities.

TennCare Title VI

We concur. In order to ensure that the Bureau's Title VI Plan will be submitted in a timely fashion, the following corrective measures have been and are being taken:

- Streamlining the responsibility for drafting and coordinating the submission of the TennCare Bureau's Title VI Updated Implementation Plan by June 30th of each year as the primary responsibility of the Non-Discrimination Compliance Coordinator.
- Reorganization of the functional reporting requirements of the Non-Discrimination Compliance Coordinator directly to the Deputy Commissioner of TennCare, in order to provide the coordinator a straight-line of communication in implementing and recommending proactive and efficient actions necessary to correct and avoid any problems in reporting and gathering data for the Title VI Plan in a timely manner.
- Recommendations provided to the Bureau's Management Information System staff during the RFP process in order to ensure that needed parity data regarding race/ethnicity, encounter data, and covered services for enrollees can be provided more efficiently and in a timely manner for analysis and inclusion in the Bureau's Title VI Plan and for other necessary EEOC documentation purposes.
- Provision of the budgetary information required, as presented in Tables B and C of the Bureau's Title VI Implementation Plan, within the appropriate timeframe by the Fiscal Budget unit of TennCare.

OBSERVATIONS AND COMMENTS

REVIEW OF NURSING HOME TAXES

As noted in the *Tennessee Comprehensive Annual Financial Report* for the year ended June 30, 2002, the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA) performed a review of the provider taxes collected for the period beginning fiscal year 1992 through September 2000. The purpose of the review was to determine whether there was a positive correlation between the nursing home provider taxes and a state grant program for private pay patients of nursing homes (Grant Assistance Program). Because CMS believes there is a positive correlation between the nursing home provider taxes and the nursing home grant assistance program, it concluded that the provider taxes are impermissible resulting in a reduction in federal financial participation. On January 19, 2001, the State received a notice of disallowance for this tax for the period October 1, 1992 through September 30, 2000. On February 16, 2001, the State appealed the disallowance. On June 11, 2001, the State received a second notice of disallowance for the period October 1, 2000 through March 31, 2001. On July 6, 2001, the State appealed the second disallowance and the two disallowances have been consolidated for appeal. If the disallowances were ultimately upheld, then CMS would offset the disallowed amounts against future federal participation in TennCare. The State eliminated the Grant Assistance Program effective August 1, 2001, and does not believe that the collection of provider taxes after that date will be challenged by CMS. The State has reserved \$50 million in the General Fund toward any potential settlement or return of the disallowance amounts.

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 U.S. Department of Health and Human Services 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. The U.S. Department of Health and Human Services then approved a waiver extension for three years beginning January 1, 1999, through December 31, 2001. There have been two extensions of the waiver. The first extension was for the month of January 2002. The second extension was originally approved effective from February 1, 2002, to January 31, 2003. Before the expiration of the second extension, the U.S. Department of Health and Human Services approved a new TennCare demonstration project for five years, effective July 1, 2002, through June 30, 2007. Under the new waiver, the Department

of Human Services enrolls and re-verifies the eligibility of TennCare enrollees, which are now referred to as TennCare Medicaid and TennCare Standard enrollees. The TennCare Medicaid category includes the Medicaid population, and the TennCare Standard category includes the uninsured and uninsurable population.

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 \$6.2 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. 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.

A recent ruling by a federal court determined that TennCare did not comply with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements. This ruling was based upon the court's finding that TennCare violated an agreement from 1998 to provide periodic health screenings to children. This ruling could result in significant changes to the program. See the observation and comment on page 178 for further details regarding this matter.

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 control 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 cannot be directed by the TennCare program without the clear support of the office of the Governor.

EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) REQUIREMENTS

As the result of and in accordance with the John B. Consent Decree, TennCare is required to provide health-screening services for 80% of TennCare enrollees under the age of 21. However, during the audit period, TennCare was not able to comply with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements.

In an effort to comply with the EPSDT requirements, TennCare follows a periodicity schedule which prescribes when children should receive screenings.

Testwork was performed to determine whether individuals under the age of 21 received EPSDT services in accordance with the periodicity schedule. It was determined that 28 of 60 individuals (47%) who should have received at least one EPSDT screening during the audit period did not receive at least one screening.

