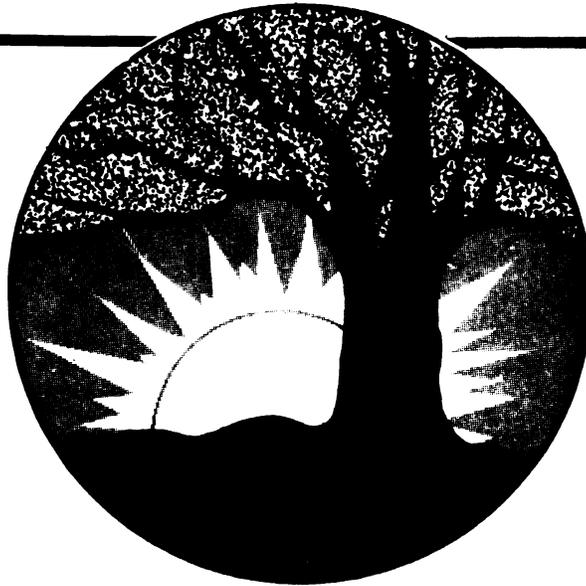


# PERFORMANCE AUDIT

Department of Finance and Administration  
April 2011



Justin P. Wilson  
Comptroller of the Treasury



State of Tennessee  
Comptroller of the Treasury  
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April 12, 2011

The Honorable Ron Ramsey  
Speaker of the Senate  
The Honorable Beth Harwell  
Speaker of the House of Representatives  
The Honorable Bo Watson, Chair  
Senate Committee on Government Operations  
The Honorable Jim Cobb, Chair  
House Committee on Government Operations  
and  
Members of the General Assembly  
State Capitol  
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the performance audit of the Department of Finance and Administration and the TennCare Pharmacy Advisory Committee. This audit was conducted pursuant to the requirements of Section 4-29-111, *Tennessee Code Annotated*, the Tennessee Governmental Entity Review Law.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the department and committee should be continued, restructured, or terminated.

Sincerely,

Arthur A. Hayes, Jr., CPA  
Director

AAH/dww  
09-074

State of Tennessee

# Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit  
**Department of Finance and Administration**  
April 2011

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## AUDIT OBJECTIVES

The objectives of the audit focused on key functions of the department. The audit work was divided in 4 major areas: (1) Divisions of Finance and Administration, (2) Office for Information Resources, (3) the Bureau of TennCare, and (4) the Division of Intellectual Disabilities Services (now part of the Department of Intellectual and Developmental Disabilities).

## FINDINGS

### Divisions of Finance and Administration

#### **The Department Has Not Developed Clear, Formal Policies and Procedures to Ensure That an Effective, Coordinated System of Disaster Recovery Plans Is Established to Ensure That the Department Will Be Able to Perform Essential Services in the Event of an Emergency**

Each division did not have a disaster recovery plan or business continuation plan. Without such plans, the department cannot ensure that it will be able to provide services in the event of an emergency (page 9).

#### **The Department of Finance and Administration Did Not Fulfill Its Contractual Responsibilities With Two Healthcare Carriers for Developing Corrective Action Plans**

Insurance carrier contracts required annual satisfaction surveys and a joint corrective action plan if the satisfaction level was below targets. With two carriers a corrective action was not developed although the department assessed a penalty. By not helping develop the joint plans, the department did not do all it could to ensure that carriers were moving to meet their customer satisfaction goals (page 11).

### **There Is Not an Adequate Formal Monitoring System for Direct Appropriations**

Direct appropriations provide funding to agencies that are not part of state government such as nonprofit organizations or local governments. State departments act as pass-through agencies to record the expenses related to the direct appropriation. The Appropriations Act requires little monitoring and agencies surveyed reported no on-site monitoring. Without onsite monitoring to ensure efficient and effective use of the appropriations, state agencies cannot ensure that recipients are using the appropriations for their intended purposes (page 13).

#### Office for Information Resources

**The Department of Finance and Administration’s Office for Information Resources Has Not Met Its Obligations in Providing Disaster Recovery Guidance to State Agencies as Required by ISC Policy 9**

Pursuant to Information Systems Council (ISC) Policy 9, the Office for Information Resources (OIR) is responsible for overseeing the State of Tennessee’s disaster recovery program—including developing and recommending to agencies the standards, procedures, and guidelines necessary to ensure recovery capabilities for the state’s information systems—and for providing management and technical consulting support to agencies in fulfilling their disaster recovery roles. During our review, we found that OIR has not met its obligations in providing guidance as required by ISC Policy 9 (page 69).

### **The Office for Information Resources Procured an Estimated \$1,000,000 of IT Consulting Services through an Existing Commodity Contract, Effectively Bypassing Non-Competitive Personal Service Contract Rules**

OIR used an existing server, hardware and maintenance contract to procure \$999,500 in IT consulting services, exceeding the limited provision for allowable professional services under the contract. In entering into a non-competitive contract for consulting services through the use of this contract, OIR officials were able to circumvent state law requiring notification of the Fiscal Review Committee, documented approval by the Commissioner of the Department of Finance and Administration, as well as rules for establishing a business case justification (page 70).

### **The Department of Finance and Administration’s Office for Information Resources Is Not Sufficiently Ensuring that Information Security Risks Are Remediated Adequately and Timely in Select Cases**

Information Systems Council (ISC) Policy 13 charges the Office for Information Resources (OIR) with managing and securing the state’s network infrastructure “to ensure the reliability, integrity, availability, and confidentiality of the operations of government and those it serves.” We found weaknesses with regard to the adequacy and timeliness with which OIR coordinates with state agencies to resolve select information security risks (page 74).

**The Office for Information Resources  
Has Developed Cost Models for Its  
Services but Lacks Adequate  
Documentation for Rate Reviews,  
Analysis, and Approval**

OIR has not adequately documented its rate reviews, analysis or approval of rates, and lacks policies and procedures for rate analysis and adjustment. Documentation of rate setting procedures is critical because as an internal service fund, all or parts of OIR bills are passed on to federal granting agencies providing funding to state agencies. Without documentation to support the entire rate setting process, OIR management cannot adequately and fully justify all rates. (page 76).

**The Office for Information Resources,  
Which Serves As Staff to the Information  
Systems Council, Lacks Written  
Guidelines for ISC Policy Review and  
Information Systems Project Reporting**

Statutorily directed to serve as staff to the Information Systems Council (ISC), OIR assists the council with its defined duties and responsibilities, which include developing guidelines for the management of the state's information systems and reviewing the effectiveness and efficiency with which the state information systems network is managed. Without guidelines for a periodic review of ISC policies, OIR cannot fully support the council in its duties and responsibilities. Further, the lack of guidelines for project reporting risks that costly, high-risk, or failing information systems projects may never be reported to the council (page 78).

Bureau of TennCare

**TennCare Has Not Been Consistent in  
Properly Assessing or Timely Collecting  
and Recording Liquidated Damages  
Against Its Managed Care Contractors,  
and Failed to Ensure That a Liquidated  
Damages Provision in One of Its Contracts  
Was Consistent With the Grier Consent  
Decree, Resulting in a Loss of Revenue**

When the Managed Care Contractors (MCCs) fail to perform in accordance with the terms and provisions of their contract, TennCare may assess liquidated damages against the organization. We found that although TennCare was assessing damages and was appropriately notifying the MCCs of the liquidated damages being assessed, it was not properly assessing or timely collecting and recording damages in all cases (page 94).

