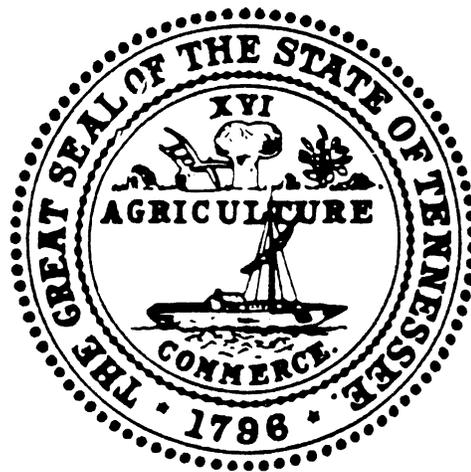


AUDIT REPORT

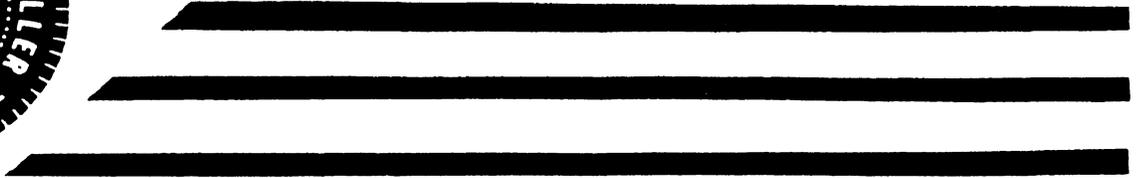
Department of Mental Health and Developmental Disabilities

August 2008



STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

Department of Audit
Division of State Audit



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STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

State Capitol
Nashville, Tennessee 37243-0260
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John G. Morgan
Comptroller

August 7, 2008

The Honorable Phil Bredesen, Governor
and

Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

and

The Honorable Virginia Trotter Betts, MSN, JD, RN, FAAN, Commissioner
Department of Mental Health and Developmental Disabilities
Cordell Hull Building, Third Floor
425 Fifth Avenue North
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the financial and compliance audit of the Department of Mental Health and Developmental Disabilities for the period September 1, 2005, through May 31, 2007.

The review of internal control and compliance with laws, regulations, and provisions of contracts or grant agreements resulted in certain findings which are detailed in the Objectives, Methodologies, and Conclusions section of this report.

Sincerely,

A handwritten signature in black ink that reads "John G. Morgan".

John G. Morgan
Comptroller of the Treasury

JGM/sah
07/066



STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
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June 21, 2007

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 Mental Health and Developmental Disabilities for the period September 1, 2005, through May 31, 2007.

We conducted our audit in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States. These standards require that we obtain an understanding of internal control significant to the audit objectives and that we design the audit to provide reasonable assurance of the Department of Mental Health and Developmental Disabilities' compliance with laws, regulations, and provisions of contracts or grant agreements significant to the audit objectives. Management of the Department of Mental Health and Developmental Disabilities is responsible for establishing and maintaining effective internal control and for complying with applicable laws, regulations, and provisions of contracts and grant agreements.

Our audit disclosed certain findings which are detailed in the Objectives, Methodologies, and Conclusions section of this report. The department's management 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 Mental Health and Developmental Disabilities' management in a separate letter.

Sincerely,

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

Arthur A. Hayes, Jr., CPA
Director

AAH/sah

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Financial and Compliance Audit
Department of Mental Health and Developmental Disabilities
August 2008

AUDIT SCOPE

We have audited the Department of Mental Health and Developmental Disabilities for the period September 1, 2005, through May 31, 2007. Our audit scope included a review of internal control and compliance with laws, regulations, and provisions of contracts or grant agreements in the areas of risk assessment, trust funds, payment cards, contracts, cash receipts, bank accounts, licensure revenue, the Behavioral Health Information System (BHIS), inventory, information systems, internal audit, and the Financial Integrity Act. The audit was conducted in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States.

AUDIT FINDINGS

Management of the Department Has Not Fulfilled Its Responsibility to Formally Assess the Department's Risks of Errors, Fraud, Waste, and Abuse

The department's management has not developed an ongoing risk assessment, which is a basic tenet of internal control (page 4).

Although Problems Have Been Noted in the Prior Three Audits, Management Still Has Not Mitigated the Risks Associated With the Inventory System Used for the Mental Health Institutes, Resulting in Inadequate Accountability for Inventory Which Could Lead to Misappropriation or Loss**

The department has not ensured that the mental health institutes have adequately addressed the risks associated with the

inventory control system used for pharmacy and central medical supply items. In sample testwork performed at each of the five mental health institutes, we noted numerous differences between the quantity on hand and the number of items shown on the inventory listing (page 10).

The Department Failed to Satisfactorily Comply With the HIPAA Security Rule, Resulting in Inadequate Contingency Planning and Inadequate Information Security

The department failed to satisfactorily comply with the HIPAA security rule in the areas of disaster recovery and information security (page 16).

** This finding is repeated from prior audits.

Financial and Compliance Audit

Department of Mental Health and Developmental Disabilities

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Financial and Compliance Audit

Department of Mental Health and Developmental Disabilities

INTRODUCTION

POST-AUDIT AUTHORITY

This is the report on the financial and compliance audit of the Department of Mental Health and Developmental Disabilities. The audit was conducted pursuant to Section 4-3-304, *Tennessee Code Annotated*, which requires the Department of Audit to “perform currently a post-audit of all accounts and other financial records of the state government, and of any department, institution, office, or agency thereof in accordance with generally accepted auditing standards and in accordance with such procedures as may be established by the comptroller.”

