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Department of Health

For the Year Ended
June 30, 1997



STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

Department of Audit
Division of State Audit



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STATE OF TENNESSEE

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COMPTROLLER OF THE TREASURY

STATE CAPITOL

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June 30, 1998

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

and
The Honorable Nancy Menke, Commissioner
Department of Health
Nashville, Tennessee 37243

Ladies and Gentlemen:

We have conducted a financial and compliance audit of selected programs and activities of the Department of Health for the year ended June 30, 1997.

We conducted our audit in accordance with generally accepted auditing standards and the standards 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 Health's compliance with the provisions of laws, regulations, contracts, and grants significant to the audit. Management of the Department of Health 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 Health's management in a separate letter.

Very truly yours,

A handwritten signature in black ink, appearing to read "W. R. Snodgrass".

W. R. Snodgrass
Comptroller of the Treasury

WRS/lb
97/095

WIC Voucher Reconciliation Procedures Inadequate

The department's inadequate reconciliation procedures contributed to thefts of WIC vouchers and allowed the situation to go undetected for five months (page 28).

Subgrantees Not Adequately Monitored**

As noted in the five prior audits, the department's subgrantees are not adequately monitored. Subgrantee audit reports were not received timely, and audit exceptions, including questioned costs, noted in the reports were not followed up or resolved timely (page 31).

Grant Payroll Cost Reallocation and Drawdown Procedures Not Adequate**

The department did not allocate payroll costs of federal programs to allow for timely draws of federal funds and therefore lost interest on state funds (page 33).

Grant-Funding Information Incorrectly Recorded in State Property Records**

The department did not properly record vital grant-funding information in the Property of the State of Tennessee (POST) equipment tracking system (page 35).

Subcontracts for TennCare Outreach Not Sufficiently Detailed*

The department's subcontracts with certain entities were not specific enough to ensure subcontractor compliance with contract requirements (page 39).

OTHER AUDIT FINDINGS

Millions in State Funds Remitted to Federal Government Because of Uncollected Provider Cost Settlements*

Because TennCare failed to collect Medicaid cost settlements from providers, state funds (\$13.3 million at December 31, 1997) were used to pay the federal portion of the cost settlements. The federal grantor requires states to remit the federal share (approximately two-thirds) within 60 days of settlement, whether or not the state has collected the amounts due from the providers (page 11).

Inappropriate Type of Agreement Used for Medical Education Payments

Instead of abiding by the Rules of the Department of Finance and Administration and establishing multi-year grant contracts for graduate medical education payments, TennCare entered into five-year memorandums of understanding with the four medical schools in the state. TennCare did not obtain signed approval from the Comptroller of the Treasury for the agreements (page 17).

Revision of TennCare's Rules Needed*

Several departmental rules governing TennCare were inconsistent with TennCare's practices or did not address certain practices (page 24).

Contracts with Community Services Agencies Not Consistent with Plans of Operation

The department entered into contracts with the community services agencies (CSAs) to administer various programs in fiscal year 1998 prior to the approval of the CSAs' fiscal year 1998 Plans of Operation, the legal instruments governing the CSAs' activities. The contracts extended the department's authority over CSA staff beyond that intended by the Plans of Operation (page 37).

Improper Employer-Employee Relationships**

For the past decade, the department has established improper employer-employee relationships through contracts with community services agencies, human resource agencies, and other nonprofit organizations (page 38).

Inadequate Revenue Controls**

Department personnel at various locations do not restrictively endorse checks immediately upon receipt; prepare receipts or listings of cash received; adequately segregate duties; periodically account for cash receipts; or reconcile related records, receipts, and reports (page 42).

* This finding is repeated from the prior audit.

** This finding is repeated from prior audits.

PAST FINDINGS NOT ACTED UPON BY MANAGEMENT

Draw Down and Use of Indirect Cost Funds

The Department of Health has not fully used the departmental indirect cost allocation plan for the recovery of indirect costs from block grants. Management uses eligible indirect costs for program expenditures and spends a large portion of previously recovered indirect costs for program services (page 46).

Administrative Controls for the Nursing Home Resident's Grant Assistance Program

The Department of Health has not established adequate administrative controls over the Nursing Home Resident's Grant Assistance Program to ensure participant eligibility and contractor performance, nor has the department set per diem limits (page 46).

Supplemental Pay

The Department of Health, without authorization, has allowed certain employees to receive supplemental pay from the counties employing them. Section 68-2-603, *Tennessee Code Annotated*, states that county health directors and county health officers "shall have compensation paid, all or in part, by the department of health." However, there is no provision in the law granting authority for supplemental pay to employees other than county health directors and county health officials (page 47).

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Financial and Compliance Audit
Department of Health
For the Year Ended June 30, 1997

AUDIT SCOPE

We have audited the Department of Health for the period July 1, 1996, through June 30, 1997. Our audit scope included those areas material to the Tennessee Comprehensive Annual Financial Report for the year ended June 30, 1997, and the Tennessee Single Audit Report for the same period. These areas included the TennCare program; the Special Supplemental Nutrition Program for Women, Infants, and Children; the Block Grant for Prevention and Treatment of Substance Abuse; and Federal Programs-Nonspecific. 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 contracts, supplemental pay, cellular phones, revenue, contingent and deferred revenue, and utilization of the Department of Finance and Administration's STARS grant module to record the receipt and expenditure of federal funds. The audit was conducted in accordance with generally accepted auditing standards and the standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

MATERIAL INTERNAL CONTROL WEAKNESSES REPORTED IN 1997 TENNESSEE SINGLE AUDIT REPORT

A material weakness in internal control over compliance is a reportable 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 the applicable requirements of laws, regulations, contracts, and grants that would be material in relation to a major federal program being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions.

TennCare Eligibility Verification Procedures Not Adequate**

The eligibility of TennCare enrollees has not been verified or reverified for a significant number of enrollees. Several thousand TennCare participants had "pseudo" social security numbers (page 6).

TennCare-Related Activities at the Department of Children's Services Not Monitored

TennCare has not monitored TennCare-related activities at the Department of Children's Services to ensure the accuracy and allowability of billings from that department despite its numerous, serious compliance and internal control problems. TennCare paid approximately \$100.8 million in reimbursement claims to Children's Services during the 1997 fiscal year (page 8).

REPORTABLE CONDITIONS

A reportable condition involves matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over compliance that, in our judgment, could adversely affect the department's ability to administer a major federal program in accordance with the applicable requirements of laws, regulations, contracts, and grants.

Federal Funds Used to Pay Health Care Costs of Incarcerated Youth

TennCare failed to identify incarcerated youth enrolled in the program and made health care payments on behalf of 30 of 32 juveniles tested (94%). Under federal regulations, the state, not the federal government, is responsible for the health care costs of juvenile and adult inmates (page 10).

TennCare's Accounts Receivable System Impediment to Collection of Cost Settlements and Federal Financial Reporting

Incorrect information in the Medicaid Accounts Receivable Recoupment System was used to prepare federal expenditure reports and has caused delays in collecting provider cost settlements (page 13).

ADP Risk Analysis and System Security Review Program Not Established

TennCare does not have a coordinated program for ADP (automated data processing) risk analysis and security system review of the TennCare Management Information System, as required by the federal grantor (page 15).

Processing of "Professional Cross-Over" Claims Needs Improvement

The TennCare Management Information System has not been modified and updated as needed to ensure Medicare professional cross-over claims are paid in compliance with state and federal laws and regulations (page 16).

Weak Controls Over TennCare Manual Checks**

Weaknesses in manual check procedures pertaining to delayed reporting, poor segregation of duties, and the reconciliation of issued checks and paid checks were noted. Manual checks totaled approximately \$193 million in fiscal year 1997 (page 19).

Allowable Rates for TennCare Mental Health Services Improperly Raised*

As a condition of the TennCare waiver, the state was allowed to continue paying for mental health services on a fee-for-service basis at the rates in existence prior to TennCare. During fiscal year 1995, however, the allowable amount for mental health services was raised for inflation (page 20).

Cross-over Provider and Nursing Home Application Information Not Verified and the Department of Children's Services Not Monitored to Ensure Eligibility of its TennCare Providers

TennCare has not established procedures for the verification of provider information upon enrollment nor procedures for updating provider files. TennCare also has not monitored to ensure the service providers used by the Department of Children's Services are eligible to participate in TennCare (Medicaid) (page 22).

Some TennCare Providers Overpaid for Medicare-Eligible Enrollees*

TennCare sometimes pays more for Medicare deductibles than departmental rules allow (page 23).

Late Return of Medicaid Refunds to the Federal Government**

Recoveries from third parties were not used to promptly reduce federal participation (page 26).

**Audit Report
Department of Health
For the Year Ended June 30, 1997**

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Department of Health For the Year Ended June 30, 1997

INTRODUCTION

POST-AUDIT AUTHORITY

This is the report on the financial and compliance audit of the Department of Health. 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 Health is to promote, protect, and restore the health of Tennesseans by facilitating access to high-quality preventive and primary care services. To fulfill this mission, the department comprises seven sections: Executive Administration, Bureau of Administrative Services, Bureau of Information Resources, Bureau of Manpower and Facilities, Bureau of Health Services, Bureau of Alcohol and Drug Abuse Services, and Bureau of TennCare.

One of the department's many responsibilities is to provide overall direction to, coordination of, and supervision for the state and local health departments to enable them to meet the health needs of the state's citizens. The department ensures the quality of medical resources available in the state through the regulation, certification, and licensure of health professionals and health care facilities. The central office works in coordination with four rural and six metropolitan regional offices and 95 county health departments to provide services which protect and promote health and prevent disease and injury. The department also works to improve access to quality health care services in underserved areas of the state and to underserved populations. To decrease the incidence and prevalence of alcohol and other drug abuse and dependence, the department coordinates prevention, treatment, and rehabilitation services. The department is also responsible for preserving and issuing copies of all vital records.

Executive Order 11 transferred all functions related to the TennCare program from the Department of Finance and Administration to the Department of Health effective January 3, 1997.

The accounting functions remained with the Department of Finance and Administration until July 1, 1997, when they were also transferred to the Department of Health.

AUDIT SCOPE

We have audited the Department of Health for the period July 1, 1996, through June 30, 1997. Our audit scope included those areas material to the Tennessee Comprehensive Annual Financial Report for the year ended June 30, 1997, and to the Tennessee Single Audit Report for the same period: the TennCare program; the Special Supplemental Nutrition Program for Women, Infants, and Children; the Block Grant for Prevention and Treatment of Substance Abuse; and Federal Programs–Nonspecific. 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 contracts, supplemental pay, cellular phones, revenue, contingent and deferred revenue, and utilization of the Department of Finance and Administration’s STARS grant module to record the receipt and expenditure of federal funds. The audit was conducted in accordance with generally accepted auditing standards and the standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

OBJECTIVES, METHODOLOGIES, AND CONCLUSIONS

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

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

Our audit of the Department of Health is also an integral part of the Tennessee Single Audit which is conducted in accordance with the Single Audit Act, as amended in 1996. The Single Audit Act, as amended, requires us to determine whether

- the state complied with rules and regulations that may have a material effect on each major federal financial assistance program, and

- the state has internal control to provide reasonable assurance that it is managing its major federal award programs in compliance with applicable laws and regulations.

We determined the following areas within the Department of Health were material to the CAFR and to the Single Audit Report: the TennCare program, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the Block Grant for Prevention and Treatment of Substance Abuse (SAPT).

To address the objectives of the audit of the CAFR and the Single Audit Report, as they pertain to these three major federal award programs, we interviewed key department employees, reviewed applicable policies and procedures, and tested representative samples of transactions. In addition, we performed analytical procedures to determine the department's compliance with the maintenance-of-effort requirement for the block grant and the one-to-one reconciliation requirement for WIC. TennCare's actual revenues and expenditures were compared to budgeted and prior-year actual revenues and expenditures, and explanations were obtained for significant variances.