**Problems Within TennCare's Provider  
Database and Filing System Weaken the  
Functionality of Enrollment  
Administration and Oversight**

TennCare's management information system, known as interChange, was implemented in 2004. It is an all-inclusive system that contains enrollee, claims, and provider information, among numerous other things. At the time of implementation, much of the information in interChange was transferred from the previous system, including all data relating to providers who offered services to TennCare enrollees. There is an abundance of decades-old files which remain in interChange that are inactive or missing required information; and many files specifically lack the proper attributes for searchability. In addition, TennCare lacks a mechanism to accurately measure and track provider enrollment processing times for all providers, specifically those providers who are not required to sign a contract (page 97).

## **OBSERVATIONS AND COMMENTS**

The audit also discusses the following issues:

Finance and Administration section: (1) status of performance-based budgeting; (2) policies and procedures for leases, (3) surplus real property disposal, and (4) the State Health Plan (page 17).

Office for Information Resources section: (1) The Office for Information Resources has taken steps to improve its billing system, however, LAN/WAN billing continues to rely on accurate agency self-reporting and (2) the Office for Information Resources has implemented an effective project management process, however, contract and project management weaknesses involving the Multi-Agency Regulatory System contract, which was terminated for cause in January 2009, contributed to project delays (page 80).

Bureau of TennCare section: (1) quality of care; (2) the pharmacy program; (3) pharmacy contract monitoring; (4) the TennCare Pharmacy Advisory Committee; (5) the disease management program; (6) the process for denying services; (7) provider networks; (8) public necessity rules; and (9) the actions taken by the bureau's Division of Long Term Care in preparing to implement the CHOICES Program (page 102).

Division of Intellectual Disabilities Services section: (1) transfer of the division to the Department of Intellectual and Developmental Disabilities; (2) the number of intellectually disabled persons on the waiting list for services; (3) the status of lawsuits; and (4) the transition of developmental center residents to community housing (page 158).

## **ISSUES FOR LEGISLATIVE CONSIDERATION**

The General Assembly may wish to consider adding language to each direct appropriation regarding the intended purpose of that appropriation, including clearly expected outcomes that are measurable. The General Assembly may also wish to add language to each appropriations act outlining when a state pass-through agency should perform on-site monitoring of grantees to ensure the grantees make efficient and effective use of direct appropriations and to avoid the appearance of open-ended grants of funds with little oversight or accountability. Criteria on whether such monitoring should be performed should take into consideration such factors as the amount of the direct appropriation and whether the direct appropriation has been granted to the same grantee for multiple years.

The General Assembly may wish to consider directing the Department of Finance and Administration, in consultation with state pass-through agencies, to develop and implement requirements (e.g., audited financial statements or other types of accounting measures) for on-site monitoring by these agencies of direct appropriations grantees to ensure the grantees are make efficient and effective use of direct appropriations. Monitoring should take into consideration whether each direct appropriation was used by the grantee in a manner that met the General Assembly's intent for this appropriation.

The General Assembly may wish to consider requiring the state pass-through agencies report to the General Assembly and the general public the results of their monitoring of direct appropriations recipients. The General Assembly may wish to use these results in making decisions about future direct appropriations, including making improvements in monitoring requirements for the state pass-through agencies.

The General Assembly may wish to consider revising Section 12-4-109(a)(1)(G), *Tennessee Code Annotated*, [Transferred to §4-56-106 effective October 1, 2011.] to ensure that the Fiscal Review Committee receives notification of procurement of all non-competitive personal, professional, and consulting services regardless of whether the services were purchased through a personal, professional, and consulting services contract or an existing General Services contract. If the General Assembly's intent is to house all procurement regulatory authority for the state within the new Procurement Commission, we recommend that Section 4-3-5504, *Tennessee Code Annotated*, pertaining to the legislative intent of ISC policymaking authority over telecommunications, computer, or computer-related equipment or services, be reviewed to determine its relevance. At a minimum, OIR management, as staff to the ISC, should assist the ISC in drafting procurement policy to comply with the legislative intent of Section 4-3-5504.

# Performance Audit Department of Finance and Administration

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# **Performance Audit**

## **Department of Finance and Administration**

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### **INTRODUCTION**

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#### **PURPOSE AND AUTHORITY FOR THE AUDIT**

This performance audit of Department of Finance and Administration was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-232, the Department of Finance and Administration is scheduled to terminate June 30, 2011. The TennCare Pharmacy Advisory Committee is also scheduled to terminate June 30, 2011. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the agency and to report to the Joint Government Operations Committee of the General Assembly. The audit is intended to aid the committee in determining whether the Department of Finance and Administration and the TennCare Pharmacy Advisory Committee should be continued, restructured, or terminated.

#### **OBJECTIVES OF THE AUDIT**

The audit focused on the core functions of the department. The objectives of the audit are listed in the Appendix, and the objectives specific to each chapter are listed at the beginning of the chapter.

#### **SCOPE AND METHODOLOGY OF THE AUDIT**

The activities of the Department of Finance and Administration were primarily reviewed for the period January 2007 through October 2010. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Methods used included

1. review of applicable federal and state legislation and regulations and review of applicable department rules, policies and procedures;
2. review of prior audit reports and documentation;
3. examination of the entity's and contractors' records, reports, and information summaries;

4. interviews with department staff, staff of other state agencies that interact with the agency, and advocates;
5. review of Information Systems Council (ISC) minutes and agendas, attendance at ISC meetings, and interviews with ISC members; and
6. attendance at relevant legislative meetings.

The State and Local Insurance Committees, the State Building Commission, and the Information Systems Council are attached to the department so the audit discusses these entities in relation to the department's operations. The Comptroller of the Treasury is a member of these entities.

## **ORGANIZATION AND STATUTORY RESPONSIBILITIES**

The department is organized in three major divisions: Intellectual Disabilities Services, Finance and Administration, and TennCare. See the organization chart on the following page. The divisions are described in each chapter.