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

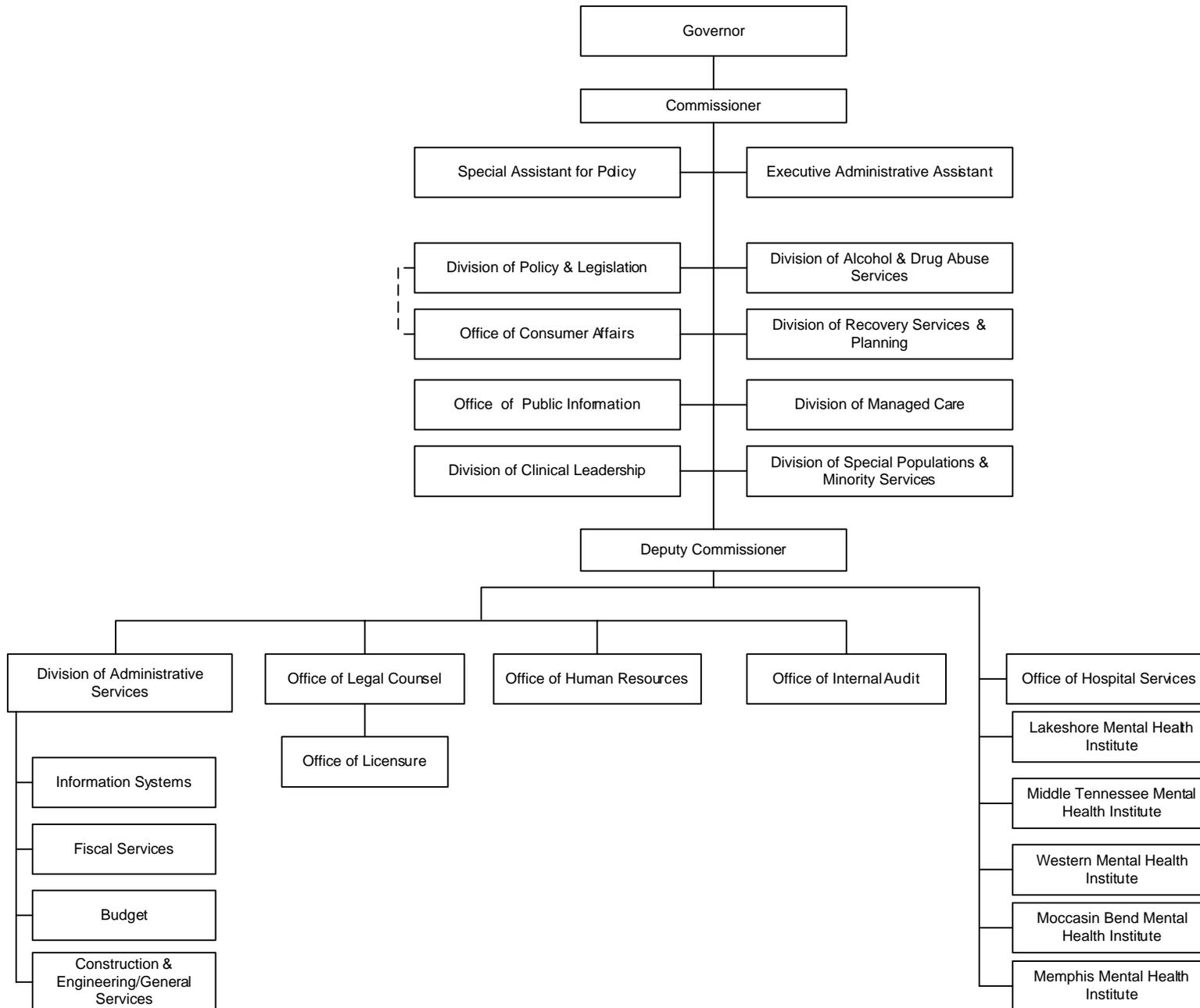
BACKGROUND

The department is the state’s mental health and developmental disabilities authority and is responsible for system planning, setting policy and quality standards, system monitoring and evaluation, disseminating public information, and advocacy for persons of all ages who have mental illness, serious emotional disturbance, or developmental disabilities. The department’s mission is to plan for and promote the availability of a comprehensive array of quality prevention, early intervention, treatment, habilitation, and rehabilitation services and supports based on needs of individuals with mental illness, serious emotional disturbance, or developmental disabilities. By agreement with the Bureau of TennCare, the department also oversees and monitors the programmatic components of the TennCare Partners Program; monitoring responsibilities include assessment of the adequacy of the provider network and the quality of services provided.

Executive Order 44 transferred the management and operations of the Bureau of Alcohol and Drug Abuse Services to the Department of Mental Health and Developmental Disabilities effective February 23, 2007. The appropriations and other revenues budgeted will be transferred to the department effective July 1, 2007. Also, the authority to license facilities operated for the provision of alcohol and drug abuse services will be transferred to the department effective July 1, 2007.