We have issued an unqualified opinion on the general-purpose financial statements of the State of Tennessee in our Independent Auditor's Report dated December 18, 1997, which is included in the CAFR for the year ended June 30, 1997. The Tennessee Single Audit Report for the year ended June 30, 1997, will include our reports on the schedule of expenditures of federal awards and on internal control and compliance with laws and regulations.

We determined the following:

- The TennCare program had significant weaknesses and needs improvement, as discussed in finding one through 14.
- Voucher reconciliation procedures for the Special Supplemental Nutrition Program for Women, Infants, and Children are inadequate, as discussed in finding 15.
- We had no findings concerning the overall administration of the Block Grant for Prevention and Treatment of Substance Abuse, although we did note weaknesses in monitoring (finding 16).

TENNCARE

To address the objectives of the audit of the CAFR and the Single Audit Report, as they pertain to this major federal financial assistance program and to determine if program participants were eligible for services and federal funds were spent only for allowable purposes, we interviewed key department employees, reviewed applicable policies and procedures, and tested representative samples of various types of transactions. These transactions were tested for adequate support and compliance with applicable laws and regulations and included year-end accrued liabilities and payments and adjustments to

- managed care organizations (MCOs) and behavioral health organizations (BHOs) for monthly capitation,
- MCOs for adverse selection (to cover enrollees with high-cost conditions),
- the Department of Children's Services, nursing homes, Medicare providers (for "cross over" claims), and mental health providers,
- providers from the reserve fund pool for malpractice insurance costs and above-average case loads,
- medical schools for graduate medical education,
- community mental health providers participating in the TennCare Partners Program, and
- other departments and professional and administrative contractors.

We also performed testwork on the following:

- Expenditures—reviewed the CPE (certified public expenditures) and EBNE (eligible-but-not-enrolled) expenditure adjustments (for costs associated with the care provided by local public hospitals).
- Expenditures—reviewed a sample of payments issued by manual check and all significant financial adjustments processed through TennCare Management Information System (TCMIS).
- Expenditures—reconciled all financial transactions (payments and adjustments) with TennCare's check registers.
- Accounts Receivable—reviewed significant overdue provider cost settlement receivables.
- Accounts Receivable—reviewed TennCare's policies and procedures pertaining to enrollee premium accounts and the related receivables.
- Revenue—tested a sample of premium payments to determine if they were posted to the correct accounts and if the premium and deductible amounts charged were correct.
- Revenue—tested total premium payments received at year-end to determine if the revenue was recorded in the correct fiscal year.

- Cash Management—tested a nonstatistical sample of drawdowns to determine compliance with the Cash Management Improvement Act (between the state and the U. S. Department of the Treasury).
- Reporting—determined if selected accounting data were properly reported to the federal grantor.

EDP General Controls

- Reviewed the organizational structure and lines of authority to determine if responsibilities were clearly assigned and functions were segregated.
- Examined reports of system user privileges and verified that passwords were changed regularly to control access to the system.
- Documented program change control procedures and tested program changes to determine if changes were made with management's knowledge and approval.

EDP Application Controls

- Tested protection established to control access to TennCare data sets.
- Documented the enrollment process and any controls present to ensure proper processing.
- Obtained evidence of periodic matching of state and federal insurance data with TennCare data to determine if an enrollee had other insurance.
- Determined and documented procedures for bypassing/overriding enrollment controls, and documented the manual enrollment process.
- Documented with evidence the payment process for capitation, nursing home, and Medicaid payments.
- Documented with evidence the payment process for payments to the Department of Children's Services and the Department of Mental Health and Mental Retardation.
- Documented procedures for pending claims and third-party liability.
- Documented controls over accuracy of premium billings and the complete and correct posting of payments to accounts.
- Documented the status and progress of obtaining and entering encounter data health care providers are required to provide.

- Examined and tested controls over and features of the TennCare security system.
- Used paid claims data to create a list of all claim types encountered and a list of all providers that received capitation payments. Determined if there were invalid data in the data fields selected.
- Used paid claims data to determine if any denied claims had been paid an amount not equal to zero, if there were invalid recipient social security numbers, and if any claims crossed over a month-end or year-end or had an end-of-month date that was not valid.
- Prepared and analyzed schedules showing the number of paid claims by claim type for each month of the fiscal year and the amount paid by claim type for each month.

The findings that resulted from our audit of the TennCare program follow. In addition to the findings, other minor weaknesses came to our attention which have been reported to management in a separate letter.

1. TennCare eligibility verification procedures were not adequate

Finding

The two prior audits of the Bureau of TennCare noted that in many cases, the eligibility of TennCare participants who are classified as uninsured or uninsurable had not been verified. Management concurred with the prior finding, stating that new procedures and major changes had been implemented. However, based on the results of this year's audit, verification procedures did not adequately ensure all TennCare participants were eligible.

Apparently, little effort has been made this fiscal year to follow up and analyze the data from the bureau's May 1996 survey of 87,000 enrollees. As a result of the survey, approximately 50,000 participants were disenrolled between August 28 and October 21, 1996. However, information concerning the bureau's actions in regard to the remaining 37,000 enrollees was unavailable at June 30, 1997.

In addition, TennCare does not systematically reverify eligibility information. At present, reverification appears random. Some enrollees' eligibility is updated as part of various activities such as data matches with the state insurance system or information obtained from the managed care organizations, the TennCare hotline, and the TennCare grievance unit. However, these methods do not ensure that the eligibility of the entire uninsured and uninsurable enrollee population is updated or that the updates are performed timely and completely. Without systematic and timely review of eligibility information, there is no assurance that current information is used to determine how many enrollees are still eligible for TennCare.

Additionally, using computer-assisted audit techniques (CAATs) to search the TennCare Management Information System (TCMIS), auditors found several thousand TennCare partici-

pants had fake or "pseudo" social security numbers, e.g., numbers that began with 8 or had all zeros in one field. According to TennCare personnel, some applicants who do not have their social security cards and newborn children who have not yet been issued social security numbers are assigned these "pseudo" numbers.

According to the *Code of Federal Regulations*, Title 42, Section 435.910, the state agency must require, as a condition of eligibility, that those requesting services (including children) provide their social security numbers. Additionally, Section 3(g) of the code states that the agency "must verify the social security number of each applicant and recipient with the Social Security Administration, as prescribed by the Commissioner, to insure that each social security number furnished was issued to that individual, and to determine whether any others were issued." The pseudo social security numbers for 15 of 19 individuals tested (79%) had not been updated to a correct social security number, and nine of these individuals had been enrolled for over three years.

Adequate verification procedures are needed to ensure that only those eligible are enrolled in TennCare. The average amount paid to a managed care organization per month for each participant is \$110. In fiscal year 1997, TennCare paid \$1,456,154,507 to managed care organizations for uninsured and uninsurable enrollees. Annual reverification is also necessary to obtain current, accurate information about family size, income, and access to other medical insurance. This information is needed to determine whether participants previously considered eligible have become ineligible because of changes in their family or personal circumstances. Also, this information is used to determine the correct premium and deductible amounts paid by participants. TennCare's inadequate verification procedures will be reported as a material internal control weakness in the 1997 Tennessee Single Audit Report.

Recommendation

The Assistant Commissioner for TennCare should ensure that verification procedures are adequate and fully implemented. To evaluate the effectiveness of the procedures, reports detailing verification results should be produced regularly and reviewed for content and accuracy. Appropriate steps should be taken in response to the results of those reports. If reports are not made timely, the reason for the delay should be determined and corrected.

Management's Comment

We concur. However, the results of the May 1996 survey were analyzed by the TennCare staff which initiated the termination of approximately 50,000 enrollees. Many of these enrollees were reinstated upon TennCare's receiving the appropriate enrollee information. No action was required on the remaining 30,000 enrollees because the requested survey response was received by TennCare. We apologize for the miscommunication on this issue.

Also relative to the eligibility verification, TennCare did implement the face-to-face enrollment and verification process in April 1997 when TennCare opened enrollment for children without insurance. This method of enrollment provides timely enrollment as eligibility information for the enrollee is confirmed onsite.

In June 1998, testing for face-to-face reverification for uninsured/uninsurables including all children and dislocated workers, was implemented in Middle Tennessee counties. In July 1998, implementation for uninsured/uninsurables is anticipated to begin statewide for this population.

In regard to enrollees with pseudo social security numbers, we do acknowledge that some enrollees may at some period in their enrollment history have a pseudo number for the reasons described in the finding. This is due to the state's wish to provide needed care to children as soon as possible. The reverification project described above will help ensure that valid numbers are obtained for enrollees when available and measures can be taken to contact the enrollee at a later date to obtain a social security number when the number is not available upon birth or enrollment. It should be noted that the eligibility determination of children is based on information from the parents or head of household, not the child. Therefore a child with a pseudo social security number does not necessarily inhibit TennCare from making a correct determination of eligibility.

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

Finding

TennCare has not monitored the Department of Children's Services (Children's Services) to ensure the accuracy and allowability of billings from that department. During the year ended June 30, 1997, TennCare paid approximately \$100.8 million in fee-for-service reimbursement claims to Children's Services. TennCare's failure to ensure Children's Services complied with all federal laws, regulations, and guidelines will be reported as a material internal control weakness in the 1997 Tennessee Single Audit report.

In accordance with its agreement with the bureau, Children's Services contracts separately with various practitioners and entities ("service providers") to provide health care benefits not provided by the managed care organizations (MCOs) and the behavioral health organizations (BHOs) under contract with TennCare. Children's Services pays these providers and bills TennCare for reimbursement.

TennCare has relied on Children's Services to ensure the following:

- Only services allowable under the grant are billed.
- The amounts billed are correct and allowable.

- The expenditures are valid and properly supported.
- Only eligible, licensed, or certified providers are providing the services.

Although TennCare relies on Children's Services to ensure compliance, the bureau does not monitor Children's Services.

This reliance includes not establishing predetermined, preapproved payment rates in the TennCare Management Information System (TCMIS), TennCare's claims processing and payment system, for all of the claims billed by Children's Services. When no rate is established in TCMIS, the system is programmed to pay any amount billed by Children's Services, without limit.

Similarly, Children's Services claims are not reviewed or tested by TennCare's internal auditors, other bureau personnel, or the Department of Finance and Administration's Division of Research and Support. Because the bureau had not monitored Children's Services' practices, TennCare was unaware that Children's Services was billing for the health care costs of incarcerated children who are not eligible for Medicaid (TennCare). See finding 3 for more details.

The TennCare Bureau had only to review the audit reports on the Department of Children's Services to note serious compliance and internal control problems. For the past three fiscal years, the audit reports on Children's Services have contained numerous findings, many of them repeated from year to year. Although the testwork at Children's Services did not always include TennCare transactions, the general lack of internal control presents an unacceptable level of risk for TennCare transactions. The deficiencies listed below highlight this risk:

- Duplicate payments and overpayments were made to providers.
- Invoices did not contain certification that services had been provided.
- Invoices were not properly approved for payment.
- Documentation was not sufficient to verify the allowability of payments.
- Controls are insufficient to prevent unauthorized changes to the system used to process payments.
- Reimbursement requests for federal dollars are not made in a timely manner.

Recommendation

The Assistant Commissioner for TennCare should establish a monitoring program to ensure billings from the Department of Children's Services comply with grant requirements before

paying the claims. The Assistant Commissioner also should ensure the Department of Children's Services properly administers TennCare funds.

Management's Comment

We concur. The Department of Children's Services does have a contractual agreement with the Department of Finance and Administration to provide fiscal monitoring and programmatic review which includes their providers or subgrantees. We will contact this agency to provide input as to future Children's Services provider reviews and obtain the results of these reviews in identifying areas of weakness. We will also work with the Department of Children's Services to provide a reasonable assurance that claims billed to TennCare are in compliance with applicable laws and regulations.