## **REVENUES AND EXPENDITURES**

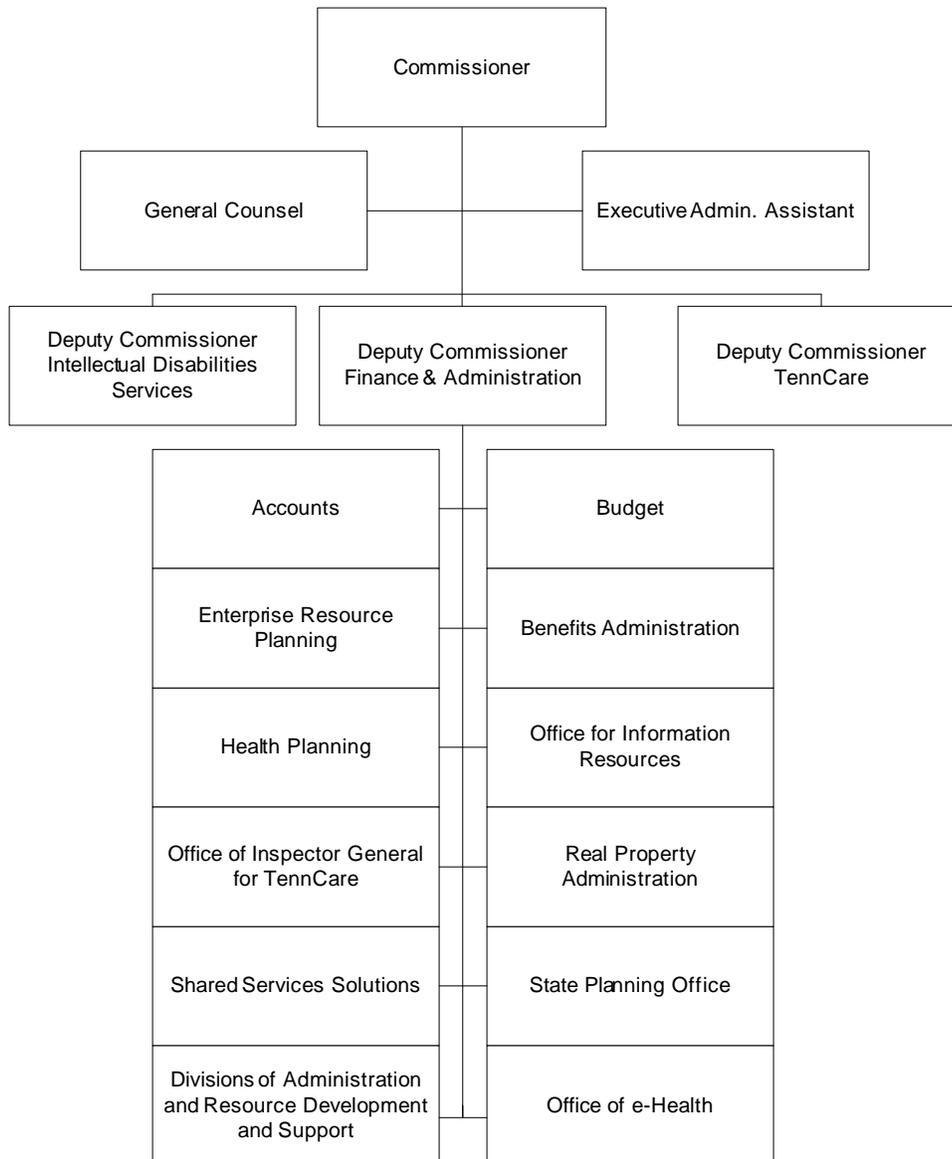
According to the Fiscal Year 2010-2011 Budget (excluding the Bureau of TennCare, Division of Intellectual Disabilities Services, and the Cover Tennessee Health Care Programs), the department had \$298,576,800 in expenditures for fiscal year 2010 (\$81,623,600 million in payroll expenditures and \$216,953,200 in operational expenditures). Of that amount, \$34,961,800 was state dollars; \$71,782,000 was federal dollars; and \$191,833,000 was from other sources.

The Division of Intellectual Disabilities Services was a division within F&A with a distinctly separate budget. For fiscal year 2009, this division had \$856,619,700 in expenditures (\$171,369,600 in payroll expenditures and \$664,250,100 in operational expenditures). Of that amount, \$69,791,300 was state dollars; \$2,058,600 was federal dollars; and \$763,769,800 was from other sources.

Cover Tennessee Health Care Programs, part of the Division of Benefits Administration, is listed separately in The Budget. In fiscal year 2009, Cover Tennessee had \$20,123,000 in expenditures, all of which were classified operational.

For revenues and expenditures of the Bureau of TennCare see page 93.

# Department of Finance and Administration Organizational Chart September 2010



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## DIVISIONS OF FINANCE AND ADMINISTRATION

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### BACKGROUND

These divisions include Accounts, Enterprise Resource Planning, Health Planning, the Office of the Inspector General for TennCare, Shared Services Solutions, Administration, Resource Development and Support, Budget, Benefits Administration, the Office for Information Resources, the State Planning Office, and the Office of e-Health. (The section on the Office for Information Resources begins on page 65.)

### Objectives

The objectives covered in this chapter were to

1. determine whether the Division of Benefits Administration has an adequate system for screening individuals and their dependents for eligibility for insurance benefit programs and whether it has adequate systems for measuring client satisfaction and handling complaints;
2. determine whether the department has developed an efficient and effective capital budget process;
3. determine the status of implementing performance-based budgeting;
4. determine whether the department's efforts to reduce the amount of deferred maintenance are efficient and effective;
5. determine whether the department adequately manages the disposal/sale of state real estate declared surplus to maximize revenue;
6. determine whether the department takes adequate measures to ensure that leases are renewed on time and holdovers (especially costly holdovers) are kept to a minimum, and whether the division ensures the proper allocation of leasing costs when billing agencies;
7. determine whether there are adequate controls over direct appropriations from the General Assembly and the department's role (and that of any other agency) in monitoring the controls;
8. review the use of a contractor for determining eligibility for CoverKids determine the adequacy of client satisfaction procedures for CoverTN, and determine the long term financial stability of AccessTN;
9. determine the responsibilities of the Office of Inspector General for investigating fraud in the TennCare and Cover Tennessee programs and any barriers to meeting those responsibilities;

10. determine the division's compliance with state law requiring a State Health Plan to guide the state in the development of healthcare programs and policies and in the allocation of healthcare resources in the state;
11. determine the current status of the e-Health Initiative, including the development and implementation of any plans, acceptance of electronic prescriptions and patient records by providers, concerns providers have about relevant training, technology issues (including privacy concerns), and other possible obstacles to implementation;
12. determine the role of the Office of Shared Technology Services in assisting with the department's disaster recovery plan; and
13. determine the Office of Shared Services Solutions' services, utilization, and client satisfaction measures.

### Organization and Statutory Responsibilities

The Department of Finance and Administration assists the Governor in developing and implementing the administration's fiscal and managerial policies. The Commissioner of Finance and Administration serves as the Governor's chief cabinet officer and directs the department. The department's responsibilities involve the coordination of a number of state government activities that are provided through administrative services, fiscal and management services, capital and facilities management services, and TennCare oversight. The Bureau of TennCare, the Division of Intellectual Disabilities Services, and the Office for Information Resources are also part of the department. They are discussed in separate chapters of this report. The department's responsibilities, described in Sections 4-3-1001 through 1020, *Tennessee Code Annotated*, are to help facilitate the successful operation of state government by providing financial and administrative support services for all departments, while also acting as the chief corporate office.

The following is a description of the department programs discussed in this chapter.

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

Enterprise Resource Planning—The Enterprise Resource Planning Division delivers an integrated enterprise software solution for addressing the state's administrative functions such as human resources, payroll, personnel, financial management, and procurement.

Health Planning—The State Health Planning Division is charged with developing and maintaining a state health plan, which is intended to guide the improvement of healthcare programs supported by state government. The division analyzes and assesses health resources and performance to coordinate and leverage relevant state programs and services to optimize health outcomes and value for Tennesseans.

Office of the Inspector General—The Office of Inspector General was created in 2004 by the TennCare Fraud and Abuse Reform Act, Section 71-5-2502, *Tennessee Code Annotated*. The mission of the OIG is to identify, investigate, and prosecute persons who commit fraud against the TennCare Program.

Shared Services Solutions—Shared Services Solutions provides transactional services to 17 small agencies, boards, and commissions within the executive branch. Services include accounting, budgeting, human resources, payroll, and procurement.

Division of Administration and Division of Resource Development and Support—The Division of Administration provides fiscal, human resources, information systems, and billing services. The Resource Development and Support program consists of two core functions: the contract review and approval function and the program operations audit and consulting function. The program also includes the Office of Criminal Justice Programs and Volunteer Tennessee.

Budget—The Division of Budget prepares the Annual Budget Document and general appropriations bill for transmittal to the General Assembly. Under the 2002 Governmental Accountability Act, the staff assists the commissioner in overseeing the strategic planning process and preparing an agency strategic plans document.