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

Department of Mental Health and Developmental Disabilities Organizational Chart



AUDIT SCOPE

We have audited the Department of Mental Health and Developmental Disabilities for the period September 1, 2005, through May 31, 2007. Our audit scope included a review of internal control and compliance with laws, regulations, and provisions of contracts or grant agreements in the areas of risk assessment, trust funds, payment cards, contracts, cash receipts, bank accounts, licensure revenue, the Behavioral Health Information System, inventory, information systems, internal audit, and the Financial Integrity Act. The audit was conducted in accordance with *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 Mental Health and Developmental Disabilities filed its report with the Department of Audit on October 31, 2006. 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 Mental Health and Developmental Disabilities has corrected previous audit findings concerning:

- improper administration of patients' trust fund balances at discharge or death,
- noncompliance with policies and procedures for payment card purchases,
- failure to approve contracts before the beginning of the contract period,
- inadequate controls over the collection of cash for licenses issued, and
- inadequate access security controls for the Behavioral Health Information System.

REPEATED AUDIT FINDING

The prior audit report also contained a finding concerning inadequate controls over inventory at the mental health institutes. This finding has not been resolved and is repeated in the applicable section of this report.

OBJECTIVES, METHODOLOGIES, AND CONCLUSIONS

RISK ASSESSMENT

Our objective was to determine whether management of the Department of Mental Health and Developmental Disabilities had assessed the department's risks of errors, fraud, waste, and abuse. We interviewed key department personnel to determine the status of the risk assessment process. As noted in finding 1, we determined that management had not fulfilled its responsibility to formally assess the department's risks of errors, fraud, waste, and abuse.

1. Management of the department has not fulfilled its responsibility to formally assess the department's risks of errors, fraud, waste, and abuse

Finding

Management of the Department of Mental Health and Developmental Disabilities has not fulfilled its responsibility to formally assess the department's risks of errors, fraud, waste, and abuse. An ongoing risk assessment process is a basic tenet of internal control.

The 2005 edition of *Governmental Accounting, Auditing, and Financial Reporting* (GAAFR) issued by the Government Finance Officers Association summarizes management's basic responsibilities as follows:

All managers share certain basic responsibilities, which include: 1) achieving the entity's purpose (effectiveness); 2) making optimal use of scarce resources (efficiency); 3) observing restrictions on the use of resources (compliance); and 4) periodically demonstrating accountability for the stewardship of resources placed in their care (reporting). Internal control comprises the tools management uses to ensure that it fulfills these important responsibilities.

A comprehensive framework of internal control must possess five essential elements. It must: 1) provide a favorable *control environment*; 2) provide for the *continuing assessment of risk*; 3) provide for the design,

implementation, and maintenance of effective *control-related policies and procedures*; 4) provide for the effective *communication* of information; and 5) provide for the ongoing *monitoring* of the effectiveness of control-related policies and procedures, as well as the resolution of potential problems identified by controls.

The above elements are also mentioned in Statement on Auditing Standards Number 55, as amended, promulgated in April 1988.

The GAAFR explains why this must be a continuous process by stating:

Changes in a government's circumstances can render once satisfactory control-related policies and procedures inadequate or obsolete. Also, controls have a natural tendency to deteriorate over time unless management properly maintains them. Accordingly, governments must periodically evaluate control-related policies and procedures to determine whether they have been properly designed and implemented and are still adequate and functioning.

In the prior audit report, we recommended that management ensure that the risks noted in the findings be adequately identified and assessed in management's documented risk assessment activities. We also recommended that all controls and control activities, including monitoring, be adequately documented. In addition, in the prior audit, we communicated that a risk assessment should be completed, and that we would review management's risk assessment during the next audit. However, our discussions with management of the department disclosed that they had not fulfilled their responsibility to formally assess the department's risk of errors, fraud, waste, and abuse as of the end of our audit, May 31, 2007. This responsibility is of paramount importance, particularly in the complex environment in which the department operates.

Risks of fraud, waste, and abuse are mitigated by effective internal controls. It is management's responsibility, in addition to performing and documenting a risk assessment, to design, implement, and monitor effective controls in the entity. This too should be an ongoing process.

Recommendation

Management should conduct regular periodic risk assessments. Each assessment should be well documented, complete, and clear. The risk assessment process should involve the active participation of staff; however, management is ultimately responsible for the results of the assessment.

The risk assessment should include consideration of the risks of errors, fraud, waste, and abuse related to the department. Management should begin with prior audit findings, ensuring

that corrective actions recommended by us have been fully implemented. Management should also think about the general types of problems that can occur, such as conflicts of interest in the procurement processes, overbillings, and theft of funds. The relative materiality of the risks should be considered as well. Qualitative as well as quantitative materiality should be considered. The results of the risk assessment should be used by management to design appropriate internal controls to mitigate the identified risks. As such, the risks should be prioritized, so that management can focus their initial attention on the greatest risks. Risks and related controls should be clearly linked.

During the next audit, we will review the risk assessment documentation prepared by management. The results of this review will be part of the basis of our conclusions about the control environment of the entity.

Management's Comment

We concur. A Risk Assessment was conducted in 2007; a Risk Assessment will be conducted in 2008 and in each year thereafter.

TRUST FUNDS

The objectives of our review of the trust funds and specific-purpose funds in the Department of Mental Health and Developmental Disabilities' five mental health institutes were to:

- review the procedures used to compute patient payroll;
- review the procedures regarding the receipt, safekeeping, and recordkeeping of patients' personal property;
- review the procedures and process for allocating interest to the trust funds and specific-purpose funds;
- review the procedures and process for reconciling the subsidiary specific-purpose accounts to the control account; and
- follow up on a prior finding to determine if each institute complied with state law in the administration of discharged and/or deceased patients' trust fund balances.