3. TennCare failed to identify incarcerated youth and thus improperly used federal funds to pay their health care costs

Finding

Because TennCare failed to identify incarcerated youth enrolled in the program, even though there are procedures to identify incarcerated adults, TennCare improperly paid for the health care costs of youth in the state's developmental centers. Under federal regulations (*Code of Federal Regulations*, Title 42, Section 435, Subsections 1008 and 1009), the state, not the federal government, is responsible for the health care costs of juvenile and adult inmates.

A sample of 32 juveniles in the youth development centers revealed that TennCare made payments totaling \$22,383.88 from July 1, 1996, to June 30, 1997, for 30 of the juveniles (94%). Of this amount, \$17,489.30 was paid to managed care organizations (MCOs); \$2,846.75 was paid to behavioral health organizations (BHOs); and \$2,047.83, to the Department of Children's Services (Children's Services). The federal financial participation was \$14,182 for these 30 juveniles.

TennCare contracts with Children's Services to determine the eligibility of children under its care and presumably to notify TennCare when these children are no longer eligible. However, Children's Services does not notify TennCare when previously eligible youth are incarcerated. Since the bureau has no procedures, such as data matching, to check for such an eventuality, it was unaware juvenile inmates were on the TennCare rolls.

According to the audit of the Department of Children's Services, the department billed TennCare for all medical expenditures incurred on behalf of children in locked facilities. Although the exact amount of unallowable medical expenditures billed to TennCare was not available, it appears that the amount does not exceed the approximately \$673,000 in "non-contract" medical expenditures billed during the audit period. Children's Services is working to determine the exact

amount of unallowable costs to be returned to TennCare. (See finding 2 for more information about the reimbursement claims from Children's Services.)

The payments to the MCOs and BHOs were monthly capitation payments—payments to managed care organizations and behavior health organizations to cover TennCare enrollees in their plans. Since the bureau was not aware of the ineligible status of the children in the youth development centers, TennCare incorrectly made capitation payments to the MCOs and BHOs on their behalf. Although we did not determine the exact amount of total unallowable capitation payments for fiscal year 1997, we estimate that the federal portion is approximately \$742,000.

All known and estimated errors will be included on the Schedule of Findings and Questioned Costs in the Single Audit report for the year ended June 30, 1997.

Recommendation

The Assistant Commissioner for TennCare should ensure the bureau develops and implements the procedures necessary to ensure federal funds are not used to pay for the health care costs of incarcerated juveniles.

Management's Comment

We concur. We will work with the Department of Children's Services to determine how they will ensure that procedures exist to prevent the billing of services provided incarcerated youth to the TennCare program. Procedures will also be developed to periodically review the TennCare enrollment for the appearance of incarcerated youth as well as address the procedures being used by the Department of Children's Services to ensure that only those eligible children appear on the TennCare enrollment.

4. Because of uncollected cost settlements, TennCare has remitted 13.3 million in state dollars to the federal government

Finding

As noted in the prior audit, because TennCare has failed to collect Medicaid cost settlements from providers, state dollars have been used to pay the federal portion of the cost settlements. (A cost settlement due the state can occur if the annual review of a provider's cost report discloses that the cost of services or charges for services were less than the payments the provider received.) The federal grantor, the Health Care Financing Administration (HCFA), requires the state to remit the federal share (approximately two-thirds) within 60 days of settlement, whether or not the state has collected the amounts due from the providers.

Although management concurred with the prior finding and stated that staff “has aggressively pursued reducing the outstanding cost settlement balances,” the problem still exists. Specifically, management stated that the balance of cost settlements over 60 days late at June 30, 1997, was \$17.4 million. However, at December 31, 1997, the balance had increased to approximately \$20 million.

Two hospitals had the largest overdue cost settlement balances at December 31, 1997—Regional Medical Center at Memphis (\$8,349,460) and George W. Hubbard Hospital of Meharry College in Nashville (\$3,009,357). Management is uncertain whether the Regional Medical Center at Memphis has the resources to pay its cost settlements and indicated that the hospital has questioned various aspects of its settlements. Also according to bureau personnel, legal questions about Hubbard Hospital’s current operating status have impeded collection.

In response to the prior report, management stated that it was exploring the possibility of working with HCFA to attach Medicare provider payments. The department, however, has been reluctant to ask Medicare to withhold any payments until the two financial information systems containing provider balances—the TennCare Information Management System (TCMIS) and the Medicaid Accounts Receivable Recoupment System—can be reconciled. (This matter is discussed further in finding 5.)

Management stated that it was also exploring having the Department of Finance and Administration use STARS to withhold other departments’ and agencies’ payments to providers. Section, 9-4-604, *Tennessee Code Annotated*, provides authority for this procedure:

No person shall draw any money from the public treasury until all debts, dues, and demands owing by such person to the state are first liquidated and paid off. The commissioner of finance and administration shall not issue any warrants upon the treasury in favor of a person in default until all of such person’s arrearages to the treasury are audited and paid.

As of December 31, 1997, TennCare had requested that the Department of Finance and Administration withhold payments to only one provider, collecting \$4,700. Considering the approximately \$20 million owed, TennCare’s failure to pursue this avenue more aggressively appears incomprehensible and contrary to statute.

It is in the state’s best interest to resolve the cost settlement accounts receivable as quickly as possible through collection or write-off after all other efforts have been exhausted. Using state funds to remit the providers’ share to HCFA deprives the state of the use of these funds. If the state determines that some of the accounts are uncollectible and the accounts are written off, the state may, in certain cases, recover what has already been remitted to HCFA.

Recommendation

To recover the state funds that have been remitted to the federal grantor, the Assistant Commissioner and the Fiscal Director for the TennCare Bureau should ensure that all outstanding cost settlements are collected or written off in a timely manner. Management should take immediate measures to resolve any questions concerning the amounts owed and each provider's ability to pay. If necessary, assistance from the Office of the Attorney General should be obtained. The Fiscal Director should contact the Department of Finance and Administration about withholding additional payments through STARS. Management should also discuss with HCFA any accounts that appear uncollectible to determine whether TennCare can receive a credit or a refund from HCFA for the funds previously remitted.

Management's Comment

We concur. However, since the inception of TennCare, the TennCare staff has aggressively pursued reducing the outstanding cost settlement balances through additional billing correspondence, legal assistance, and other available offsets. After following the appropriate procedures, TennCare has written off those accounts determined uncollectible, including when a provider has filed bankruptcy and the court has upheld the bankruptcy. Four providers have been referred to Medicare, and we will continue to pursue Medicare where possible. We have been selective about these referrals to Medicare due to the reconciling issue between the recoupment system and TCMIS. We will, however, continue to pursue the collections from Medicare, legal actions, write-offs, or other options that might be available to reduce the outstanding balances.

The process previously addressed has reduced the balances outstanding at June 30, 1997, from \$17.4 million to \$6.9 million as of March 31, 1998. The additional outstanding balance of \$13 million at March 31, 1998, is the result of new cost settlements received subsequent to July 1, 1997. As of June 9, 1998, the total outstanding balances over 181 days old was \$13.1 million.

5. TennCare's Medicaid Accounts Receivable Recoupment System is an impediment to the collection of cost settlements and accurate federal financial reporting

Finding

The Medicaid Accounts Receivable Recoupment System (Recoupment System) is adversely affecting collection of provider cost settlements and federal financial reporting. This system, a database created many years ago to track and age Medicaid program receivables (including provider cost settlement receivables), should not be relied on because it contains old, inaccurate information.

Although aware of the system's unreliability, TennCare still uses the system to determine the amount of overpayment adjustments (reductions in expenditures claimed because of overpayments) reported on quarterly federal expenditure reports to the Health Care Financing Administration (HCFA). However, management is concerned enough about the system's reliability to delay requests to Medicare to withhold provider payments until the cost settlement balances can be researched and analyzed in detail using the TennCare Management Information System (TCMIS). (See finding 4 for more information about working with Medicare to collect provider cost settlements.)

When TennCare management began to compare provider balances on the Recoupment System with those on TCMIS, the more reliable system, discrepancies were noted creating uncertainty about the exact amounts some providers owe TennCare for cost settlements. Because of the complexity of TCMIS and the many transactions it processes daily (e.g., new and voided claims, retroactive rate adjustments), management had been reluctant until recently to undertake the time-consuming task of reconciling provider balances on the two systems. Had the balances on the two systems been reconciled periodically over time, TennCare would not now be having such difficulty.

Accurate financial information is essential to effectively manage the fiscal operations of TennCare. When financial information and the systems used to compile the information are unreliable, management cannot make sound financial decisions, take appropriate action, and ensure the accuracy of federal financial reporting.

Recommendation

To facilitate effective program financial management, including collection of accounts receivable, the Fiscal Director should take the necessary measures to ensure the provider balances on the TennCare Management Information System and the Medicaid Accounts Receivable Recoupment System are reconciled at least quarterly. Management should focus first on the most significant balances.

Management's Comment

We concur. TennCare staff have taken steps to identify and reconcile balances between TCMIS and the recoupment system. (See response to finding number 4.) As a result of improving our collections process, timely updates and reconciliations of our accounts receivable systems should be achieved; however, the updates to the recoupment system are still manual. We are also pursuing obtaining aged accounts receivable data through TCMIS. Once this is achieved, we will no longer need the recoupment system.

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

Finding

TennCare does not have a coordinated program for ADP (automated data processing) risk analysis and security system review of the TennCare Management Information System (TCMIS). Although the bureau has a system administrator in charge of passwords and terminal access, the bureau has apparently relied on the Office for Information Resources to oversee the security of the system. There is no documentation, however, to substantiate any review of the system.

According to Office of Management and Budget (OMB) Circular A-133 and the *Code of Federal Regulations*, Title 45, Subtitle A Section 95.621, 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 (HHS) programs. TCMIS can be categorized as such an operating system and is one of the largest in the state.

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

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

- Physical security of ADP resources
- Equipment security to protect equipment from theft and unauthorized use
- Software and data security
- Telecommunications security
- Personnel security
- Contingency plans to meet critical processing needs in the event of short- or long-term interruption of service
- Emergency preparedness
- Designation of an agency ADP security manager

Recommendation

The Assistant Commissioner for TennCare should assign the Director of Information Services specific responsibility for the development and implementation of procedures for ADP

risk analysis and system security reviews. The Commissioner should monitor the procedures implemented and ensure the appropriate actions have been taken.

Management's Comment

We concur. However, TCMIS has been reviewed by the Health Care Financing Administration (HCFA) since the implementation of TennCare, and this issue was not raised as a concern. We are in the process of obtaining guidance from HCFA regarding their expectations from states of this regulation and will take steps to comply. Also, TCMIS is included in the Office for Information Resources' disaster recovery plan and security controls.

7. TCMIS processing of Medicare professional cross-over claims needs improvement

Finding

There are several control weaknesses in the processing of Medicare professional cross-over claims (claims paid partially by both Medicare and Medicaid). The TennCare Management Information System (TCMIS) used to process these claims has not been modified and updated as needed to ensure claims are paid in compliance with state and federal laws and regulations.

- Responsibility for determining which medical procedure codes and payment rates should be used to update the TCMIS had been assigned to a system analyst in the Information Services division. Because of a lack of expertise in this area, the system analyst has made decisions about the codes and rates, based on assumptions which may or may not be correct. Prior to TennCare, Medicaid policy division personnel were responsible for analyzing the procedure codes and rates.
- Payment rates from Medicare effective January 1, 1996, were not updated until May 1997 because management did not assign this responsibility to staff during 1996. The rate update effective January 1, 1997, was also not performed until May 1997.
- Because certain procedure codes were entered into TCMIS in 1996 without rates, some claims were paid as billed (in full), and cost savings were not maximized.
- According to bureau personnel, claims may have been incorrectly denied because of the delay in updating the 1997 procedure codes, and TennCare did not reprocess the affected claims.
- Although 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). However, TCMIS had not been updated to detect third-party resources on these cross-over claims. It is highly likely that for years TennCare has paid claims that should have been denied because other insurance was available.