Benefits Administration—The Division of Benefits Administration is responsible for servicing three basic groups of employees by managing their state-provided insurance benefits. The state plan consists of state government and higher education employees. The local education plan is available to local K-12 school systems that choose to participate in the plan. The local government plan is available to local city and county governments and to certain quasi-governmental agencies that choose to participate. The state, local education, and local government plans are each authorized by Sections 8-27-101, 8-27-207, and 8-27-301, *Tennessee Code Annotated*, to offer a basic plan (health care) and such optional plans as the respective governing board (the insurance committee) authorizes. Benefits Administration is also responsible for the administration of the Cover Tennessee Health Care Programs.

According to department officials, aside from dental carriers, the department requires each of the health benefit carriers that it contracts with to be certified by the National Committee for Quality Assurance (NCQA). NCQA does not certify dental carriers. The NCQA is a private non-profit organization whose purpose is to improve health care quality. Organizations that wish to be NCQA-certified must establish rigorous comprehensive reviews of their operations based upon criteria established by NCQA depending upon the nature of their particular product.

*Cover Tennessee Act*. The Cover Tennessee Act of 2006 (Section 56-7-3001–3027, *Tennessee Code Annotated*) authorizes the creation of the CoverTN program. The goal of the program is to provide basic health insurance to eligible uninsured Tennesseans. CoverTN is open to uninsured Tennesseans, at least 19 years old, who work for qualifying small businesses, are self-employed or work but do not have health insurance. In addition, those who have recently become unemployed or had work hours reduced may also be eligible. The spouse of a CoverTN member may also be eligible for coverage under CoverTN.

The CoverKids Act of 2006 (Section 71-3-1101–1112, *Tennessee Code Annotated*) authorizes the creation of the CoverKids program. The goal of the program is to provide health insurance coverage to eligible children and pregnant women. CoverKids provides free, comprehensive health coverage for qualifying children 18 and younger. The coverage includes an emphasis on preventive health services and coverage for physician services, hospitals, vaccinations, well-child visits, the healthy babies program, developmental screenings, and mental health, vision, and dental care.

Sections 56-57-101–106, *Tennessee Code Annotated*, authorize the creation of a prescription drug discount plan that became known as CoverRx. The goal of the program is to provide pharmacy assistance to eligible Tennesseans. CoverRx is a pharmacy assistance program designed to assist those who have no pharmacy coverage but have a need for medication.

The Access Tennessee Act of 2006 (Section 56-7-2903–2915, *Tennessee Code Annotated*) authorizes the creation of a nonprofit entity to operate an insurance pool under the supervision of an AccessTN Board of Directors. (Under Section 56-7-2916, the law creating the board is effective until June 30, 2015.) The goal of the program is to provide health insurance coverage to eligible uninsurable individuals.

Real Property Administration—The Division of Real Property Administration supervises all capital outlay projects involving any improvement or demolition of real property in which the state has an interest. The division also makes space assignments, prepares long-range housing plans, manages leases, and analyzes space needs for state agencies.

Office of e-Health—The electronic health initiative is designed to improve efficiencies in the electronic exchange of healthcare data between governmental entities and various organizations in the health-care community. The program enables the exchange of electronic health information in Tennessee in a secure and confidential manner and works to improve the health of Tennesseans by ensuring providers have complete patient information at the point of care.

Office of Tennessee Recovery Management—The department serves as the primary support agency for the Office of Tennessee Recovery Management (TRAM). The Governor’s office created TRAM in March 2009 to replace the State Planning Office as the agency responsible for implementing the American Recovery and Reinvestment Act (ARRA) in Tennessee and monitoring recovery act monies. A quasi-state agency, TRAM reports to the Governor. While TRAM is not technically a section of the department, the department is the primary support agency to TRAM and provides all of the agency’s 11 staff members. TRAM is staffed by individuals from various divisions within the department who provide part-time service to TRAM while continuing to fulfill their other commitments. TRAM’s primary purpose is to provide agencies with federal guidelines, assist them with required quarterly 1512 reporting on how Recovery Act dollars are being spent and jobs created, and to monitor this reporting. Section 1512 of ARRA requires detailed quarterly reporting of monies spent. Initially, TRAM is assisting with the reporting, but eventually the agencies will be responsible for reporting on their own.

TRAM is in the process of transition to have all state agencies do their own quarterly reporting. Currently, the agencies enter data into a tracking system internally known as TRAM Track; then TRAM staff export files and upload them to FederalReporting.gov, a web-based system operated by the Recovery Accountability and Transparency Board in the President's office. This manner of F&A involvement allows for oversight of the reporting process, as agencies become familiar with the process. Eventually, the agencies will submit the data directly to the federal government, with some F&A oversight to continue. TRAM has divided the state agencies receiving stimulus monies into three groups, and each group will be trained to become self-reliant in reporting. TRAM staff have developed training guidelines to assist the agencies. Each training group will coincide with a quarterly reporting deadline, and provided there are no problems, agencies will be allowed to do their own reporting at that training deadline. The first group of agencies was trained, and the agencies were allowed to do their own reporting for the quarter ending March 31, 2010. The department planned that the second and third groups would do their own reporting beginning June 30, 2010, and September 30, 2010, respectively. In the absence of major problems, all state agencies were to be doing their own reporting by December 31, 2010.

#### Prior Division of State Audit Work on Project Edison

Project Edison is the state's Enterprise Resource Planning (ERP) system. ERP systems use an integrated software package to perform administrative business functions, such as preparing various financial statements and accounting, procurement, payroll, benefits, and personnel administration. The ERP Division (Project Edison) within the Department of Finance and Administration was created in May 2005 to plan, design, develop, and implement the correct ERP solution for the information systems like STARS and TOPS, which had relied on separate databases. Edison uses a common database that allows the system to share information between business functions within an agency and across agencies statewide. The following is a description of work done by the Division of State Audit separate from this performance audit.

In the spring of 2009, the Comptroller's Office sent out an online survey to 40,941 state-assigned e-mail addresses for state employees. There were 15,795 responses to the survey, identifying a number of concerns about the way the system was working and the manner in which problems were being addressed. The Comptroller's Office also sent surveys to 51 human resource directors in various departments of state government, of which 32 responded. Based on the results of the surveys, the Comptroller's Office recommended that the Department of Finance and Administration immediately contact all state departments and agencies to obtain a comprehensive list of operational issues related to Edison's performance in handling personnel functions.

The Comptroller's Office also conducted a follow-up report on Project Edison in the latter part of calendar year 2009. The report recommended that the Project Edison team develop a complete list of problems that had been identified with the financial component and resolve those problems as quickly as possible. The survey respondents also reported numerous problems, including inability to pay vendors in a timely fashion. The Comptroller's Office

recommended an independent technical review of both the human resources and financial functions and delays in the implementation of the financial component of Edison for agencies not yet using the software. The Project Edison team employed an independent reviewer and announced delays in implementing the financial component for 12 of the 14 agencies that had been scheduled to make the transition on July 1, 2009.

Some additional work that has been performed by the Comptroller's Office on Project Edison includes weekly meetings with upper management to disclose significant Edison issues and failures, follow-up meetings with the fiscal directors of 22 departments on the Financial and Supply Chain Management component to determine the most current status of Edison, and meetings with the Human Resources component of Edison to discuss whether paper documentation could be reduced while providing a necessary audit trail.