We interviewed key department personnel and reviewed policies and procedures to gain and document an understanding of the controls over trust funds and specific-purpose funds, patient payroll, patients' personal property, interest allocation to trust funds and specific-purpose funds, and reconciliation of subsidiary specific-purpose accounts to the control account. We selected one day per month for June, July, August, and September 2006, and examined the trust

fund account balances for patients who had been discharged or were deceased to determine if institute staff properly handled the patients' trust fund balances in compliance with state law.

Based on our interviews, reviews, and testwork, we determined that:

- procedures used to compute patient payroll were adequate;
- procedures regarding the receipt, safekeeping, and recordkeeping of patients' personal property were adequate;
- procedures and the process for allocating interest to the trust funds and specific-purpose funds were adequate;
- procedures and the process for reconciling the subsidiary specific-purpose accounts to the control account were adequate; and
- each institute in all material respects complied with state law in the administration of discharged and/or deceased patients' trust fund balances.

PAYMENT CARDS AND CONTRACTS

The objectives of our review of payment cards and contracts in the Department of Mental Health and Developmental Disabilities central office and the five mental health institutes were to:

- determine whether payment card purchases complied with the *State of Tennessee Payment Cardholder Manual* concerning purchases that were split to avoid bid requirements, improper or suspicious vendors, card limits, purchases made on weekends and holidays, purchases made by unauthorized cardholders, and purchases with negative amounts (resulting from voids, no sales, and returns);
- follow up on a prior finding to determine if cardholders were properly approved, terminated employees' payment cards were revoked timely and remnants of terminated employees' payment cards were retained, payment card purchases were adequately supported and approved, and payment card purchases complied with Department of General Services' purchasing policies and procedures concerning recurring purchases, purchases from statewide contract, and purchases requiring bids;
- determine whether the use of noncompetitive negotiation for contracts was justified; and
- follow up on a prior finding to determine if contracts were approved before the beginning of the contract period.

We interviewed key department personnel and reviewed policies and procedures to gain and document an understanding of the controls over purchases using payment cards. We reviewed all payment card purchase transactions for the cycles ended June 15, 2006, through January 15, 2007, to look for purchases that were split to avoid bid requirements, purchases from improper and suspicious vendors, purchase amounts that exceeded card limits, purchases made on weekends and holidays, purchases made by unauthorized cardholders, and purchases with negative amounts. We obtained a listing of active cardholders to determine if signed and approved cardholder agreements were on file for all active cardholders. We also obtained a listing of terminated employees to determine whether the cardholders' payment card privileges were terminated timely and remnants of the terminated cardholders' payment card were retained by the department. We tested all payment card transactions from the listings for the cycles ended August 15, September 15, and October 15, 2006, to determine if transactions were adequately supported and approved and complied with Department of General Services' purchasing policies and procedures concerning recurring purchases, purchases from statewide contract, and purchases requiring bids.

We interviewed key department personnel and reviewed a nonstatistical sample of noncompetitive contracts for the period September 1, 2005, through January 31, 2007, to evaluate the department's justification for the decision to pursue noncompetitive negotiation for those contracts. We also selected a nonstatistical sample of contracts for the period June 1, 2006, through May 31, 2007, to determine if the contracts were properly approved before the beginning of the contract period.

Based on our interviews, reviews, and testwork, we determined that:

- management and cardholders complied with the *State of Tennessee Payment Cardholder Manual* concerning proper bid requirements, appropriate vendors, and allowable purchase limits; we did not find evidence of inappropriate purchases made on weekends or holidays or by unauthorized cardholders; and for any negative amounts on receipts, funds were properly credited back to the payment card;
- cardholders were properly approved, terminated employees' payment cards were revoked timely and remnants of terminated employees' payment cards were retained, payment card purchases were adequately supported and approved, and payment card purchases complied with Department of General Services' purchasing policies and procedures concerning recurring purchases, purchases from statewide contract, and purchases requiring bids with minor exceptions;
- the department's use of noncompetitive negotiation in contracts was appropriate; and
- although not all contracts were approved before the beginning of the contract period, staff did not make payments to contractors before the contracts were properly approved.

CASH RECEIPTS, BANK ACCOUNTS, AND LICENSURE REVENUE

The objectives of our review of cash receipts, bank accounts, and licensure revenue in the Department of Mental Health and Developmental Disabilities' central office and the five mental health institutes were to:

- determine if revenue amounts received at the institutes were reconciled with the revenue amounts recorded in the State of Tennessee Accounting and Reporting System (STARS);
- determine if bad checks were handled appropriately;
- determine if petty cash or change funds were authorized by the Department of Finance and Administration;
- determine if bank accounts were reconciled each month, and the reconciliations were adequately supported; and
- follow up on a prior finding to determine if licensure revenue received and deposited at the central office was reconciled to licenses issued.

We interviewed key department personnel and reviewed policies and procedures to gain an understanding of the controls over cash receipts, each institute's reconciliation procedures, collection efforts related to bad checks, and bank accounts. We reviewed the authorization for the department's petty cash funds. We also reviewed the bank account reconciliations at the five mental health institutes to ensure that bank accounts were reconciled monthly and that reconciliations were adequately supported. We reviewed the reconciliations of provider licenses issued to licensure revenue received and deposited by the department for the period July 1, 2005, through March 31, 2007, and we examined supporting documentation for line items on the reconciliations for July 2006 and February 2007.