- Despite the complex nature of the claims processing, bureau staff do not routinely perform manual pricing tests to determine if the system is paying claims properly. Rather, according to bureau personnel, TennCare relies on providers to notify the bureau if claims are not paid properly.
- TennCare's fee-for-service claims pricing manual has not been updated.

Recommendation

The Assistant Commissioner for TennCare should ensure job responsibilities are assigned only to those individuals with the necessary knowledge, training, and experience. Management and staff should keep abreast of new and changing program requirements and should ensure the bureau's policies, procedures, and computer system are updated timely to reflect new developments. The Assistant Commissioner should ensure that the claims pricing and payment subsystem of the TCMIS is tested routinely by knowledgeable staff personnel, and that problems noted are documented and corrected timely. The director of the policy division should ensure that the claims pricing and payment manual is revised and updated to reflect changes in the law and grant guidelines.

Management's Comment

We concur. Periodically we will review policies, procedures, and computer systems in order to make necessary modifications. The claims pricing and payment manual will also be reviewed for any indicated revisions and will be updated to reflect changes in the law and grant guidelines.

8. TennCare used memorandums of understanding to disburse payments to medical schools

Finding

TennCare did not use an appropriate type of agreement for graduate medical education (GME) payments. Instead of abiding by the Rules of the Department of Finance and Administration, Chapter 0620-3-3, "Personal Service, Professional Service, and Consultant Service

Contracts,” and establishing multi-year grant contracts, TennCare entered into memorandums of understanding.

In June 1996, the Health Care Financing Administration (HCFA) approved TennCare’s five-year plan for determining and disbursing graduate medical education (GME) payments to the four medical schools in the state—East Tennessee State University, the University of Tennessee at Memphis, Meharry Medical College, and Vanderbilt University. The approved plan was for payments each fiscal year from July 1, 1995, through June 30, 2000. Subject to the availability of state and federal funding, total annual GME expenditures are expected to range from \$48 million for fiscal year June 30, 1996, and fiscal year June 30, 1997, to \$53,566,000 for fiscal year June 30, 2000.

According to information from the Office of Contracts Administration, Department of Finance and Administration, the type of agreement under which TennCare disbursed these funds was not an acceptable mechanism. The appropriate mechanism would have been multi-year grant contracts. These contracts are developed to safeguard the interests of the department and the state, ensure compliance, and effectively communicate the rights, responsibilities, and obligations of all parties.

In addition, the MOUs (and amendments) were not signed by the Comptroller of the Treasury, as required by *Tennessee Code Annotated*, Section 12-4-110 paragraph (a)(1): “Contracts calling for expenditures from appropriations of more than one (1) fiscal year must also be approved by the comptroller of the treasury.” These agreements were, however, signed by the Commissioner of Finance and Administration.

Recommendation

The Assistant Commissioner should comply with all state laws and rules for contracts. Each school’s memorandum of understanding (MOU) should be replaced with a multi-year grant contract signed by all parties and approved by the Commissioner of Finance and Administration and the Comptroller of the Treasury.

Management’s Comment

We concur. The current memorandums of understanding expire in December 1998. These agreements with the four universities will be continued via state contracts in compliance with all state laws and rules for contracts.

9. Controls over manual checks need strengthening

Finding

As noted in the prior two audits and despite management's concurrence with the findings, the TennCare Bureau needs to continue to improve controls over manually prepared checks. In fiscal year 1997, these checks totaled approximately \$193 million.

Delayed Reporting

Most checks, such as payments to nursing homes, are generated through TCMIS each Friday. However, the bureau bypasses the system and prepares checks manually when immediate payment is needed

Because TCMIS is not linked with the State of Tennessee Accounting and Reporting System (STARS), TennCare fiscal staff must key accounting information into STARS based on TCMIS reports. Manually prepared checks, however, are not reflected in TCMIS reports for up to two weeks. In April 1996, TennCare's fiscal agent began to notify TennCare fiscal staff and the Department of the Treasury by memorandum of any manual checks issued. The success of this effort to improve controls was hampered because the TennCare fiscal unit was not located in the TennCare building with the fiscal agent and other program staff until February 1997.

If the fiscal agent does not promptly notify TennCare of manually prepared checks, they may not be recorded in STARS timely. This delay does not, however, affect the timeliness of drawdowns because TennCare may draw federal funds before expenditures are recorded in STARS.

Poor Segregation of Duties

The fiscal agent assigned responsibility for preparing these checks did not sufficiently segregate manual check-preparation duties. During the audit period, one employee had access to both the manual check stock and the signature stamp and could have controlled the process from beginning to end and issued a check for unauthorized purposes.

The only compensating control used was a reconciliation of checks issued and cleared each month. This reconciliation involves records from the Department of the Treasury, the Department of Finance and Administration's Division of Accounts, and TennCare. This reconciliation ensures that TennCare's and Treasury's records of checks issued and cleared correspond to STARS. However, the reconciliations were not completed in a timely manner. As of December 1997, reconciliations had been performed only through May 1997.

An additional compensating control would be daily reconciliations of all checks issued with payments in the Department of the Treasury's Account Reconciliation Package (ARP) system. As a result of a prior finding, the Department of the Treasury provides the fiscal agent

daily reports to assist in this reconciliation. However, neither the TennCare Bureau nor the fiscal agent uses these reports.

Effective internal controls require that no one person have the ability to control the entire check-issuance process and that reconciliations of accounting records with bank activity be timely.

Recommendation

The Assistant Commissioner for TennCare should seriously consider either using the automated clearing house process to make all payments to MCOs and providers or using STARS to issue checks outside of normal TCMIS processing to ensure that expenditures are recorded timely and that transactions are approved by management. Checks processed through STARS are available overnight, and the Director of Accounts has the ability to issue manual checks if needed immediately. The Assistant Commissioner for TennCare should consult with officials in the Department of Finance and Administration to determine which method is preferable.

If management decides to continue to issue manual checks, the Assistant Commissioner for TennCare should ensure duties are adequately segregated. In addition, each month, the Department of the Treasury, the Division of Accounts, and TennCare should reconcile checks issued and cleared with Account Reconciliation Package (ARP), STARS, and TCMIS records. The TennCare Bureau should reconcile all checks issued with payments in the Department of the Treasury's ARP system daily.

Management's Comment

We concur. We will contact the Department of Finance and Administration and discuss either using the automated clearing house to make payments or using STARS to issue checks outside of TCMIS. The access to checks has been limited, and the signature stamp has been segregated. We will monitor these duties to ensure they remain adequately segregated. We continue to work with the Department of the Treasury and the Division of Accounts in the reconciliation of checks issued.

10. TennCare should seek clarification of grant requirements

Finding

As noted in the prior audit, modifications to TennCare's grant requirements are often necessary because TennCare is a relatively new approach to Medicaid for both the state and the Health Care Financing Administration (HCFA). However, the intent of some requirements

becomes unclear with the changes. The payment rates for certain psychiatric services is one such case.

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

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

Without seeking guidance from HCFA, TennCare interpreted this waiver as allowing the state to continue to adjust for inflation SPMI and Department of Children's Services (Children's Services) rates for psychiatric hospitals and community mental health centers as it had done under Medicaid. During fiscal year 1995, TennCare also adjusted these rates to cover additional costs, such as capitalization of fixed assets and property taxes, and enhanced the rates by a Medicaid "disproportionate share factor" to help cover hospital charity costs. Prior to TennCare, these costs and the disproportionate share factor were not a part of the rates.

On July 1, 1996, TennCare implemented the TennCare Partners Program to provide mental health services in a managed care setting and discontinued fee-for-service payments for SPMI. Children's Services, however, continues to be paid with adjusted rates on a fee-for-service basis.

Although management agreed that all policies and programs and resulting payments should comply with grant requirements, management has not obtained documentation from HCFA regarding its position on the adjusted rates. If HCFA does not agree with TennCare's interpretation, the state could be required to return the additional payments to HCFA plus interest and penalties.

Recommendation

The Assistant Commissioner for TennCare should contact HCFA to determine whether the adjusted rates are allowable. The Assistant Commissioner should also ensure that all policies or programs and resulting payments comply with grant requirements. If these requirements are unclear or if a substantial change is made, TennCare should seek guidance from the grantor before implementing the change.

Management's Comment

We concur. We will contact the appropriate HCFA representatives and obtain clarification of this issue.

11. **TennCare does not verify or update cross-over and nursing home provider enrollment application information and does not monitor the Department of Children's Services to ensure the eligibility of its TennCare providers**

Finding

TennCare has not established procedures for the verification of provider information upon enrollment nor procedures for updating provider files. To enroll in TennCare, "cross-over" providers (professional and institutional medical providers paid first by Medicare) and nursing homes are only required to complete a short application, which requires basic information such as name, address, practicing address, and license number. TennCare personnel stated that there is no need to verify this information since most providers are already participants in the Medicare program.

Through the department's Health Related Boards, TennCare can determine if the provider is licensed and otherwise eligible for participation in the program before any payments are made. Although TennCare receives provider termination information from Medicare, this information does not go directly to TennCare and may not arrive in time to stop payments to the provider. When TennCare learns that a provider is ineligible, steps are taken to recoup any payments. However, the recoupment process would be unnecessary if provider information were verified before enrollment.

In addition, TennCare has not monitored to ensure the service providers used by the Department of Children's Services (Children's Services) are eligible to participate in the TennCare (Medicaid) program. Children's Services contracts with these providers for therapeutic services for the children under its supervision, even though TennCare ultimately pays for these services. See finding 2 for more information about Children's Services' service providers and billings to TennCare.

According to the Rules of the Tennessee Department of Health, section 1200-13-12-.08, "Bureau of TennCare," participation in the TennCare program is limited to providers who "maintain Tennessee...medical licenses and/or certifications as required by their practice, or licensure by the Tennessee Department of Mental Health and Mental Retardation." The rules go on to state that participation is limited to providers that "are not under a Federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification." Additionally, Office of Management and Budget (OMB) Circular A-133 requires that the state

plan “specify criteria for determination of validity of disbursed payments” and that the state ensure payments “are disbursed only to eligible providers.”

Recommendation

The Assistant Commissioner for TennCare and the Director of Operations should develop verification and update procedures for all provider information and assign the implementation of such procedures to the TennCare Provider Enrollment staff. The Assistant Commissioner should monitor the Department of Children’s Services to ensure all service providers are eligible to participate in the program. The Assistant Commissioner should ensure that the information is verified, updated, and maintained by either Children’s Services or the TennCare Provider Enrollment staff.

Management’s Comment

We concur. In general, TennCare has relied on Medicare for the verification of provider eligibility information for cross-over and nursing home providers and the Department of Children’s Services for providers for children in state custody. Medicare’s resources for verification are extensive, and we believe this process is sufficient for complying with our rules. There are, however, some providers that do not enroll in Medicare. For these providers, we agree that greater verification of eligibility needs to occur. It is our understanding that within a few weeks, information regarding licensure of all medical professionals will be available on the Internet. Access to this information should allow for verification of provider eligibility for all future providers requesting to enroll in the program. This should also allow for periodic review of disciplinary actions. We will also review with the Department of Children’s Services their providers verification and address any weaknesses that are revealed.

12. TennCare’s computer system does not prevent overpayments to certain providers

Finding

As noted in the prior audit, because TennCare has not complied with departmental rules, providers caring for enrollees who are both TennCare and Medicare recipients are sometimes overpaid. Management concurred with the prior finding, and stated that the rules would be reviewed and revised as determined necessary to agree with the bureau’s current operating procedures. However, no changes have been made.

Medicare recipients are required to pay coinsurance and a deductible to the provider for services they receive. If the patient is also eligible for Medicaid, Medicare bills TennCare instead of the patient for the coinsurance and deductible. According to departmental rules, the total

amount paid by all parties (Medicare, patient, and TennCare) cannot exceed the fee limitations set by TennCare. However, TennCare's computer system always pays the entire deductible billed for outpatient hospitalization services regardless of how much Medicare or the patient paid or any limitations set by the Medicaid fee schedule.