In August 2010 Comptroller Justin Wilson issued a letter concerning the *Comprehensive Annual Financial Report (CAFR)*, the annual audited financial report for the state which shows the state's financial position. The CAFR for the fiscal year ending June 30, 2009, was released in August 2010, seven months late. (F&A released the 2010 CAFR, with audit opinions, in March 2011.) In addition, the *Tennessee Single Audit Report*, which provides information to the federal government on the state's accountability for federal funds, was not completed by the federal deadline of March 31, 2010, because of the late CAFR. The letter stated, "The financial integrity and the efficient and effective ongoing operations of the State of Tennessee depend upon the successful operation and maintenance of the Edison system." The letter made several recommendations for improving the ongoing operations of the Edison system and for minimizing future information system implementations.

## **FINDINGS**

- 1. The department has not developed clear, formal policies and procedures to ensure that an effective, coordinated system of disaster recovery plans is established to ensure that the department will be able to perform essential services in the event of an emergency**

### **Finding**

The preparation of disaster recovery and Continuity of Operations plans has become a coordinated effort between a few of the divisions within the Department of Finance and Administration (F&A) although it is unclear which divisions are responsible for that task. The Office of Shared Technology Services is a separate division from OIR and has previously worked with F&A's Office of Audit and Consulting Services for the development of F&A's Continuity of Operations Plan. The plan, which details how the department will function in the event a disaster occurs, is based on the guidelines set by FEMA and Homeland Security. There are no formal written policies and procedures that specify which division is responsible for preparing the disaster recovery plan. According to OIR's Director of Information Technology Planning, the Office of Shared Technology Services should maintain the disaster recovery plan, as well as the

Continuity of Operations Plan for all of F&A. However, the Office of Shared Technology Services only maintains a Disaster Recovery Documentation Record, which details the steps required to recover business applications and is updated semi-annually. Disaster recovery is the process an organization uses to recover access to its data, software, and hardware that are needed to resume operations. The department performs many services critical to the State of Tennessee and state government. Without a disaster recovery plan, the department cannot ensure that it will be able to perform these services in the event of an emergency. Based on the information provided by the Director of the Office of Shared Technology and the OIR Director of Technology Planning during the audit, there was not a disaster recovery plan or business continuation plan for each individual division within F&A, except for OIR. However, as of April 2010, the department had an updated Continuity of Operations Plan covering all divisions.

### **Recommendation**

The commissioner should promptly initiate steps to develop formal policies and procedures that clearly state who is responsible for preparing the disaster recovery plan and Continuity of Operations Plan for each division within the department.

### **Management's Comment**

We concur. At the time of the audit, the department did not have a formal written policy that specified which division is responsible for preparing the disaster recovery plan(s). The department has drafted a new Policy (021) – Disaster Recovery Policy within the Office of Information Technology Services (ITM). This office was formerly known as the Office of Shared Technology Services (OSTS) and is referred as such in the body of the audit report. This new policy outlines that F&A has four distinct and separate divisions that provide systems/applications for their customers as follows:

- Enterprise Resource Planning (ERP) – Edison System
- Office for Information Resources (OIR) – Enterprise Systems and Network Infrastructure available to all agencies (e.g. Shared Network Drives, Email, Enterprise Content Management, Shared Databases, Mainframe Operations, etc.)
- Office of the Inspector General (OIG) – OIG Case Tracking System
- Information Technology Management (ITM) – All other F&A systems/applications (e.g. AIMS/LIS, PITS, STARS, etc.)

The new policy outlines that each of these groups is responsible for development of their respective Disaster Recovery (DR) Plan, and that each DR Plan should be reviewed annually for completeness and correctness. Further, each DR Plan should specify the frequency for testing the covered systems/applications. Test occurrences will be determined by criticality level for the system/application.

The department's Continuity of Operations Plan that addresses each division of F&A shall be maintained by the Office of Technology Management (ITM).

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**2. The Department of Finance and Administration did not fulfill its contractual responsibilities with two healthcare carriers for developing corrective action plans**

**Finding**

The Department of Finance and Administration (F&A) contracts with six healthcare carriers. Two of the six healthcare carriers are dental plans, one is a behavioral health plan, and three are medical plans. Members covered by the carriers include state government, local government, and local education subscribers. All carrier contracts require carriers to annually conduct customer satisfaction surveys, using statistically determined sample sizes and randomly drawn participants. F&A's role is to review the survey results of all carriers. According to the language in each carrier contract, F&A will assess a financial penalty to contractors who fail to achieve their satisfaction performance target.

A second contractual obligation covers the development and implementation of joint corrective action plans by both the carriers and F&A. If carrier survey results do not achieve the performance target, both the carrier and F&A are contractually required to develop joint action plans to correct significant deficiencies identified in the surveys and increase member satisfaction percentages. Two carriers acknowledged that joint action plans should have been developed but had not been produced. Furthermore, officials with F&A state that they did not develop a formal corrective action plan with the carriers. Hence, neither the carriers nor F&A had fulfilled their joint contractual obligation.

As shown in Table 1 below, Assurant's performance guarantee target for member satisfaction for 2008 was 85%; however, only 75% of members surveyed were satisfied with the dental plan. While F&A assessed (and the carrier paid) a \$10,000 penalty, the department did not work with the carrier to develop a joint corrective action plan.

**Table 1  
Customer Satisfaction Survey Results**

<b>Carrier</b>	<b>2008 F&amp;A Performance Guarantee Targets</b>	<b>% Of Surveyed Members Satisfied With Overall Carrier Activities</b>	<b>% Above/Below F&amp;A Performance Guarantee Target</b>
1. Assurant	85%	75%	-10.0
2. Delta Dental	80%	96%	+16.0
3. Magellan	90%	98.6%	+8.6
4. BC/BS	90%	94.7%	+4.7
5. Cigna	90%	93%	+3.0
6. United Healthcare	90%	87.4%	-2.6

Source: Target and actual data provided by Benefits Administration, Department of Finance and Administration.

Another carrier who did not meet its performance guarantee target for 2008 was United Healthcare. United Healthcare had a member satisfaction target of 90%; but only 87.4% of surveyed respondents reported that they were satisfied. As a result of the carrier not meeting its annual member satisfaction target, F&A assessed United Health Care a \$50,000 penalty, which it subsequently paid. As with Assurant, the carrier and F&A did not prepare a joint corrective action plan.

According to carrier officials, a joint action planning process should have been launched when a carrier failed to meet a performance guarantee. Officials from Assurant and United Healthcare reported that they both failed to meet their performance guarantees and recognized that both officials from their respective plans and F&A should have developed joint corrective action plans. By not assisting the carriers to develop joint corrective action plans, F&A failed to do all it could to ensure that the healthcare plans were moving to meet their customer satisfaction goals.

**F&A Should Communicate Future Contractual Changes to Health Benefit Carriers**

Timely and accurate communication between F&A and the carriers of future changes to contractual requirements is important to the successful implementation of the contracts. For example, the department released a RFP (Request for Proposal) in March 2010 that places an emphasis on health provider carriers being subject to liquidated damages. The RFP stipulates that carrier performance will be measured on a quarterly basis instead of waiting for survey data to determine whether a fine should be imposed and whether a corrective action plan should be generated.

## Recommendation

In the future, the department should adhere to all contractual responsibilities with carriers. If contract requirements are deemed to be unnecessary, the department should amend the contract to address this change.

## Management's Comment

We concur. Benefits Administration will adhere to all contractual responsibilities with carriers. In August 2010, Benefits Administration designated a position to monitor performance measures for all Public Sector contracts. Benefits Administration successfully procured the medical Third Party Administrator contracts effective January 1, 2011. As part of the contract implementation phase, Benefits Administration communicated to the carriers the contractual requirements and expectations concerning performance measures.