Although TennCare has adequate procedures in place to inform enrollees of the availability of EPSDT services, it has little control over whether the children and/or their parents or guardians ensure that the child goes to all their screenings. On this basis, this screening requirement does not appear to be an attainable goal for the Bureau of TennCare. Management does appear to have control over children who are in the state's custody and according to management, approximately 94% of children in state custody have had their yearly screening.

APPENDIX

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 – Internal Service Fund
- 317.06 Criminal Justice Programs
- 317.07 Resource Development and Support

- 317.10 Real Property Management
- 317.11 Commission on National and Community Services
- 317.30 Management Information Systems
- 317.86 Tennessee Insurance System
- 317.99 Division of Accounts - Other
- 318.01 Office of Health Services
- 318.65 TennCare Administration
- 318.66 TennCare Services
- 318.67 Waivers and Crossover Services
- 318.68 Long-Term Care Services
- 339.01 Mental Retardation-Administration
- 339.21 Developmental Disabilities Services
- 339.22 Community Mental Retardation Services
- 339.25 West Tennessee Region (Arlington)
- 339.26 Middle Tennessee Region (Clover Bottom)
- 339.27 Greene Valley Developmental Center
- 355.02 State Building Commission
- 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, 2002.

Finding Title / Page No.	Single Audit Finding Number	Finding Type	Federal Known Questioned Costs
Top management still has failed to address the TennCare program’s numerous and serious administrative and programmatic deficiencies / 25	02-DFA-03	Material Weakness	

TennCare did not require the Department of Human Services to maintain adequate documentation of the information used to determine Medicaid eligibility / 40	02-DFA-08	Material Weakness	
TennCare does not have a court-approved plan to redetermine or terminate the TennCare eligibility of SSI enrollees that become ineligible for SSI / 44	02-DFA-09	Material Weakness	
Internal control over TennCare eligibility is still not adequate / 46	02-DFA-10	Material Weakness	\$370,044
TennCare should improve internal control over the eligibility of state-only enrollees and should ensure that no federal dollars are used for state-only enrollees / 56	02-DFA-11	Reportable Condition	\$140,204
For the third consecutive year, TennCare made payments on behalf of full-time state employees, resulting in new federal questioned costs of \$54,106 and an additional cost to the state of \$31,019 / 58	02-DFA-12	Reportable Condition	\$54,106
TennCare incorrectly reimbursed Managed Care Organizations, Consultec, Volunteer State Health Plan, and the Department of Children's Services for services that were unallowable or not performed, resulting in federal questioned costs totaling \$241,287; TennCare also claimed to have newly written procedures to address the Children's Services issues but would not provide those procedures during the audit / 62	02-DFA-13	Reportable Condition	\$241,287
TennCare incorrectly reimbursed the Department of Children's Services for services that are covered by and should be provided by the behavioral health organizations, resulting in federal questioned costs of \$123,067 / 68	02-DFA-14	Reportable Condition	\$123,067
TennCare has not adequately monitored TennCare-related activities at the Department of Children's Services / 69	02-DFA-15	Material Weakness	
TennCare still does not adequately monitor the Medicaid Home and Community Based Services Waivers / 73	02-DFA-16	Material Weakness	

TennCare is still not paying claims for services provided to the mentally retarded and developmentally disabled in accordance with the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled / 80	02-DFA-17	Material Weakness	
TennCare has still failed to ensure 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 / 87	02-DFA-18	Material Weakness	\$18,075
TennCare's monitoring of the pharmacy program payments still needs improvement / 93	02-DFA-19	Material Weakness	
TennCare's monitoring of the payments for TennCare Select needs improvement / 95	02-DFA-20	Material Weakness	
For the second year, TennCare chose to go against the direction of the Centers for Medicare and Medicaid Services and inappropriately claimed federal matching funds for premium taxes related to the graduate medical education program and pool payments made to Meharry Medical College and essential provider hospitals / 97	02-DFA-21	Material Weakness	\$919,767
For the fifth consecutive year, TennCare did not recover capitation payments made to managed care organizations for deceased individuals (who had been dead for more than a year), and for the second year, TennCare did not recover fee-for-service payments made for deceased enrollees; this has resulted in new federal questioned costs of \$207,499 and additional costs to the state of \$118,479 / 99	02-DFA-22	Reportable Condition	\$207,499
A Medicaid enrollee's pre-admission evaluation was not on file, and medical necessity could not be substantiated / 103	02-DFA-23	Non-compliance	\$19,843
The Bureau of TennCare overstated the amount of Certified Public Expenditures / 107	02-DFA-25	Reportable Condition	\$185,757
TennCare's providers did not substantiate the medical costs associated with fee-for-services claims or provide evidence that the service was actually provided / 108	02-DFA-26	Material Weakness	\$4,636*
TennCare inappropriately paid \$32,247 for administrative leave for the former Director and a former Assistant Commissioner who terminated employment / 111	02-DFA-27	Non-compliance	\$16,124