Recommendation

The Assistant Commissioner for TennCare should ensure that the Director of Information Services makes the necessary changes to the TennCare Management Information System to bring the method of payment into compliance with departmental rules or have the rules amended.

Management's Comment

We concur. We will examine whether it is more appropriate to change the rules or our method of payment.

13. TennCare has failed to follow its own rules and has failed to revise its rules

Finding

As noted in the prior audit, the Bureau of TennCare has ignored several of the departmental rules it created or has acted before rules were developed. Among the reasons cited for bypassing the rules were that some of the rules were out-of-date and no longer addressed the situation and that adherence to some of the rules was not feasible. Management concurred with the prior finding and stated that the rules would be reviewed and revised as determined necessary. However, little or no progress has been made.

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

- As noted in the prior finding, the bureau did not comply with Rule 1200-13-12-.08(10) pertaining to the Reserve Fund Pool. The rule states that encounter data, such as enrollee and procedure performed, from managed care organizations will be used to determine which providers will receive incentive payments and how much those payments will be. Because these data had not been refined and were therefore

unavailable, the bureau used an alternative method. Since the prior finding, no payments have been made from this pool.

- Even though the bureau has contracted to make adverse selection payments to those managed care organizations with a disproportionate share of enrollees requiring extensive health services, and has made \$115 million in such payments, the bureau has not established rules concerning these types of payments. The contracts, which obligate the state to pay up to \$55 million annually, do not specifically describe how the payments will be calculated; they only state that the payments will be made using a formula developed by TennCare and approved by the Health Care Financing Administration.
- The bureau is paying some providers more than is allowed by departmental rules. The method used to calculate outpatient hospitalization payments to providers caring for enrollees who are both TennCare and Medicare recipients sometimes results in payments that exceed limits. (See finding 12 for more details.)
- The bureau has not revised its rules to include changes in the method it uses to determine payments to medical schools for graduate medical education.
- The rules pertaining to the Home and Community Based Services waiver program have not been revised to reflect changes in the program. For example, TennCare no longer pays provider claims based on a per diem rate.

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

Recommendation

The Assistant Commissioner should exhibit a strong commitment to the importance of up-to-date rules and the necessity of complying with rules. TennCare management and staff should comply with the bureau's rules, and the Assistant Commissioner should take appropriate measures including a system for monitoring relevant program changes to ensure that the rules are revised to remain current.

Management's Comment

We concur. TennCare is finalizing recommended changes to departmental rules. TennCare division directors have made recommendations relative to changes deemed necessary. Appropriate rule changes are now in process.

14. Medicaid refunds were not returned to the federal grantor promptly

Finding

As noted in the three prior audits, TennCare has not promptly used the amounts recovered from third parties to reduce federal drawdowns. Management concurred with the prior audit findings and stated:

Since the TennCare fiscal staff has now moved to the same location as the program operations, perhaps this timeline will become less significant. Also, beginning July 1, 1997, the certification of deposit will be completed and keyed by the TennCare fiscal staff which will eliminate the delay caused by the deposit being performed at another location.

Although the timeline for entering refund information into STARS has significantly decreased, the timeliness of remittances to HCFA has not improved. Based on reports provided by the department, refunds totaling \$13,462,533.78 were deposited in fiscal year 1997. Our review of \$8,159,430.02 of refund deposits disclosed that \$2,750,812.87 was not remitted to HCFA in a timely manner. Occasionally, refunds were delayed up to three weeks before remittance to HCFA.

The timeliness of remittances to HCFA involves two components: TennCare's prompt keying of information into STARS and the Division of Accounts' (within the Department of Finance and Administration) prompt approval to process the transactions. Frequently, however, the Division of Accounts is not aware of the nature and priority of the transactions.

The Cash Management Improvement Act Agreement holds the state liable for interest on refunds from the date the refund is credited to a state account until the date the refund is subtracted from drawdowns. Both TennCare and Department of Finance and Administration personnel indicated that the interest is properly remitted. However, timely remittance to HCFA would reduce and possibly eliminate these interest payments.

Recommendation

The Assistant Commissioner for TennCare should ensure refunds are promptly entered into STARS and forwarded to the Department of Finance and Administration. TennCare staff should communicate the priority of processing these refund transactions and monitor them until drawdowns are reduced. Both TennCare and the department should coordinate efforts to ensure timely remittance to HCFA.

Management's Comments

Department of Health, Bureau of TennCare:

We concur. We will continue to work with the Department of Finance and Administration to further improve the timely processing of refund transactions that affect the federal draw of funds.

Department of Finance and Administration:

The Department of Finance and Administration concurs. Staff at the Department of Finance and Administration have spoken with fiscal staff at TennCare to ensure that HCFA remittances are properly identified and prompt approval and processing occurs.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

To address the objectives of the CAFR and the Single Audit, as they pertain to this major federal financial assistance program, we interviewed key department employees, reviewed applicable policies and procedures, and tested representative samples of transactions. Our specific objectives were to determine whether

- program participants were eligible for services,
- federal funds were spent only for allowable purposes,
- the department complied with the one-to-one WIC voucher reconciliation requirement, and
- the department adequately monitored local WIC agencies and authorized WIC food vendors.

We found that the department did not adequately reconcile WIC vouchers and did not have follow-up procedures in place to ensure this federal requirement was met. In addition to the finding, other minor weaknesses came to our attention which have been reported to management in a separate letter.

Furthermore, on July 1, 1997, the department notified our office of the suspected theft of approximately \$11,000 in WIC vouchers from the Southland Mall Clinic in Memphis by a former administrative technician. To address this allegation, we interviewed relevant staff of the Southland Mall Clinic and the Memphis/Shelby County Health Department. Cashiers at seven food markets in Shelby County were also interviewed along with an acquaintance of the former technician. We reviewed the preliminary work performed by the department's internal audit staff,

vouchers issued during the employment of the former technician, and reports issued by the department regarding vouchers redeemed but unmatched to valid issuances in the system. Our specific objectives of this review were to determine

- the nature and extent of any impropriety relating to the suspected theft and subsequent redemption of WIC vouchers;
- to examine the internal controls over the custody and issuance of vouchers from the clinic;
- to recommend appropriate actions to correct any deficiencies; and
- to report our findings to the proper authorities through this audit report and a subsequent special report.

15. **The department's WIC voucher reconciliation procedures are inadequate**

Finding

Although the Department of Health's one-to-one reconciliation rate for WIC vouchers met federal requirements, the department's inadequate reconciliation procedures contributed to thefts of WIC vouchers.

Federal WIC regulations require the state agency to reconcile vouchers with issuance records. The *Code of Federal Regulations*, Title 7, Section 246.12(n), states:

The State agency shall identify disposition of all food instruments as: Validly redeemed, lost or stolen, expired, duplicate, voided or not matching issuance records. Reconciliation of food instruments shall entail reconciliation of each food instrument issued with food instruments redeemed and adjustment of previously reported financial obligations to account for actual redemptions and other changes in the status of food instrument.

The department's reconciliation process is inefficient primarily because of the inflexibility of its data system. This system does not allow changes to the status of a voucher once that voucher has been recorded as unmatched in the system. To compensate for this system flaw, the department modified its reconciliation formula in the state plan. This modification, however, distorted the department's rate, forcing it to exceed the one percent acceptable rate. But when the U.S. Department of Agriculture's formula (unmodified formula) is used, the department met the rate.

Despite the system flaw, the department did not attempt to manually reconcile unmatched vouchers using unmatched voucher reports from the county clinics. In fact, these reports from the clinics were seldom reviewed.

The department's lack of manual reconciliations and the lack of proper reconciliation at the clinical level allowed the theft of WIC vouchers by a former administrative technician to go undetected for five months. The theft and redemption of 103 WIC vouchers totaling \$11,508.10 occurred during the period October 1996 through May 1997. A proper reconciliation would have indicated missing vouchers as early as December 1996.

The technician misappropriated 103 vouchers by falsifying manual vouchers she was responsible for and by pilfering computer-generated vouchers held at the Southland Mall Clinic for WIC clients. The technician took one or two vouchers from groups of vouchers prepared for clients. The technician avoided detection by indicating that these computer-generated vouchers had been voided on the voucher logs (maintained to account for each WIC voucher). If the clinic clerical staff had properly accounted for each voided voucher individually rather than by groupings of vouchers by client during their monthly reconciliations of unclaimed vouchers with voucher logs, the theft would have been detected in December 1996.

In an interview, the former technician's acquaintance admitted that he and the technician had both redeemed some of these 103 vouchers by signing fictitious names on the vouchers and redeeming them for infant formula at various participating food markets. The acquaintance also admitted that they subsequently sold the infant formula to other non-WIC food markets.

The administrative technician's employment with the Memphis/Shelby County Health Department was terminated effective May 28, 1997, for falsification of information and acts of misconduct. She did not appeal this decision.

The matter was referred to the Office of the State Attorney General and the Office of the District Attorney General, Thirtieth Judicial District (Shelby County), in Memphis, Tennessee, on September 30, 1997.

Recommendation

The Director of the Special Supplemental Nutrition Program for Women, Infants, and Children should assign staff specific responsibility for ensuring all unmatched redeemed vouchers are accounted for. Procedures should be implemented to ensure that reconciliation rates meet federal guidelines.

Although the department's new system of issuing vouchers on-site in most counties apparently addresses internal control problems relating to the receipt, custody, issuance, and disposal of unclaimed vouchers, the department should monitor the control procedures for the new system and adapt other monitoring procedures as necessary to ensure the safeguarding of assets.

Management's Comment

We concur. The department implemented the "On-Site Voucher Printing System" on June 30, 1997. With this system, automated WIC vouchers are issued on-site at each county health clinic and has eliminated virtually all unmatched redeemed vouchers. If any should occur in the new system, the Regional WIC Director will be responsible, in consultation with the WIC Central Office, for follow-up on any such vouchers. Additionally, the WIC Central Office staff is incorporating new procedures into the clinic monitoring visits that are designed to ensure internal controls on voucher security. The Regional Office staff who monitors the clinics is also using these procedures. The new system of computer-printing vouchers on-site when the participant is in the clinic removes the opportunity for fraudulent issuance of unclaimed vouchers.

BLOCK GRANT FOR PREVENTION AND TREATMENT OF SUBSTANCE ABUSE

Our objectives in reviewing this major federal financial assistance program focused on determining whether

- federal funds were spent only for allowable purposes,
- program subcontractors were monitored for compliance with program guidelines,
- the department complied with the maintenance-of-effort requirement, and
- the department complied with regulations concerning the revolving funds for the establishment of homes for recovering substance abusers.

We interviewed key department personnel, reviewed applicable policies and procedures, and tested representative samples of transactions. We had no findings related to the overall administration of the block grant; however, we did note weaknesses in monitoring (finding 16) and minor weaknesses which have been reported to management in a separate letter.

FEDERAL PROGRAMS—NONSPECIFIC

Our objective was to follow-up prior-year findings related to the monitoring of subgrantees, the adequacy of grant payroll cost reallocation and drawdown procedures, and federal equipment records.

We interviewed key department personnel and obtained an understanding of the department's procedures for monitoring subgrantees and receiving subrecipient audit reports. We tested nonstatistical samples of monitoring reports and subrecipient audit reports. We also reviewed the department's payroll cost reallocation and drawdown procedures.

We tested a nonstatistical sample of federally funded equipment purchases to determine whether the grant information (grant number and percentage of federal funds) was entered into the property system. The information was not entered properly, as discussed in finding 18.

Although the department has made some improvement in these areas, problems still exist, and the findings are repeated.

16. Monitoring of subgrantees is not adequate

Finding

As noted in the five prior audits since 1992, subgrantees of the Department of Health are not adequately monitored. Management concurred with the prior findings, and although improvements have been made, monitoring problems continue.