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### 3. There is not an adequate formal monitoring system for direct appropriations

#### Finding

Direct appropriations, as opposed to regular appropriations, provide funding to agencies that are not part of state government (e.g., nonprofit organizations and local governments) through a state pass-through agency. (For example, funds appropriated for public television stations go through the Department of Education.) The state pass-through agency is used to record the expenses related to the direct appropriation, according to the Division of Budget's Director. (See Table 2 for fiscal year 2010 direct appropriations and related pass-through state agencies.) Otherwise, direct appropriations go through the same legislative approval process as regular appropriations. Fiscal year 2010 had \$8,120,840 in direct appropriations.

**Table 2**  
**Fiscal Year 2010 Direct Appropriations Grants**

State Pass-through Agency	Grant Description	Appropriation
Arts Commission	Stieglitz Collection at Fisk University for operational costs.	\$80,000
Board of Probation and Parole	Project Return	*\$182,000
	Dismas, Inc. - From these funds, \$25,000 is earmarked for Chattanooga Endeavors, and \$8,000 is earmarked for Better Decisions for program assistance.	\$136,500
Bureau of TennCare	Population-based grants to Chattanooga, Knoxville, Memphis, and Nashville for governmental emergency services (from TennCare reserves)	\$750,000

<b>State Pass-through Agency</b>	<b>Grant Description</b>	<b>Appropriation</b>
Department of Agriculture	Future Farmers of America (non-recurring grant, earmarked from Market Development)	\$250,000
	4-H Foundation (non-recurring grant, earmarked from Market Development)	\$250,000
Department of Children's Services	A Secret Safe Place for Newborns of Tennessee, Inc. for programs, services, and operational expenses.	\$25,000
Department of Correction	Amachi Mentoring Program operated by Big Brothers Big Sisters, distributed based on number of children served.*	\$250,000
Department of Economic and Community Development	Nashville Minority Business Center	\$100,000
	Minority Enterprise Development	\$100,000
	Four Lakes Regional Development Authority	\$419,900
Department of Education	\$250,000 recurring and \$250,000 non-recurring for equal grants to each public television station for equipment, programs, and operations.	\$500,000
	Save the Children literacy programs.	\$1,000,000
Department of Finance and Administration	University of Tennessee Center for Business And Economic Research - Research assistance to the Department of Finance and Administration.	\$125,000
	University of Tennessee Center for Business and Economic Research - State Census Data Center services under contract with U. S. Census Bureau.	\$40,000
	University of Tennessee Center for Business and Economic Research - Population and Demographics Forecasting.	\$238,000
	Tennessee Coalition Against Domestic and Sexual Violence to support the activities of the Tommy Burks Victim Assistance Academy. Funded by interdepartmental revenue from Criminal Injuries Compensation Fund.	\$100,000
	Recurring grant to the National Civil Rights Museum for programs, services, and operational expenses.	\$250,000
	Tennessee Public Safety Network for operational expenses.	\$5,000
	Tennessee Association of Rescue Squads	\$71,300
	YMCA Youth Legislature	\$25,000
	YMCA Community Action Program	\$350,000
	Forensic Center at Quillen College of Medicine	\$100,000
Department of Health	St. Jude Hospital for patient and family travel assistance.	\$113,700
	Promotion of men's health awareness.	\$95,000
	St. Jude Hospital for patient & family travel expenses (non-recurring).	\$136,300
	Grant to the MED Foundation to support the Diggs-Kraus Sickle Cell Center.*	\$75,000

State Pass-through Agency	Grant Description	Appropriation
	Meharry Medical College wellness programs for historically black colleges and universities.	\$2,000,000
Department of the Treasury	Criminal Injuries Compensation Fund for grants to the District Attorneys General for domestic violence prevention and drug enforcement authorized by Section 29-13-116, <i>Tennessee Code Annotated</i> .	**\$223,140
Historical Commission	Stax Museum in Memphis to defray operating costs.	\$100,000
	National Medal of Honor Museum of Military History in Hamilton County to be used for volunteer staff training at the Campbell Center for Historic Preservation Studies.*	\$30,000

\* The state pass-through agency in 2009 Public Acts, Chapter 554, is the Department of Finance and Administration. According to the Budget Office Director, in most instances where the fiscal year 2010 appropriations act (Chapter 554) appropriates direct appropriations funds to the Department of Finance and Administration, these funds would be allotted to Miscellaneous Appropriations, which is administered by the department, under authority of Section 35, Item 12, of the appropriations act. Item 12 allows Miscellaneous Appropriations “to be allocated and transferred to the appropriate organizational units and programs of state government by the Commissioner of Finance and Administration.”

\*\* Not to exceed this amount.

Source: 2009 Public Acts, Chapter 554.

According to the Budget Office Director, direct appropriations must have a public purpose, including regional economic development. Private companies cannot receive such funding, although they can benefit from economic development efforts funded by direct appropriations (e.g., industrial site preparation by local governments). Language in the appropriations act does not describe the specific purpose for a direct appropriation and does not go beyond general instructions on how the funds are to be spent. Section 55 of the fiscal year 2010 Appropriations Act (2009 Public Acts, Chapter 554) has the only monitoring requirements for state agencies regarding direct appropriations (and the requirements do not apply to governmental grantees):

Notwithstanding any provision of this act to the contrary, a direct appropriation to a non-governmental agency or entity shall not be disbursed until the recipient has filed with the head of the agency through which such disbursement is being made a plan specifying the proposed use of such funds and the benefits anticipated to be derived therefrom. As a prerequisite to the receipt of such direct appropriation, the recipient shall agree to provide to the agency head, within ninety (90) days of the close of the fiscal year within which such direct appropriation was received, an accounting of the actual expenditure of such funds including a notarized statement that the report is true and correct in all material respects; provided, however, that the head of the agency through which such disbursement is being made may require, in lieu of the accounting as provided above, an audited financial statement of the non-governmental agency or entity. A copy of such accounting or audit, as the case may be, shall be filed with the Office of the Comptroller of the Treasury.

The above language has not changed since the fiscal year 2006 Appropriation Act. Each year, the Division of Budget provides the heads and budget officers of state pass-through agencies instructions on how to handle direct appropriations, including Section 55 language. In addition, the division provides the agencies with standard direct appropriations letter of agreement forms for governmental and non-governmental grantees.

The Budget Office Director said that any monitoring that may be done would be done by the pass-through agencies. We contacted budget officers in the five state agencies, other than the Department of Finance and Administration, with the highest amount of direct appropriations flowing through them in fiscal year 2010 to determine how they monitored direct appropriations recipients. These agencies were the Departments of Agriculture (\$500,000), Economic and Community Development (\$619,900), Education (\$1,500,000), and Health (\$2,420,000), and the Bureau of TennCare (\$750,000) (we treated the bureau as a separate entity of the Department of Finance and Administration). Although agency officials stated that they have reviewed year-end reports from non-governmental recipients (one agency official stated that he also reviewed independent audits of financial statements), none of the officials reported on-site monitoring of recipients, either governmental or non-governmental, to ensure efficient and effective use of direct appropriations. Without such on-site monitoring using specific criteria and clearly expected outcomes, especially for direct appropriations that are large and/or have been given to the same grantees for multiple years, both the pass-through agencies and the Department of Finance and Administration cannot ensure that recipients are using the appropriations for their intended purposes. Such monitoring is especially important in good fiscal years, where there are “sometimes hundreds if not thousands of direct appropriation grants,” according to the Budget Office Director.