Based on our interviews, reviews, and testwork, we determined that:

- revenue amounts received at the institutes were reconciled with the revenue amounts recorded in STARS;
- bad checks collection efforts were handled appropriately;
- petty cash or change funds were authorized by the Department of Finance and Administration;
- bank accounts were reconciled each month, and the reconciliations were adequately supported; and
- licensure revenue received and deposited at the central office was reconciled to licenses issued.

BEHAVIORAL HEALTH INFORMATION SYSTEM

The objective of our review of the Behavioral Health Information System (BHIS) in the Department of Mental Health and Developmental Disabilities' five mental health institutes was to follow up on a prior finding to determine if the institutes terminated access to BHIS in a timely manner when individuals left the department's employment.

For each institute, we interviewed key personnel, and we obtained a listing of all individuals with access to BHIS. We compared that listing to the listing of active employees to determine if all individuals with access to BHIS were still active employees at the institute.

Based on our interviews and testwork, we determined that the institutes did terminate access to BHIS in a timely manner except for a few instances at Lakeshore Mental Health Institute and Middle Tennessee Mental Health Institute.

INVENTORY

The objective of our review of inventory at the five mental health institutes was to follow up on a prior finding to determine if inventory records matched the actual inventory amounts on hand.

We performed test counts of selected inventory items at each of the five mental health institutes, noting any differences between the inventory records and the quantity that we counted. Based on our test counts, we determined that the number of items on hand did not always agree with the inventory records. See finding 2 for further details.

2. **Although problems have been noted in the prior three audits, management still has not mitigated the risks associated with the inventory system used for the mental health institutes, resulting in inadequate accountability for inventory which could lead to misappropriation or loss**

Finding

As noted in the prior three audits, the department has not ensured that the mental health institutes have adequately addressed the risks associated with the inventory control system used for pharmacy and central medical supply items. The institutes use a perpetual inventory system to maintain up-to-date information regarding the amounts of inventory on hand. Under this system, staff update the inventory records at the time items are added to or removed from the inventory.

Management concurred with the prior findings, and in response to the most recent finding, stated:

Software and hardware for the new pharmacy system have been purchased and installed. Implementation at a pilot hospital is scheduled to begin June 1, 2006. The issue of accuracy of the perpetual inventory record will be resolved in the new system.

Management's response to this finding from earlier audits is exhibited in the appendix titled "Management's Comments From Prior Audits."

In the department's Audit Follow-up Report dated October 26, 2006, management stated:

The Department purchased a new hospital information system which included a pharmacy module. During the installation of the new pharmacy module, we discovered critical discrepancies between the pharmacy module and the system as described in the vendor's proposal. After a series of attempts to resolve the differences, we concluded that the vendor was unable to reconcile the issues we identified. Accordingly, we cancelled the pharmacy module component of the contract and are currently in the process of developing an RFP for a new pharmacy system.

In our discussion with the Director of Information Systems, she stated that it was spring 2007 before they were able to resolve all of the legal and financial issues related to the cancellation of the pharmacy module, and they released an RFI for a new pharmacy system on April 9, 2007.

We performed inventory test counts at each of the five mental health institutes, which revealed that for 50 of 78 items counted (64%), the quantity on hand did not match the number of items shown on the inventory listing. For 30 of the 50 items (60%), the quantity on hand was greater than the quantity on the listing. For 20 of the 50 items (40%), the quantity on hand was less than the quantity on the listing. The following discrepancies were noted:

- For 8 of 10 pharmacy items (80%) and 2 of 10 central medical supply items (20%) counted at Lakeshore Mental Health Institute, the quantity on hand did not match the inventory listing. For 5 of the 8 pharmacy items, the quantity on hand was greater than the quantity on the listing; the differences ranged from 2 to 102 units. For 3 of the 8 pharmacy items, the quantity on hand was less than the quantity on the listing; the differences ranged from 12 to 148 units. The Pharmacy Director stated that the differences were most likely caused by the fact that the inventory system is old and labor intensive and there might also have been some human error involved. For 1 of the 2 central medical supply items, the quantity on hand was 1 unit greater than the quantity on the listing. For 1 of the 2 central medical supply items, the quantity on hand was 48 units less than the quantity on the listing. The Director of Procurement

stated that he thought the first difference was where an item had been returned to inventory but not properly documented and the second difference was the result of items being taken for patient use but not documented as being withdrawn from the inventory.