- The Bureau of Alcohol and Drug Abuse Services and the Bureau of Health Services do not regularly conduct on-site fiscal monitoring reviews of all subgrantees.
- The Bureau of Alcohol and Drug Abuse Services does not have uniform written procedures for fiscal monitoring. Additionally, the Bureau of Health Services does not have uniform written procedures for fiscal or program monitoring.
- The files for 39 subrecipients of grants administered by the Department of Health were reviewed for evidence of compliance and fiscal monitoring. The fiscal activities of five subrecipients had not been monitored, neither had the programmatic goals and objectives of three subrecipients. In addition, two subrecipients had not been monitored on-site since 1994.

Office of Management and Budget (OMB) Circular A-133, "Audits of State, Local Governments, and Non-Profit Organizations," requires the department to "monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved." Also, Section 40 of OMB Circular A-102, "Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments (Common Rule)," states that the grantee is responsible for monitoring both its own and its subgrantees' activities.

The Bureau of Health Services issued a monitoring policy in December 1996, but the policy did not specify the monitoring procedures that program personnel and fiscal staff were to use during their evaluations. In addition, the policy did not establish criteria for selecting which subgrantees to monitor. Although the bureau policy states that a site-visit schedule will be developed, no such schedule was established.

Monitoring also involves obtaining and reviewing subrecipients' audit reports, prepared by independent CPA firms. Occasionally these reports contain questioned costs and indicate amounts due to the state. The department did not meet federal requirements in the following instances:

- The costs in four of the seven reviewed reports that contained questioned costs were not resolved within six months of receipt of the reports.
- For two of these four reports, the resolution process was completed seven to 203 days after the six-month period ended.
- For the other two reports, which were received in September 1995 and 1996, the resolution process had not been completed as of August 1997.
- At September 1997, two of these subgrantees had not refunded to the state total questioned costs of \$7,114.
- The department's review of the audit reports did not include following up on other reported audit exceptions such as internal control weaknesses.
- Two of 20 reports reviewed contained deficiencies that were not appropriately noted in the department's database or followed up.
- Five of eight subrecipients continued to receive federal funding even though prior years' audit reports had not been received or the audits were not performed in compliance with OMB Circular A-133.

Circular A-133 states that it is the recipient's (Department of Health's) responsibility to "issue a management decision on audit findings within six months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action." Furthermore, the circular states that "in cases of continued inability or unwillingness to have an audit conducted in accordance with this part, ... pass-through agencies [Department of Health] shall take appropriate action using sanctions such as...withholding a percentage of Federal awards until the audit is completed satisfactorily" or "suspending Federal awards until the audit is conducted."

In addition, the department has not used the one method available to collect subrecipient audit reports—discontinue funding. The Department of Health did not receive 29 of 40 audit reports within nine months of the end of the reporting period, as required in the department's standard contract with subgrantees and as required by OMB Circular A-133. Reports were received from 51 to 1,216 days after the nine-month period. Furthermore, 31 audit reports with due dates ranging from March 31, 1994, to March 31, 1997, had not been received at June 30, 1997. Despite these delays, the subrecipients continued to receive funding.

The department cannot determine compliance with applicable laws and regulations if it does not monitor subrecipients. Additionally, funds could be used for objectives not associated with the grant or contract.

Recommendation

The commissioner and related bureau directors should assign staff specific responsibility for annual program and fiscal monitoring of all subrecipients. Policies should establish specific procedures for selecting which subgrantees to monitor and what criteria to use. Staff should sufficiently document all monitoring and promptly report deficiencies to subgrantees. Significant deficiencies should be reported to the department's Office of Audit and Investigation and to the Comptroller of the Treasury. Recommendations and deficiencies previously noted should be followed up, and this process should also be documented.

All audit exceptions should be followed up and resolved within six months of the receipt of the subrecipient's audit report. The department should seriously consider withholding federal funding from subgrantees that do not submit the required audits.

Management's Comment

We concur. Staff will be assigned specific responsibility for program and fiscal monitoring of selected subgrantees on an annual basis. Policies will be established for the selection of which subgrantees will be monitored and the criteria to be used in the monitoring process. Any deficiencies will be promptly reported to the subrecipient and any significant deficiencies will be reported to the Office of Audit and Investigations and to the Comptroller of the Treasury. A follow-up review of all deficiencies and the resulting actions taken will be documented for possible payment sanctions if deemed necessary.

17. Grant payroll cost reallocation and drawdown procedures were not adequate

Finding

As noted in the prior two audits, the department did not promptly draw down federal funds because reallocation journal vouchers were processed late. In addition, these journal vouchers were not based on current data. Management concurred with the prior findings and stated that the payroll costs were reallocated each pay period using estimates based on the most recent actual month's time study available. Management also stated that estimates were corrected to actual upon receipt of the actual time study information and that federal funds were adjusted accordingly. Although improvements have been made, some allocations were late, and outdated information was used for estimates.

To reallocate certain payroll costs to various federal grants, the department used a time study through June 30, 1997, to measure the amount of time direct service employees (employees who provide direct services in local and regional health departments) worked on various programs and activities.

Payroll costs are not drawn for federal programs until a reallocation journal voucher is processed. For three of 19 time periods, reallocations were processed 31 to 59 days after month's end. Department of Finance and Administration Policy 20, Attachment 20 - A, parts 2 and 3, states that "payroll costs...associated with grants must be redistributed to recover federal revenue on a timely basis...the payroll costs must be entered in STARS on a reallocation journal voucher within 30 days of each month-end." However, one of 19 periods spanned one and a half months, causing an entire month to be reallocated untimely. Ideally, payroll costs should be reallocated each pay period, but never less than once per month.

Because reallocations of payroll costs were late, federal revenue associated with those payroll costs was not recovered timely. When federal funds are not drawn down promptly, state funds are used to fund federal grant expenditures, resulting in the loss of interest income on those funds.

In addition, three of 12 estimated reallocations were initially calculated using time study data from prior periods, not current periods. Time study data from periods as much as three months prior to the payroll month were used for estimates when data from the prior month would have been more appropriate.

Recommendation

The Director of Fiscal Services should ensure that payroll costs are allocated timely for each pay period and never less than once per month (within 30 days of month-end as required by Department of Finance and Administration Policy 20). The accounting manager in the Bureau of Health Services should also ensure that time study information is collected promptly so that reallocations can be based on current-period data.

Management's Comment

We concur. The intended procedure for allocation of payroll cost is the application of available reallocation data to actual payroll cost for each pay period and the allocation of all other costs at least once each month. Currently, the Division of Fiscal Services relies on this data to come from another bureau. We will work with that bureau to decrease the time it takes to get the monthly services data in order to speed up the reallocation process. We will also investigate the possibility of using "distribution tables" in STARS to automatically distribute cost as opposed to using the current journal voucher process.

18. The department did not record correct grant-funding information in the state's property records

Finding

The prior two audits noted that correct grant information (grant number and percentage of federal funds) was not entered into POST (Property of the State of Tennessee), the state's property and equipment-tracking system, for some equipment items purchased with federal funds. Although grant information is entered into POST, the correct information was not entered for 16 of 23 federally funded equipment purchases tested. Management concurred with the prior finding and stated that all bureaus and divisions of the department would be required to document the source of funding, percentage of each funding source, and federal grant number, if applicable, on all purchase requests for equipment. Although the department has made improvements, problems continue.

The department must be able to distinguish between state and federal property. The U.S. Department of Health and Human Services' "Public Health Service (PHS) Grants Policy Statement (Rev. April 1, 1994)" states that in certain cases grantees should report income earned from the sale of equipment purchased with grant funds on the Federal Financial Status Report: "PHS has the right to require transfer of the equipment including title, to the Federal Government or to an eligible third party" (pages 8-14). If the equipment is damaged beyond repair, lost, or stolen, the recipient may be accountable to PHS for "an amount equal to the Federal share of the original equipment times the fair market value." If equipment purchased with federal grant funds is not correctly identified in the property records, the department's ability to transfer equipment, dispose of equipment, or reimburse the federal government in accordance with federal laws and regulations is greatly diminished.

Recommendation

Employees who initiate equipment purchases that are to be funded with federal funds should include correct grant information on the face of the purchase documents. The Director of the Division of General Services should ensure that staff consistently follow the procedures developed to ensure that the appropriate grant information is entered into POST.

Management's Comment

We concur. Once this problem was brought to our attention in July 1997, procedures were implemented that returned purchase requests to the program that did not provide appropriate grant information. We continue to monitor grant information being entered into the POST system to ensure accuracy.

CONTRACTS

Our primary objective in the area of contracts was to follow up prior audit findings to determine whether they had been resolved. Our specific objectives were to determine

- whether the department appropriately entered into contracts with community services agencies,
- whether the department continued to enter into contracts that establish improper employer-employee relationships,
- whether the department's subcontracts for TennCare Outreach services (see below) appropriately delineated that the contracted activities were TennCare related, and
- whether the department ensured that certain TennCare subcontractors complied with the requirements of the department's contract with the Department of Finance and Administration.

TennCare Outreach includes a variety of activities:

- Provides information, assistance with the application process, education concerning proper utilization of the managed care system, and assistance in locating providers for various types of services for families and individuals who may be eligible for TennCare.
- Assists TennCare in the evaluation of the adequacy and effectiveness of service provided by TennCare managed care organizations through home visits, personal contacts in clinic settings, phone calls, and written communications.
- Analyzes TennCare-specific data from the perspective of population-based indicators.
- Performs assessments to determine the adequacy of TennCare provider networks and to determine consumer satisfaction and concerns about TennCare managed care organizations and TennCare.
- Recruits health care providers into areas with insufficient TennCare providers.
- Assists in the identification of problems which preclude the establishment of a health care delivery system sufficient to meet the needs of TennCare recipients.

We interviewed key department personnel and reviewed contracts, contract payment support, and memorandums. We determined that the department had inappropriately entered into contracts with community services agencies as discussed in finding 19. We determined that the department has continued to enter into contracts that create improper employer-employee

relationships, as discussed further in finding 20. We also determined that the department's subcontracts for outreach services are not specific enough to ensure that the subcontractors are aware of the relationship to TennCare (finding 21).

19. The department's contracts with the community services agencies were inconsistent with the Plans of Operation

Finding

Prior to the approval of the fiscal year 1998 Plans of Operation, the Department of Health entered into contracts with the community services agencies (CSAs) to administer various programs in fiscal year 1998. The Plans of Operation are the legal instruments governing the activities of the community services agencies [*Tennessee Code Annotated*, Section 37-5-310(a)] and must be approved by the Commissioner of Children's Services, the Commissioner of Finance and Administration, and the Comptroller of the Treasury.

The department, in addition to implementing the contracts early, included language in the contracts' scope of services relating to the Community Development Program that contradicts the scope of services in the Plans of Operation. The contracts specify that Community Development staff of the CSAs will work "under the programmatic supervision of the Department of Health's Regional Director." The scope of the Plans of Operation, however, specifies that staff will "work for the purpose of conducting coordinated" services with the Department of Health (emphasis added). The contracts, therefore, extend the department's authority over CSA staff beyond that intended by the Plans of Operation.

Although aware of the differences in scope and the dangers of creating fiscal-agent relationships, the Department of Health made no effort to amend the contract language to be consistent with the Plans of Operation. Such language indicates the possibility that the department would use the CSAs to carry out functions legally residing with the department. In similar situations, outside entities such as human resource agencies have been used to circumvent state laws, rules, regulations, and policies through fiscal-agent relationships with state departments. It is unclear what purpose this contract language serves except to facilitate such improper arrangements.

Recommendation

The department should not enter into contracts with the community services agencies until the Plans of Operation have been approved. The department should amend its contracts with the community services agencies to reflect the scope of services in the Plans of Operation. Since the Plans of Operation establish the parameters of CSA activities relative to the department and are the documents reviewed and approved by appropriate state officials, the commissioner should not authorize, condone, or accede to any activities or arrangements inconsistent with the letter and intent of the plans.