### **Recommendation**

The General Assembly may wish to consider adding language to each direct appropriation regarding the intended purpose of that appropriation, including clearly expected outcomes that are measurable. The General Assembly may also wish to add language to each appropriations act outlining when a state pass-through agency should perform on-site monitoring of grantees to ensure the grantees make efficient and effective use of direct appropriations and to avoid the appearance of open-ended grants of funds with little oversight or accountability. Criteria on whether such monitoring should be performed should take into consideration such factors as the amount of the direct appropriation and whether the direct appropriation has been granted to the same grantee for multiple years.

The General Assembly may wish to consider directing the Department of Finance and Administration, in consultation with state pass-through agencies, to develop and implement requirements (e.g., audited financial statements or other types of accounting measures) for on-site monitoring by these agencies of direct appropriations grantees to ensure the grantees are make efficient and effective use of direct appropriations. Monitoring should take into consideration whether each direct appropriation was used by the grantee in a manner that met the General Assembly’s intent for this appropriation.

The General Assembly may wish to consider requiring state pass-through agencies report to the General Assembly and the general public the results of their monitoring of direct appropriations recipients. The General Assembly may wish to use these results in making decisions about future direct appropriations, including making improvements in monitoring requirements for the state pass-through agencies.

### **Management's Comment**

We concur. Since the recommendations are directed to the General Assembly for consideration and not the Department of Finance and Administration, management defers to the will of the General Assembly concerning these recommendations.

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### **OBSERVATIONS AND COMMENTS**

The topics discussed below did not warrant a finding but are included in this report because of their effect on the operations of the Department of Finance and Administration and on the citizens of Tennessee.

#### **The Status of Performance-Based Budgeting in Tennessee**

With the passage of the Tennessee Governmental Accountability Act of 2002, Tennessee implemented a series of reforms in an effort to improve the state's system for appropriating public funding. The objective was to transition from a budgeting process with indistinct links between funding and performance, to a system of strategic planning, performance-based budgeting, and performance reviews, which taken collectively, fully inform the public and enable resource allocation decisions to be based on results. The act modified budget law by requiring the phase-in of strategic planning and performance-based budgeting by all state agencies, boards, and commissions, beginning in fiscal year 2004-2005, with all agencies, boards, and commissions included by fiscal year 2011-2012.

The State of Tennessee is in the ninth year of implementing the requirements established in the Governmental Accountability Act. Since fiscal year 2003-2004, the Department of Finance and Administration has required all Executive Branch agencies to prepare and submit annual five-year strategic plans. In fiscal year 2010-2011, 37 state agencies/divisions are operating under performance-based budgeting (see Table 3 for the performance-based budgeting implementation schedule). Higher Education, TennCare, and Cover Tennessee are the only remaining Executive Branch agencies/divisions to be phased in and are scheduled for 2011-2012 implementation. A list of primary responsibilities delineated in the act can be seen in the table on the following page.

**Table 3**  
**Governmental Accountability Act of 2002**  
**Strategic Planning and Performance-Based Budgeting (PBB) Requirements**

<b>Department of Finance and Administration</b>	<b>State Agencies, Boards and Commissions</b>	<b>General Assembly</b>	<b>Comptroller of the Treasury</b>	<b>Governmental Accountability Commission</b>
<ul style="list-style-type: none"> <li>• Develop schedule for including agencies in PBB review, with all agencies phased in by FY 2011-2012.</li> <li>• Annually issue instructions for the development of performance measures and standards for each program for which an agency submits budget requests.</li> <li>• Review (and revise as necessary) agency submitted performance measures and include measures in the budget request.</li> <li>• Submit agency strategic plans to the General Assembly and Governor no later than September 1 each year.</li> <li>• Report (annually) on the adjusted performance measures and standards to the Chairmen of the Senate and House Finance, Ways and Means Committees.</li> <li>• Annually evaluate each agency's compliance with its strategic plan and report to the Governor and the Senate and House Finance, Ways &amp; Means Committees on agency compliance. May make recommendations on the use of incentives and/or disincentives for inclusion in the appropriations bill.</li> </ul>	<ul style="list-style-type: none"> <li>• Pursuant to implementation schedule developed by F&amp;A, submit (annually) an agency-specific strategic plan meeting the requirements outlined in the Governmental Accountability Act no later than July 1 each year.</li> <li>• Submit to F&amp;A proposed performance measures and standards for each program for which a budget request must be submitted.</li> <li>• Submit to F&amp;A (annually) any documentation required by the Commissioner of F&amp;A regarding the validity, reliability, and appropriateness of each performance measure.</li> </ul>	<ul style="list-style-type: none"> <li>• Maintains final approval of all strategic plans, performance measures, and standards through the appropriations bill.</li> <li>• May specify through appropriations bill incentives or disincentives relative to performance-based budgeting.</li> </ul> <p><b>Incentives</b> may include</p> <ul style="list-style-type: none"> <li>• additional flexibility in budget management, salary rate, and position management;</li> <li>• retention of up to 50% of unexpended and unencumbered balances (with limited exclusions) that may be used for non-recurring purposes; and</li> <li>• additional funds for, but not limited to lump-sum bonuses, employee training, or productivity enhancements.</li> </ul> <p><b>Disincentives</b> may include</p> <ul style="list-style-type: none"> <li>• mandatory quarterly progress reports;</li> <li>• program elimination/restructuring;</li> <li>• position and/or appropriation reduction; and</li> <li>• reduction of managerial salaries.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct performance reviews of agencies operating under performance-based budgeting including such matters as deemed appropriate related to the manner in which the entity is delivering its services and achieving its objectives, including but not limited to <ul style="list-style-type: none"> <li>• the efficient use of state and federal resources and user fees;</li> <li>• additional non-state revenue or cost savings that the entity could achieve; and</li> <li>• the extent to which the entity has achieved the objectives of its strategic plan.</li> </ul> </li> <li>• The Comptroller serves as chairman of Tennessee Governmental Accountability Commission. (Refer to "Governmental Accountability Commission" requirements in next column.)</li> </ul>	<ul style="list-style-type: none"> <li>• A three-member commission established by the Governmental Accountability Act. The Commission is comprised of the Comptroller, who serves as the Chairman; the Executive Director of the Fiscal Review Committee, who serves as Vice Chairman; and the Director of the Legislative Budget Office, who serves as Secretary.</li> <li>• Commission to meet at least annually to review the annual performance report submitted by the Commissioner of F&amp;A and make comments and recommendations to the Senate and House Finance, Ways and Means Committees on (1) agency strategic plans and actual performance of agencies during the prior fiscal year, (2) the reasonableness of recommended performance measures and standards in the budget in the next fiscal year, and (3) on any other matter the Commission deems appropriate.</li> </ul>

Strategic Planning and Performance-Based Budgeting Funding

Since fiscal year 2002-2003, the State of Tennessee expended \$14.4 million (\$11.8 million from the General Fund) implementing the planning, performance-based budgeting, and program evaluation components of the Tennessee Governmental Accountability Act. The total dollars spent represent the eight-year total cost of 29 additional full-time planning, budget, and audit staff across 14 state agencies from fiscal year 2002-2003 and fiscal year 2006-2007. Beginning in fiscal year 2007-2008, there were no new performance-based budgeting positions authorized, as newly phased-in agencies were required to implement performance-based budgeting within existing resources. The following table reflects the 29 performance-based budgeting positions by agency as of July 1, 2010.