- For 3 of 10 pharmacy items (30%) counted at Memphis Mental Health Institute, the quantity on hand did not match the inventory listing. For 1 of the 3 items, the quantity on hand was 16 units greater than the quantity on the listing. The Pharmacy Director stated that he thought the difference was due to a keying error. For 2 of the 3 items, the quantity on hand was less than the quantity on the listing; the differences were 16 and 60 units. For the difference of 16 units, the Pharmacy Director stated that he thought the difference was due to a keying error. For the difference of 60 units, the Pharmacy Director stated that there are three emergency boxes of that particular item each of which holds 20 units, and apparently the items in those boxes had not been taken out of the inventory.
- For 6 of 10 pharmacy items (60%) and 6 of 10 central medical supply items (60%) counted at Middle Tennessee Mental Health Institute, the quantity on hand did not match the inventory listing. For 4 of the 6 pharmacy items, the quantity on hand was greater than the listing; the differences ranged from 1 to 180 units, with 3 of the differences being less than 10 units. For 2 of the 6 pharmacy items, the quantity on hand was less than the quantity on the listing; the differences were 9 and 76 units. The Pharmacy Director stated that the inventory system is old and labor intensive and the differences noted could have been caused by human error. For 2 of the 6 central medical supply items, the quantity on hand was greater than the quantity on the listing; the differences were 1 and 10 units. For 4 of the 6 central medical supply items, the quantity on hand was less than the quantity on the listing; the differences ranged from 2 to 12 units. The LPN stated that she thought some differences could arise when staff members pick up supplies after hours. The staff member has to complete a requisition that is approved by their supervisor and sign for the supply room key from the front desk. The staff member will leave a copy of the requisition for her so she can update the inventory the next day. However, she has no way of knowing if the person picked up exactly what was on the requisition. In addition, she thought a staff member could be in a hurry and might forget to write something on the requisition.
- For 16 of 18 pharmacy items (89%) counted at Moccasin Bend Mental Health Institute, the quantity on hand did not match the inventory listing. For 10 of the 16 items, the quantity on hand was greater than the quantity on the listing; the differences ranged from 2 to 293 units, with half of the differences being less than 10 units. For 6 of the 18 items, the quantity on hand was less than the quantity on the listing; the differences ranged from 1 to 634 units. The Pharmacy Director stated that he thought the differences were caused by the inventory system and gave the example that the system may subtract more from the inventory than what was actually used and due to

the age of the system no one knows how to correct it. He also stated that quantities are corrected during the annual inventory.

- For 9 of 10 pharmacy items (90%) counted at Western Mental Health Institute, the quantity on hand did not match the inventory listing. For 7 of the 9 items, the quantity on hand was greater than the quantity on the listing; the differences ranged from 1 to 74 units. For 2 of the 9 items, the quantity on hand was less than the quantity on the listing; the differences were 10 and 100 units. The Pharmacist stated that the differences were most likely caused by the fact that the inventory system is old and labor intensive and there might also have been some human error involved.

Without mitigating the risks associated with inaccurate inventory records, the institutes cannot ensure that inventory items are adequately safeguarded from misappropriation or loss.

Recommendation

In our previous three audits, which covered the period July 1, 1998, through August 31, 2005, we recommended that the Superintendents/Director of Fiscal Services in conjunction with the Superintendent of each institute/Commissioner take appropriate action to resolve this finding and to ensure that the inventory systems reflect accurate information. The Commissioner should take immediate action to ensure that an adequate inventory system is put in place to properly account for the pharmacy inventory and the central medical supply inventory at each mental health institute. The Fiscal Director at each institute should ensure perpetual inventory records are kept up to date and that periodic physical inventory counts are performed and necessary adjustments are made to inventory records. The Fiscal Director should ensure that significant shortages, particularly of sensitive items, are promptly investigated.

The Commissioner should ensure that risks such as those noted in this finding are adequately identified and assessed in management's documented risk assessments. The Commissioner should identify specific staff to be responsible for the design and implementation of internal controls to prevent and detect exceptions timely. The Commissioner should also identify staff to be responsible for ongoing monitoring for compliance with all requirements and taking prompt action should exceptions occur.

Management's Comment

We concur. The Department continues to work toward procurement of a new pharmacy system, as well as two additional components including Computerized Provider Order Entry (CPOE) and Bedside Administration. With this combination, we will have a complete record of medication history from the time the prescription is ordered by a physician through dispensing and finally administration by nursing staff. We expect to have a completed RFP ready for review by OIR, OCR, and the eHealth Advisory Council by November 2008. This will allow us to

publish the RFP in early 2009, with a contract award anticipated at the beginning of the following fiscal year. In addition to upgrading technical systems, an internal workgroup consisting of pharmacy, nursing, and executive management has been created and will be implemented before the end of this calendar year to establish new procedures for the handling of medication inventory.

INFORMATION SYSTEMS

The Information Systems section of the Division of State Audit performed two reviews related to the Department of Mental Health and Developmental Disabilities. One review was of the Behavioral Health Information System (BHIS), and the other review was of the Safety Net application.

Behavioral Health Information System

For their review of the Behavioral Health Information System, the IS auditors selected the central office, Memphis Mental Health Institute, and Middle Tennessee Mental Health Institute. The objectives of their review of were to:

- determine that adequate general and administrative controls were in place relative to BHIS;
- determine the adequacy of programmed application controls and manual user controls; and
- determine that duties were appropriately segregated.

The IS auditors interviewed key department personnel and reviewed policies and procedures to gain an understanding of the general and administrative controls, programmed application controls, and manual user controls over BHIS. They made observations and performed testwork to determine that selected control procedures had been placed in operation and evaluated the effectiveness of selected control procedures. They also reviewed the organization chart for the IT function to evaluate segregation of duties.

As a result of their interviews, reviews, and testwork, the IS auditors determined that:

- general and administrative controls were lacking in the areas of disaster recovery and physical security as noted in finding 3, and there were some other minor exceptions;
- programmed application controls and manual user controls were adequate; and
- duties were appropriately segregated.