Management's Comment

We concur. The department will not contract with the community services agencies until the Plans of Operation have been approved. However, if the Plans of Operation are not timely and we do not have contracts in effect to make payments to the CSAs, serious cash flow problems could develop.

20. **For the past decade, the department has continued to establish improper employer-employee relationships**

Finding

As noted in each audit report since 1986, the Department of Health has entered into contracts with nonprofit organizations, human resource agencies, and community services agencies (CSAs) to assist in implementing the Special Supplemental Food Program for Women, Infants, and Children; Infant Follow-Up Services; Prenatal Services; Community Development; and other programs. Through these contracts, the department has directed these organizations and agencies to hire and pay certain individuals who perform duties in state facilities and are directly supervised by state officials. These contracts apparently create "employer-employee" relationships between the department and these individuals

The practice of allowing employees of nonstate entities such as the community services agencies to report directly to Department of Health officials/employees in carrying out what can be construed as state programs raises policy and legal issues. We do not believe that these situations should be accepted as a matter of policy. Additionally, it is unclear as to whether *Tennessee Code Annotated*, Section 37-5-315(2), completely insulates the state from legal liability. This legal concern arises from a review of the factors commonly used in determining the existence of an employer-employee relationship. These factors include, most importantly, an entity's or individual's right to hire and fire and the right to control the performance of a job or work. The Department of Health should consult with the Office of the Attorney General concerning the legal ramifications of such employer-employee relationships.

In addition, the state apparently has incurred additional cost by contracting with nonstate entities to operate programs. Over the years, the CSAs have operated programs for various departments of the state. In addition to direct program costs, the CSAs have received funding from each state department to defray the costs of administration. These costs included the salaries and benefits of the executive director and the fiscal officer, and costs of travel, supplies, and equipment used by the administrative staff.

In prior years, the Department of Health provided program funding to the CSAs to be used for a Community Development program, the focus of which was determined by the CSAs with the department's approval. However, in fiscal year 1996, the Department of Health

transferred the responsibility of the program from the CSAs to the department's regional offices. When the responsibility for the program was transferred back to the department, the state continued to maintain the administrative funding at the same level as in the past. With state personnel operating this program, it would appear that the administrative funding paid to the CSAs would have decreased. However, the Department of Health did not decrease the administrative funding even though the department now controls the hiring and firing of CSAs community staff and makes the program decisions. It appears that the cost of administering this program has been shifted to the state rather than being borne by the CSAs.

Recommendation

The Department of Health should not contract with community services agencies, nonprofit organizations, and human resource agencies to establish employer-employee relationships. Individuals who are in effect performing state services should be placed on the state payroll system through the proper hiring procedures. When appropriate, the department should establish either professional service or personal service contracts. In addition, either complete control of the community development program should be returned to the CSAs, or complete fiscal responsibility should be borne by the department.

Management's Comment

We concur. We will review our current contract arrangements relative to functions and responsibilities we have required. For those functions being provided that do not include the complete control of the function, an effort will be made to return function to the department staff. In the future, when contracting for outside services, we will evaluate whether this is a function we want the contractor to maintain complete control. If not, we will retain the function within the duties of the department's personnel.

21. **The department's subcontracts for TennCare outreach services are not sufficiently detailed**

Finding

Under a contract with the Department of Finance and Administration, the Department of Health was to provide TennCare-related services during fiscal year 1997. The contract specifically listed the types of services to be provided and set forth in an "Allocation Plan for Outreach Identification" the methods the department was to use to identify and report time spent on TennCare Outreach. The funding of the contract was 50% federal-50% state and totaled \$15,000,000.

The Department of Health subcontracted a portion of this contract to the community services agencies (CSAs). The wording of these subcontracts, however, did not clearly establish that the contract activities were related to TennCare administration. Furthermore, the subcontracts did not include the "Allocation Plan for Outreach Identification" to help the CSAs account for their activities. For example, in the department's 1997 fiscal year contract with Mid-Cumberland CSA, TennCare was not mentioned in the scope of services in "Community Development Services." In addition, the methods to be used to identify and report time spent on TennCare outreach activities were not specified in these subcontracts nor did they indicate that a portion of the funding would be from TennCare.

Even though the department subcontracted the services, it is still responsible for compliance with the Department of Finance and Administration contract. The contracts between the department and the CSAs are not adequate to ensure that the subcontractors perform the appropriate TennCare-related activities. In addition, the method in which the CSAs bill the department does not adequately ensure that only the portion of Community Development Services that relates specifically to TennCare is funded with TennCare dollars.

Recommendation

The Director of the Bureau of Health Services should ensure that subcontracts for TennCare-related services are sufficiently detailed to inform the subcontractors of all contract requirements and the portion of federal funding. In addition, the director should ensure that only TennCare-related activities are funded with TennCare dollars.

Management's Comment

We concur. The agreement with TennCare now defines Community Development activities as TennCare Outreach. Language of the subcontracts now clearly defines all of the Community Development contract activities as one process which includes TennCare Outreach.

SUPPLEMENTAL PAY

Our work in the area of supplemental pay consisted of following up a prior audit finding to determine whether the problem had been resolved. Our objective was to determine whether the department had ensured that all supplemental pay recipients met department and *Tennessee Code Annotated* eligibility requirements.

We interviewed key department personnel to gain an understanding of the department's supplemental payroll system and its evolution. We also reviewed department policies, *Tennessee Code Annotated* (Section 68-2-603), supplemental pay records, and memorandum agreements with the counties. We found the department had discontinued inappropriately increasing the number of employees receiving supplemental pay but had not corrected all previously noted

inappropriate supplemental pay to ineligible employees. This issue is discussed in Past Findings Not Acted Upon by Management.

CELLULAR PHONES

Our review of cellular phone monitoring procedures consisted of following up a prior audit finding to determine whether the problem had been resolved. The objective of this review was to determine whether cellular phone use was adequately monitored and whether the department had established written policies and procedures for monitoring cellular phone use.

We interviewed key personnel to determine whether cellular phone use was monitored and whether any written procedures for monitoring were in place. We also reviewed cellular phone statements for evidence of monitoring. We found that the department had improved its monitoring of cellular phone use and had established written policies and procedures.

REVENUE

Our objectives in reviewing the revenue controls and procedures focused on determining whether

- departmental controls ensured that transactions were properly supported, that receipts agreed with amounts deposited, that deposit slips were completed properly, that departmental records were reconciled with STARS, and that funds were properly controlled and deposited intact;
- revenue functions were adequately segregated;
- the Department of Finance and Administration's policy for timely deposit of funds received had been followed;
- proper support for journal vouchers was maintained; and
- the department complied with applicable federal rules, regulations, and guidelines when federal funds were involved.

We interviewed key department personnel to gain an understanding of the department's procedures for and controls over receiving, receipting, controlling, safeguarding, and depositing funds. We also reviewed supporting documentation and tested nonstatistical samples of revenue transactions. Through our interviews and review of records, we found that many of the department's internal controls either were not effectively designed or were not in place.

22. For the seventh consecutive year, the department's revenue procedures and controls are inadequate

Finding

As noted in the six prior audits, the department's revenue procedures are inadequate. Although improvements have been made, department personnel indicated certain control weaknesses when responding to our internal control questionnaire:

- a. The Administrative Services Assistant (ASA) at Health Statistics Information stated that individual receipt numbers for the prenumbered cash receipt books are not accounted for periodically.
- b. According to the Director of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) at the Chattanooga–Hamilton regional office, individual receipt numbers for the prenumbered cash-receipt books are not accounted for periodically.
- c. The ASA at the Bureau of Information Resources stated that not all checks are restrictively endorsed immediately upon receipt.
- d. According to personnel in Health Related Boards, certifications of deposit are not reconciled with monthly accounting reports timely.
- e. At the Milan Health Department, personnel stated that no receipt or cash-receipt listing is prepared when the mail is opened. One employee writes receipts, prepares the deposit, and takes the deposit to the bank.
- f. In the Bureau of Administrative Services, the comparison of the daily mail log with written receipts is not documented. In addition, certifications of deposit are not reconciled with monthly accounting reports timely.
- g. In the Children's Special Services clinic and the administrative area of the Northeast regional office, one employee issues receipts and reconciles the cash drawer report. In addition, certifications of deposit are not reconciled with monthly accounting reports.
- h. According to the Director of WIC at the Metro–Davidson regional office, a receipt or cash-receipt listing is not prepared as the mail is opened; receipts are not issued for WIC vendor reclaims (reimbursements for overcharges on WIC-approved foods); checks are not restrictively endorsed immediately upon receipt; and the reconciliation of checks with the certification of deposit is not documented.
- i. At the Southeast regional office, the regional director stated that a receipt or cash receipt listing of WIC vendor reclaims is not prepared as the mail is opened, certifications of deposit are not reconciled with monthly accounting reports, and deposits are not made in compliance with the Department of Finance and

Administration Policy 25, "Deposit Practices Policy." In addition, one employee issues receipts, reconciles the cash drawer report, and prepares the deposit.

- j. The WIC coordinator of the Knoxville-Knox regional office stated that the reconciliation of receipts, checks, and the cash-receipt listing with the certification of deposit is not documented.
- k. At both the Marion County and Sequatchie County Health Departments, personnel stated that no receipt or cash-receipt listing is prepared as the mail is opened.
- l. The WIC administrator at the Sullivan regional office stated that checks are not restrictively endorsed immediately upon receipt.
- m. At Vital Records, reconciliations of certifications of deposit are not reconciled with monthly accounting reports timely.

Recommendation

The Director of Administrative Services should assign staff specific responsibility for ensuring that all revenues are properly controlled and should monitor staff's efforts. Written procedures for correctly accounting for receipts, segregating duties, reconciling accounts, preparing receipts or receipt listings, and endorsing revenue items should be developed, implemented, and monitored.

Management's Comment

We concur. Fiscal Office staff will be assigned to specifically work with each bureau to ensure that all revenues are properly controlled. Revenue procedures will be developed and distributed to each bureau within the Department of Health. The Director of Administrative Services will monitor these activities and notify any bureau director of noncompliance with revenue procedures developed.

CONTINGENT AND DEFERRED REVENUE

Our objectives in reviewing contingent and deferred revenue controls and procedures and subaccount balances focused on determining whether

- contingent/deferred revenue accounts were used for the intended purpose,
- transactions were properly supported,

- only applicable items were recorded as contingent or deferred revenue and in the proper amounts,
- revenue was transferred from contingent/deferred to earned when the applicable criteria were met,
- the department had complied with applicable federal rules, regulations, and guidelines when federal funds were involved, and
- large variances between current and prior-year ending balances could be reasonably explained.

We interviewed key department personnel to gain an understanding of the department's procedures for and controls over deposits into the subaccounts and transfers of earned revenue. We reviewed supporting documentation and tested nonstatistical samples of transactions. We also compared June 30, 1997, subaccount balances with balances reported at June 30, 1996, and obtained explanations for significant variances. We had no findings related to contingent and deferred revenue.

DEPARTMENT OF FINANCE AND ADMINISTRATION POLICY 20, "RECORDING OF FEDERAL GRANT EXPENDITURES AND REVENUES"

Department of Finance and Administration Policy 20 requires that state departments whose financial records are maintained on the State of Tennessee Accounting and Reporting System (STARS) fully utilize the STARS Grant Module to record the receipt and expenditure of all federal funds. Our objectives focused on determining whether

- appropriate grant information was entered into the STARS Grant Control Table upon notification of the grant award, and related revenue and expenditure transactions were coded with the proper grant codes;
- appropriate payroll costs were reallocated to federal programs within 30 days of each month-end using an authorized redistribution method;
- the department made drawdowns at least weekly using the applicable STARS reports;
- the department had negotiated an appropriate indirect cost recovery plan, and indirect costs were included in drawdowns, and
- the department used the appropriate STARS reports as bases for preparing the Schedule of Expenditures of Federal Awards and reports submitted to the federal government.