For the third consecutive year, TennCare did not pay provider claims in a timely manner / 113	02-DFA-28	Reportable Condition	\$55,718
TennCare did not comply with purchasing guidelines, used incorrect vendor authorization forms, and used a delegated purchase authority to circumvent the competitive bid process for purchases for legal services / 115	02-DFA-29	Reportable Condition	\$28,925
The Bureau's overall compliance with the special terms and conditions of the TennCare program needs improvement / 125	02-DFA-33	Material Weakness	
For the fourth consecutive year, internal control over provider eligibility and enrollment was not adequate to ensure compliance with Medicaid provider regulations / 128	02-DFA-34	Material Weakness	\$2,241*
For the fourth consecutive year, TennCare did not comply with federal regulations and the Tennessee Medicaid State Plan concerning unnecessary utilization of care and services and suspected fraud / 137	02-DFA-35	Material Weakness	
The TennCare Management Information System lacks the necessary flexibility and internal control / 142	02-DFA-36	Material Weakness	
Management has misrepresented the corrective action taken regarding controls over access to the TennCare Management Information System / 144	02-DFA-37	Material Weakness	

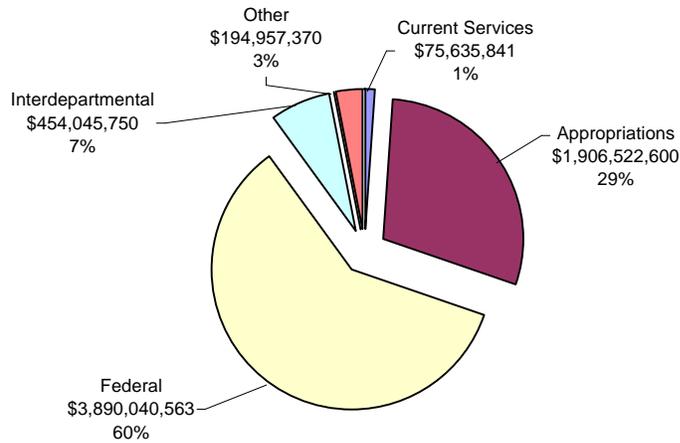
For the purpose of this table, a material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that noncompliance with applicable requirements with laws, regulations, contracts, and grants that would 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, 2002 (Unaudited)

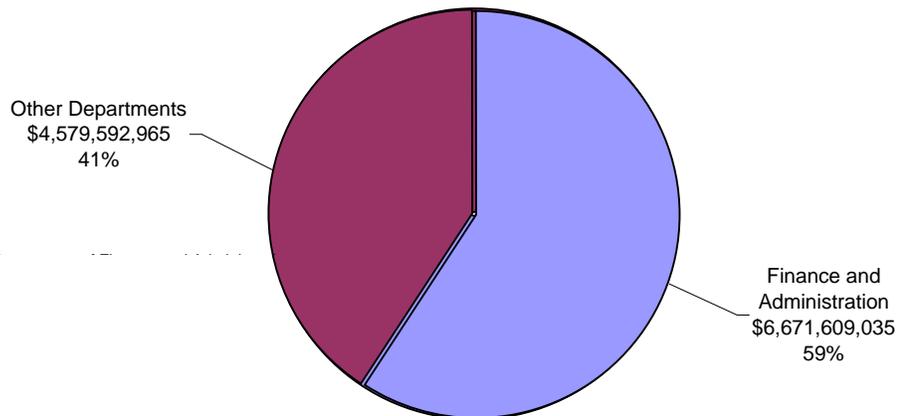


Source: Department of Finance and Administration

Note: OIR, Tennessee Insurance System, Division of Accounts, Facilities Revolving Fund, and State Building Commission are not included because they are not part of the General Fund.