Safety Net Application

This review focused on the control environment relative to the Safety Net application (also known as the Clinical Therapeutics and Recovery system) and its supporting infrastructure. The Safety Net application was designed and developed as an internet-based system to make payments to providers of Safety Net services. The objectives of the IS auditors' review were to:

- determine that selected IS application controls, user controls, and manual follow-up procedures were in operation and working effectively;
- determine if system development and maintenance procedures were adequate to ensure the application performs as intended and satisfies business objectives;
- determine that computers hosting the application components were appropriately configured so as to reduce the risk of compromise;
- determine that development staff had considered and taken appropriate measures to guard against common vulnerabilities relevant to web-based applications; and
- determine that the Safety Net application was in compliance with the technical safeguards requirements of the HIPAA security rule.

The IS auditors interviewed key department personnel and reviewed policies and procedures to gain an understanding of the Safety Net application and its supporting infrastructure, selected IS application controls, user controls, manual follow-up procedures, and system development and maintenance procedures. They made observations and performed testwork to determine that selected IS application controls, user controls, and manual follow-up procedures had been placed in operation and evaluated the effectiveness of selected control procedures and the adequacy of system development and maintenance procedures. They reviewed the configuration of the servers hosting the application program and database for compliance with best security practice to reduce the risk of compromise. They reviewed the configuration and maintenance of the application database to determine that development staff had considered and taken appropriate measures to guard against common vulnerabilities relevant to web-based applications. They reviewed controls in place for compliance with the HIPAA security rule's technical safeguards

Based on their interviews, reviews, and testwork performed, the IS auditors determined that:

- selected IS application controls, user controls, and manual follow-up procedures were in operation and working effectively with minor exceptions;
- system development and maintenance procedures were adequate to ensure the application performs as intended and satisfies business objectives;
- computers hosting the application components were appropriately configured so as to reduce the risk of compromise with one minor exception;

- development staff had considered and taken appropriate measures to guard against common vulnerabilities relevant to web-based applications with one minor exception; and
- the Safety Net application was in compliance with the technical safeguards requirements of the HIPAA security rule with one minor exception.

3. The department failed to satisfactorily comply with the HIPAA security rule, resulting in inadequate contingency planning and inadequate information security

Finding

The Department of Mental Health and Developmental Disabilities failed to satisfactorily comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security rule in the area of disaster recovery. The HIPAA security rule in 45 CFR, Part 164 states, in the following section:

§164.308 (a) (7) (ii) (B) - Contingency plan, disaster recovery plan (required).
Establish (and implement as needed) procedures to restore any loss of data.

Management and staff at the Department of Mental Health and Developmental Disabilities' central office, the Memphis Mental Health Institute, and the Middle Tennessee Mental Health Institute had not prepared a written disaster recovery plan for the Behavioral Health Information System. Failure to properly document the measures and resources required for disaster recovery is a departure from best practice for information systems governance and is not in compliance with the requirements of the HIPAA security rule for contingency planning. Without a written plan that has been properly tested, the department cannot be certain that all vital systems and data can be restored if a catastrophic event should occur.

We also observed control deficiencies that violated the HIPAA security rule for information security controls. The wording of this finding does not identify specific vulnerabilities that could allow someone to exploit the department's systems. Disclosing those vulnerabilities could present a potential security risk by providing readers with information that might be confidential pursuant to Section 10-7-504(i), *Tennessee Code Annotated*. We provided the department with detailed information regarding the specific vulnerabilities we identified as well as our recommendations for improvement.

Recommendation

The Director of Information Systems should initiate a dialog and coordinate with the Office for Information Resources (OIR) to determine the specific resources and infrastructure that department management will rely on OIR to supply and the measures for which the department will be responsible, if a disaster should occur. She should also ensure that

appropriate measures are properly documented in a written disaster recovery plan. The written disaster recovery plan should clearly define the respective roles of the department and OIR in a disaster scenario and should be periodically tested to ensure its viability. The Director of Information Systems should coordinate activities among the regional mental health institutes and assist in developing disaster recovery plans for each of the regional facilities. A copy of each institute's plan should be retained at the central office with at least one additional copy stored securely off-site. The central office plan should be stored off-site as well.

The Director of Information Systems should also immediately correct the control deficiencies that violated the HIPAA security rule for information security controls. These conditions should be remedied by the prompt development and implementation of effective controls (standards and procedures).

The Commissioner should ensure that risks such as those noted in this finding are adequately identified and assessed in management's documented risk assessments. The Commissioner should identify specific staff to be responsible for the design and implementation of internal controls to prevent and detect exceptions timely. The Commissioner should identify staff to be responsible for ongoing monitoring for compliance with all requirements and taking prompt action should exceptions occur.

Management's Comment

We concur. Since the time of this audit, the Department has developed new, standardized Disaster Recovery documents in Central Office and all five Regional Mental Health Institutes. The plans include systems inventory and prioritization as well as detailed recovery procedures, updated contact information with key OIR, Agency, and Vendor roles identified, technical diagrams, and other appendices. These plans will be tested at least annually. Copies of the plans are kept offsite for all key staff. In addition, we have reviewed access control procedures to ensure the physical security of our equipment. We will also be participating in the forthcoming Disaster Recovery workgroup, which is planned for the IT community and will be guided by the Disaster Recovery Consultant for Finance and Administration. We expect to continue revising our plan documents over the next several months and have identified key staff to lead that project.

INTERNAL AUDIT

The objectives of our review of the internal audit section of the Department of Mental Health and Developmental Disabilities were to:

- review internal audit reports for any pertinent findings;

- determine that the internal auditors have adequate education, experience, and supervision;
- determine that the internal audit unit is independent from the program functions of the department; and
- determine that the internal auditors prepared sufficient working papers to document their work.