We interviewed key personnel to gain an understanding of the department's procedures and controls concerning Policy 20. We reviewed supporting documentation and tested nonstatistical samples of grant awards, revenue and expenditure transactions, drawdowns, and reports submitted to the federal government. We also reviewed payroll cost reallocations and the schedule of expenditures of federal awards. We determined that the department did not always reallocate the payroll costs to federal programs timely and was not consistent in how it estimated the reallocations. These problems were discussed in finding 17.

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 Health's follow-up report and the follow-up report for the TennCare program were due December 1, 1997. The Office of the Comptroller notified the Chairmen of the Finance, Ways and Means Committees on February 2, 1998, that the reports had not been received. On February 28, we received the reports.

RESOLVED AUDIT FINDINGS

The current audit disclosed that the Department of Health had corrected previous audit findings concerning adequately monitoring cellular phone use and reserve fund pool payment procedures.

REPEATED AUDIT FINDINGS

The prior audit reports also contained findings concerning revenue procedures and controls; grant payroll cost reallocation and drawdown procedures; monitoring of subgrantees; recording of grant-funding information in state property records; employer-employee relationships; subcontracts for TennCare Outreach services; TennCare eligibility verification procedures; uncollected cost settlements; controls over manual checks; the intent of grant requirements; overpayments to providers; departmental rules; and Medicaid refunds. These findings have not been resolved and are repeated in the applicable sections of this report.

PAST FINDINGS NOT ACTED UPON BY MANAGEMENT

Prior audits of the Department of Health have contained findings concerning the drawdown and use of indirect cost funds, implementation of effective controls in the Nursing Home Resident's Grant Assistance Program, and supplemental pay.

Draw Down and Use of Indirect Cost Funds

The Department of Health has not fully used the departmental indirect cost allocation plan for the recovery of indirect costs from block grants. Management uses eligible indirect costs for program expenditures and spends a large portion of previously recovered indirect costs for program services.

The department enters into an annual agreement with the Division of Cost Allocation in the U. S. Department of Health and Human Services specifying the terms of the indirect cost allocation plan. The plan identifies departmental, bureau, divisional, and statewide indirect costs. The departmental, bureau, and divisional indirect costs are those incurred at a particular level for a common purpose, which benefit more than one program, function, or activity, and therefore are not directly assignable to a single program, function, or activity. Statewide indirect costs are the costs of central governmental services distributed through the statewide cost plan that are not otherwise treated as direct costs. Using the indirect cost allocation plan, the department can allocate total indirect costs by bureau or by division.

When indirect costs are not systematically drawn as a part of the program's operating costs, they are, in effect, hidden and must be paid from other sources. Although the allocation of indirect costs may actually shift the use of available federal funds from program operations to administrative overhead, the allocation is essential to present fairly the costs of administering the programs. Likewise, when earned indirect costs are used to fund program services, the true level of state expenditures incurred to fund the program is hidden, and state funds are used to fund activities at the departmental level. The decision whether additional state funds should be used for federal programs is more appropriately addressed through the legislative budget process than by each department.

Management has concurred with the finding, stating that the department's policy is to maximize the utilization of all available federal grant dollars and that the budget is predicated and reflective of these efforts. Furthermore, management has stated that any policy or procedural change requiring indirect cost funds to be used solely for administrative expenditures would necessitate a budget reorganization within the department that would have to be approved by the Commissioner of Finance and Administration and the legislature through the Appropriation Request process. However, the Department of Health has not revised its budget to address this issue.

Administrative Controls for the Nursing Home Resident's Grant Assistance Program

The Department of Health has not established adequate administrative controls over the Nursing Home Resident's Grant Assistance Program to ensure participant eligibility and contractor performance, nor has the department set per diem limits.

The program's intent is to provide a small amount of assistance to nursing home residents whose care is not paid by a state or federal program and who are income-eligible.

A private contractor is responsible for maintaining a systematic process to provide financial support for eligible individuals. However, neither the department nor the contractor verifies the accuracy of information on the applications or on the documents each nursing home completes to certify the number of days residents did not receive other assistance and to report the average per diem expense. In addition, the department does not monitor the program contractor.

If patient eligibility and contractor performance are not monitored, funds could be disbursed to ineligible participants.

Management concurred in part with the finding, stating that as the program was planned and designed, the department believed certain controls would not be cost-effective nor reasonable. Management also stated that although there are some very broad eligibility requirements in the law establishing this program, certain other financial eligibility information verification is left to the discretion of the department. When designing the program, the department chose not to further verify participant eligibility or the accuracy of information reported by nursing homes. Management agreed that the department could develop and implement procedures to more accurately verify participant eligibility and the accuracy of information reported by nursing homes, but stated that it was not appropriate to do so particularly in the early stages of developing the program, given the population involved, the intent of the program, and the relatively small grant amounts available. Management said the department would look at this situation further to determine if additional, more formal procedures were needed to adequately monitor the program contractor. However, no additional procedures have been established.

Supplemental Pay

The Department of Health, without authorization, has allowed certain employees to receive supplemental pay from the counties employing them. Section 68-2-603, *Tennessee Code Annotated*, states that county health directors and county health officers "shall have compensation paid, all or in part, by the department of health." However, there is no provision in the law granting authority for supplemental pay to employees other than county health directors and county health officers.

Although the Department of Health has concurred with this repeat finding, its position until 1996 was to allow no new unauthorized employees to receive supplemental pay, claiming that attrition would correct the situation. In 1996, however, the department increased the positions. No new positions were added in 1997.

OBSERVATIONS AND COMMENTS

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

Tennessee Code Annotated, Section 4-21-901, requires each state governmental entity subject to the requirements of Title VI of the Civil Rights Act of 1964 to submit an annual Title VI compliance report and implementation plan to the Department of Audit by June 30, 1994, and each June 30 thereafter. For the year ending June 30, 1997, the Department of Health filed its compliance report and implementation plan on July 3, 1996.

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 State Planning Office in the Executive Department was assigned the responsibility of serving as the monitoring agency for Title VI compliance, and copies of the required reports were filed with the State Planning Office for evaluation and comment. However, the State Planning Office has been abolished. The Office of the Governor is currently evaluating which office in the Executive Branch will be the new monitoring agency.

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.

OIR OVERCHARGES

The Office for Information Resources (OIR) in the Department of Finance and Administration continues to charge the Department of Health for leased computer equipment the department no longer has. Despite the requests by the department to stop the charges, OIR continues to automatically charge the department's allotment codes and cost centers for this surplused equipment each month, using front-end billing journal vouchers. Because OIR's detailed list of charges did not list equipment tag numbers before June 1995, the department could not determine precisely what equipment it was being billed for each month. OIR made changes to the billing format to include tag numbers; however, Department of Health personnel determined that the tag numbers used are not always accurate.

OIR changed its billing format again after June 30, 1996, and stated in a memorandum that even though "there are several changes in the billing processes, . . . there is still a lot of work to be done to complete the reporting and to provide . . . access to the detail information." OIR continues to charge the department for equipment it does not have and has made no attempt to reimburse the department for the excess charges.

Some of the allotment codes and cost centers automatically charged by the monthly front-end billing journal vouchers are used exclusively for federal grants, and some have been charged for a portion of the surplused equipment. Because the department could not isolate these costs, it was unable to determine which grants and what amounts were charged and are still being charged. According to Office of Management and Budget, Circular A-87, "Cost Principles for State and Local Governments," charges must be "necessary and reasonable for proper and efficient administration of the grant program." The department, therefore, may face questioned costs for these equipment charges.

APPENDIX

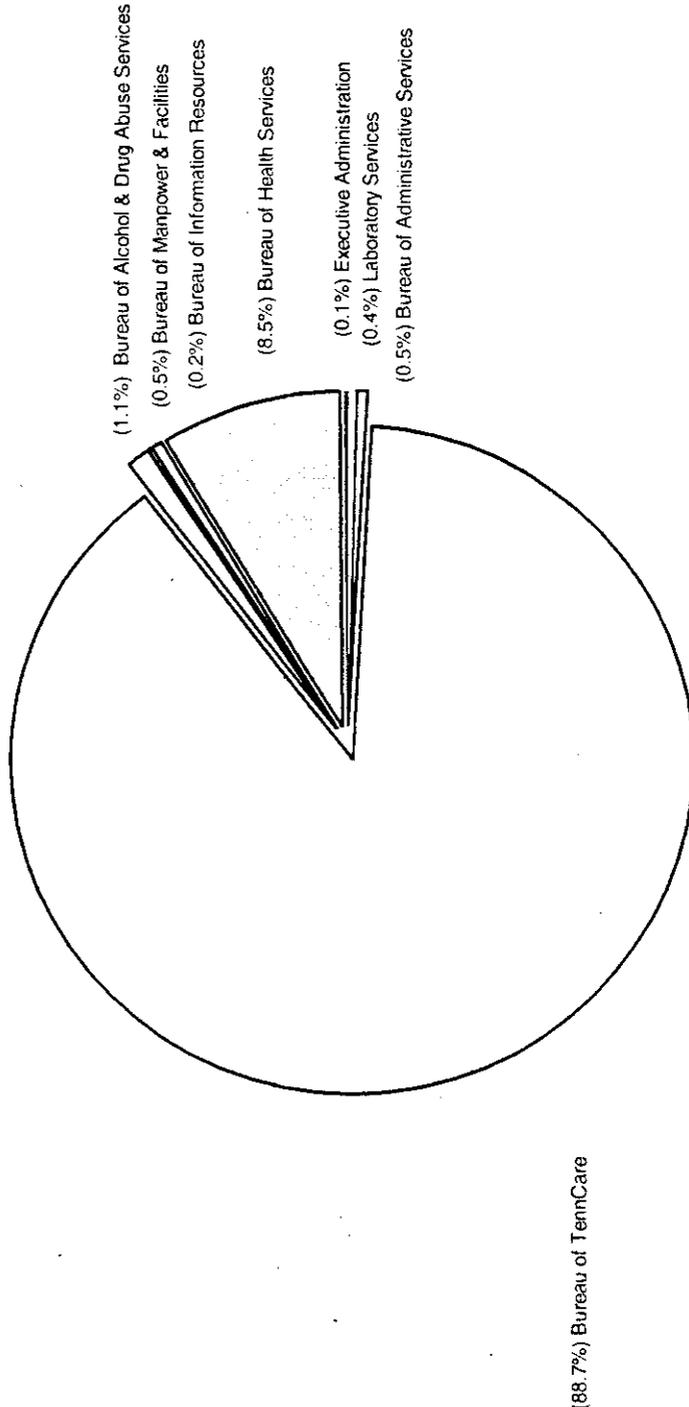
DIVISIONS AND ALLOTMENT CODES

Department of Health divisions and allotment codes:

| | |
|--------|--|
| 343.01 | Executive Administration |
| 343.03 | Administrative Services |
| 343.04 | Information Resources |
| 343.05 | Manpower and Facilities |
| 343.07 | Emergency Medical Services |
| 343.08 | Laboratory Services |
| 343.10 | Health Related Boards |
| 343.12 | Chronic Renal Disease |
| 343.13 | Hemophilia |
| 343.39 | Division of General Environmental Health |
| 343.44 | Alcohol and Drug Services |
| 343.45 | Health Services |
| 343.47 | Maternal and Child Health |
| 343.48 | Division of Special Services |
| 343.49 | Communicable Disease Control |
| 343.50 | HSA Medical Programs |
| 343.52 | Population Based Services |
| 343.53 | WIC Supplemental Foods |
| 343.60 | Local Health Services |
| 343.70 | Nursing Home Grant Assistance Program |
| 318.65 | TennCare Administration |
| 318.66 | TennCare Services |
| 318.67 | Waivers and Crossover |
| 318.68 | Long-term Care |

Expenditures by Allotment & Division

Fiscal Year Ended June 30, 1997 (Unaudited)



(88.7%) Bureau of TennCare

Source: Department of Health