General Fund Departmental Expenditures

Fiscal Year Ended June 30, 2002 (Unaudited)

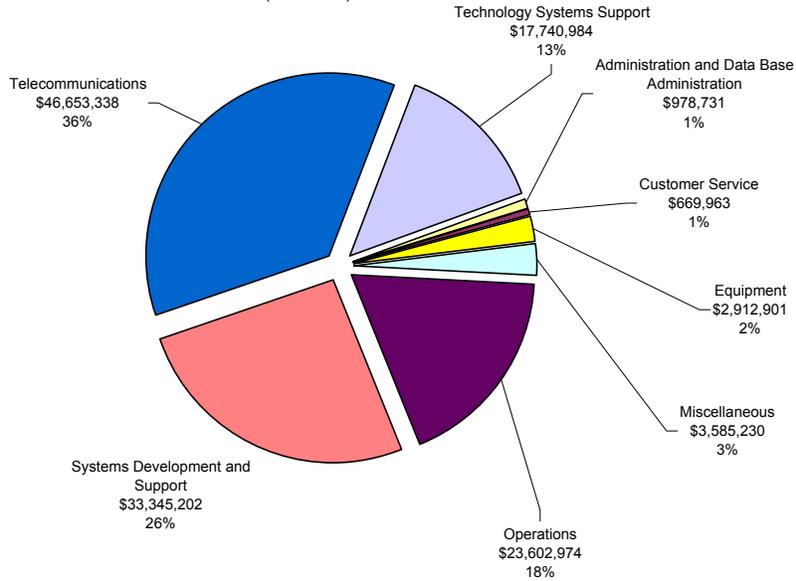


Source: Department of Finance and Administration

Note: OIR, Tennessee Insurance System, Division of Accounts, Facilities Revolving Fund, and State Building Commission are not included because they are not part of the General Fund.

OIR Total Billable Services - \$129,489,323

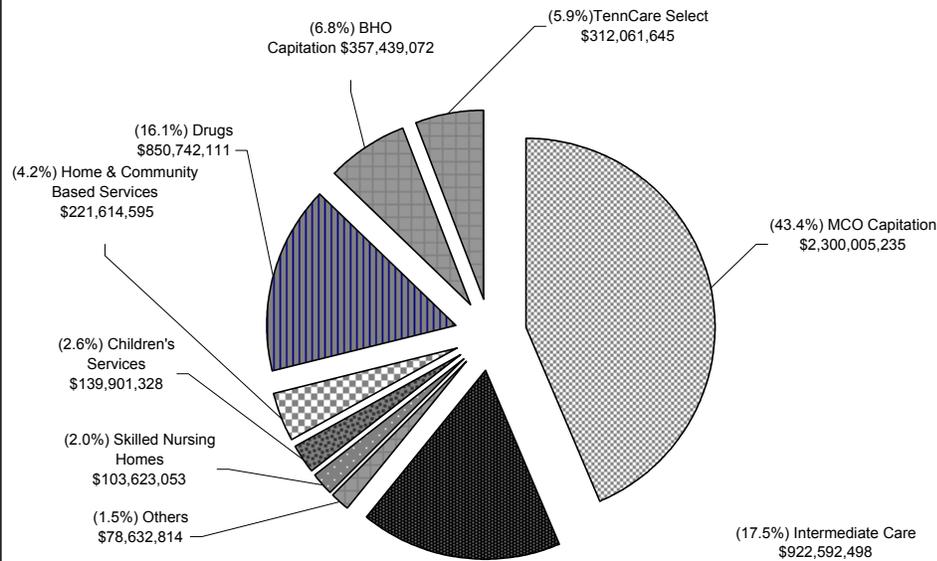
For the Year Ended June 30, 2002
(Unaudited)



Source: Department of Finance and Administration

TennCare Dollars Paid by Claim Type

Fiscal Year Ended June 30, 2002 (Unaudited)



Source: Bureau of TennCare