We reviewed internal audit reports issued during our audit period. We also reviewed the personnel files of the internal audit staff and the department's organization chart. For selected audit reports, we reviewed internal audit's supporting working papers.

Based on our reviews, we determined that:

- some of the internal audit reports noted problems with inventory at the mental health institutes, which supported the results of our testwork in that area;
- the internal auditors had adequate education, experience, and supervision;
- the internal audit unit is independent from the program functions of the department; and
- internal audit's working papers were sufficient to document their work.

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 each year. In addition, the head of each executive agency is 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 objective was to determine whether the department's June 30, 2006, responsibility letter was filed in compliance with Section 9-18-104, *Tennessee Code Annotated*.

We reviewed the June 30, 2006, responsibility letter submitted to the Comptroller of the Treasury and the Department of Finance and Administration to determine adherence to the submission deadline. We determined that the Financial Integrity Act responsibility letter was submitted on time.

OBSERVATIONS AND COMMENTS

MANAGEMENT'S RESPONSIBILITY FOR RISK ASSESSMENT

Auditors and management are required to assess the risk of fraud in the operations of the entity. The risk assessment is based on a critical review of operations considering what frauds could be perpetrated in the absence of adequate controls. The auditors' risk assessment is limited to the period during which the audit is conducted and is limited to the transactions that the auditors are able to test during that period. The risk assessment by management is the primary method by which the entity is protected from fraud, waste, and abuse. Since new programs may be established at any time by management or older programs may be discontinued, that assessment is ongoing as part of the daily operations of the entity.

Risks of fraud, waste, and abuse are mitigated by effective internal controls. It is management's responsibility to design, implement, and monitor effective controls in the entity. Although internal and external auditors may include testing of controls as part of their audit procedures, these procedures are not a substitute for the ongoing monitoring required of management. After all, the auditor testing is limited and is usually targeted to test the effectiveness of particular controls. Even if controls appear to be operating effectively during the time of the auditor testing, they may be rendered ineffective the next day by management override or by other circumventions that, if left up to the auditor to detect, will not be noted until the next audit engagement and then only if the auditor tests the same transactions and controls. Furthermore, since staff may be seeking to avoid auditor criticisms, they may comply with the controls during the period that the auditors are on site and revert to ignoring or disregarding the control after the auditors have left the field.

The risk assessments and the actions of management in designing, implementing, and monitoring the controls should be adequately documented to provide an audit trail both for auditors and for management, in the event that there is a change in management or staff, and to maintain a record of areas that are particularly problematic. The assessment and the controls should be reviewed and approved by the head of the entity.

FRAUD CONSIDERATIONS

Statement on Auditing Standards No. 99, *Consideration of Fraud in a Financial Statement Audit*, promulgated by the American Institute of Certified Public Accountants requires auditors to specifically assess the risk of material misstatement of an audited entity's financial statements due to fraud. The standard also restates the obvious premise that management, not the auditors, is primarily responsible for preventing and detecting fraud in its own entity. Management's responsibility is fulfilled in part when it takes appropriate steps to assess the risk

of fraud within the entity and to implement adequate internal controls to address the results of those risk assessments.

During our audit, we discussed these responsibilities with management and how management might approach meeting them. We also increased the breadth and depth of our inquiries of management and others in the entity as we deemed appropriate. We obtained formal assurances from top management that management had reviewed the entity's policies and procedures to ensure that they are properly designed to prevent and detect fraud and that management had made changes to the policies and procedures where appropriate. Top management further assured us that all staff had been advised to promptly alert management of all allegations of fraud, suspected fraud, or detected fraud and to be totally candid in all communications with the auditors. All levels of management assured us there were no known instances or allegations of fraud that were not disclosed to us.

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

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 June 30 each year. The Department of Mental Health and Developmental Disabilities filed its compliance report and implementation plan on June 30, 2006.

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 Tennessee Title VI Compliance Commission is responsible for monitoring and enforcement of Title VI.

APPENDICES

MANAGEMENT'S COMMENTS FROM PRIOR AUDITS

Current Finding

Management still has not mitigated the risks associated with the inventory system used for the mental health institutes, resulting in inadequate accountability for inventory which could lead to misappropriation or loss

Management's Comments

For the Period July 1, 2000, Through May 31, 2003

We concur. The department's existing pharmacy system is now over 10 years old and no longer is capable of maintaining an acceptable level of accountability for the pharmaceutical inventory. The department is currently in the process of identifying and purchasing a new pharmacy system, which will provide the level of accountability required; funding limitations are a significant factor in the decision.

For the Years Ended June 30, 2000, and June 30, 1999

We concur. The department will establish a plan to conduct routine spot check counts of the stock items throughout the year. Concluding that a portion of the discrepancies can be attributed to the pharmacy software, the department is currently investigating a pharmacy software package to replace the existing pharmacy software.

ALLOTMENT CODES

Department of Mental Health and Developmental Disabilities divisions and allotment codes:

339.01	Administrative Services Division
339.08	Community Mental Health Services
339.10	Lakeshore Mental Health Institute
339.11	Middle Tennessee Mental Health Institute
339.12	Western Mental Health Institute
339.16	Moccasin Bend Mental Health Institute
339.17	Memphis Mental Health Institute
339.40	Major Maintenance – Equipment