**Table 4**

**Tennessee Governmental Accountability Act  
Authorized Positions by Agency  
As of July 1, 2010**

<b>Agency</b>	<b>Authorized Positions <sup>1</sup></b>
Finance and Administration – Division of Budget	3
Comptroller	6
Revenue	1
Environment and Conservation	2
Safety	2
Human Services	2
Finance and Administration	1
Economic and Community Development	1
Agriculture	1
Correction	2
Transportation	2
Education	2
Labor and Workforce Development	1
Military	1
General Services	1
Commerce and Insurance	1
	<hr style="width: 100%; border: 0.5px solid black;"/> 29

<sup>1</sup> Executive Branch agency positions are planning and budget staff. Comptroller positions are Performance Auditor positions.

Source: Department of Finance and Administration, Division of Budget Staff.

In fiscal year 2009-2010, the total recurring cost to fund the 29 performance-based budgeting positions totaled \$1.75 million. The following chart depicts the total incremental recurring funding and net newly authorized performance-based budgeting positions between fiscal year 2002-2003 and fiscal years 2009-2010.

**Table 5**

**Tennessee Governmental Accountability Act  
Recurring Funding and Net Authorized Positions  
Fiscal Years 2002-2003 through 2009-2010**

Fiscal Year	Incremental Recurring Funding				Planning/PBB Positions Authorized
	General Fund	Highway Fund	Departmental Revenue	Total	
2002-03	\$892,600	-	\$92,100	\$984,700	13
2003-04	\$185,300	144,000	-	\$329,300	4
2004-05	\$112,300	-	-	\$112,300	1
2005-06	\$316,100	-	-	\$316,100	5
2006-07	\$312,800	-	\$254,500	\$567,300	8
2007-08	-	-	-	-	-
2008-09	(\$68,600) <sup>1</sup>	-	(\$72,100) <sup>2</sup>	(\$140,700)	(2)
2009-10	-	-	-	-	-
<b>TOTAL</b>	<b>\$1,750,500</b>	<b>\$144,000</b>	<b>\$274,500</b>	<b>\$2,169,000</b>	<b>29</b>

1. Reduction in one budget and planning position with F&A Division of Budget.

2. Reduction in one budget and planning position within the Department of Financial Institutions

Source: Department of Finance and Administration Budget Staff.

In fiscal year 2010-2011, due to budget constraints, the General Assembly replaced \$986,300 in recurring general fund funding with non-recurring dollars. These general fund dollars, in addition to \$278,100 in departmental revenue, support 20 of the 29 performance-based budgeting positions. Only the three planning and budget positions in the Department of Finance and Administration Division of Budget and the six Comptroller Performance Audit positions remain funded in the current year with recurring dollars.

Requirement for Annual Appropriation Through 2011-2012 to Prevent Nullification

Section 8 of Public Chapter 875, Public Acts 2002 (Tennessee Governmental Accountability Act), states, “This act shall be null and void unless appropriations necessary to implement its provisions are made in each general appropriations act for fiscal years 2002-2003, 2003-2004, and any future years in which the requirements of this act are being extended to additional state agencies. The Commissioner of Finance and Administration shall certify to the Tennessee Code Commission any fiscal year in which appropriations necessary to implement the

provisions of this act are not made in the general appropriations act.” Therefore, should the General Assembly decide not to appropriate funding for performance-based budgeting in fiscal year 2011-2012, the last year of the agency phase-in, the Act would consequently become null and void.

### Key Observations

In order to assess the status of the implementation of performance-based budgeting and other requirements of the Tennessee Governmental Accountability Act, auditors met with officials within the F&A Division of Budget to discuss the status of implementation. Auditors also drew upon previous work including interviews with officials at the initial nine performance-based budgeting agencies, observations of legislative budget hearings, and testwork of program performance measure results at the Departments of Safety, Revenue, Environment and Conservation, and Agriculture. The following observations were made as a result of information obtained through these interviews, observations and testwork.

#### *Performance Measures Presented in the Agency Strategic Plan Document Need to be Improved So That They Are Useful in Critical Management and Budget Decision-making Processes, Align Clearly with Stated Goals, and Have Achievable yet Challenging Targets*

While state agencies have demonstrated a sustained commitment to strategic planning and to the establishment of performance measures, improvement is still needed to enhance the quality and the overall usefulness of performance measures. In reviewing performance measures listed in the *Agency Strategic Plans* documents, and in conducting testwork on the accuracy, reliability, and validity of reported performance measure results, auditors identified many instances where individual performance measures either lacked clear definitions; did not report on information which would be useful for strategic or budgetary decision-making; and had questionable targets which did not challenge the agency or that were counter to the standards established for the program. In addition, a limited number of performance measure results were not auditable or were inaccurate or invalid.

Section 9-4-5606, *Tennessee Code Annotated*, states that “each state agency subject to performance-based budgeting shall submit to the Commissioner of Finance and Administration any documentation required by the Commissioner regarding the validity, reliability, and appropriateness of each performance measure and standard and regarding how the strategic plan and the performance measures are used in management decision-making and other agency processes.” However, according to the Director of the Department of Finance and Administration’s Division of Budget, the Commissioner of F&A has not required any such documentation.

According to agency personnel involved in the development of agency strategic plans, one of the most difficult aspects of the strategic planning process is developing meaningful performance measures that support overall agency goals and programs. Some of the reasons

given were the requirement that measures have to be developed for every allotment code even when the allotment codes do not represent actual programs, a lack of data in inadequate information systems that prevent the agency from gathering information in a timely manner, and limited financial and personnel resources to develop and track performance data.

Department personnel stated that the biggest hurdle to developing meaningful performance measures has been linking performance measures to every budget allotment code. Per the requirements of the act, all state agencies are required to develop performance measures on a program-by-program basis (or by allotment code). It is not efficient or effective for agencies to develop, track, and report performance measures for every function or activity. This requirement increases the number of measures that must be tracked, and in the long run, the volume of information presented to decision-makers diminishes the overall value of the performance information provided. Agency personnel stated that they would like to have greater flexibility in creating and revising performance measures than the allotment code provision currently allows.

*Departments Need to Improve Controls over Information Systems and Other Data Capture Methods as Well as Establish Policies and Procedures Regarding Data Collection, Data Verification, and Performance Reporting Activities to Better Ensure Accuracy, Reliability, and Validity of Reported Performance Results*

To ensure the accuracy and reliability of reported performance results, state agencies under performance-based budgeting need to improve controls over information systems and other methods for collecting, storing, analyzing, and reporting performance information. Also, state agencies need to develop policies and procedures over their performance management activities, with specific emphasis on data collection, data verification, and data reporting.

With limited resources available to state agencies to acquire new information technology to implement a performance measurement system or for upgrading existing information systems, state agency staff have adapted by using data extracted from existing information systems, or by developing an internal data collection, tracking, analysis, and reporting system. Since arriving at a performance measure result typically involves performing one or more calculations, agency personnel have extracted the necessary performance data from an existing information system, or self-maintained database, and manually perform the necessary calculations (typically within an electronic spreadsheet) to arrive at the actual performance measure result. As observed by auditors, and as reported in interviews with agency personnel, the databases and spreadsheets used to collect, track, analyze, and report performance data rarely have adequate access or data entry controls to minimize or prevent reporting errors.

With respect to limited resources for new information systems, it should be noted that \$1.8 million was appropriated by the General Assembly in fiscal year 2002-2003 for use in systems development; however, this funding went unspent for this intended purpose. Rather, per officials with the Department of Finance and Administration Division of Budget, all of the

funding had been held in reserve until it was reverted to the General Fund at June 30, 2008, as part of the reserve taken to close fiscal year 2007-2008 as authorized in the 2008 Appropriations Act (Public Acts of 2008, Chapter 1203, Section 67).

In addition to improving system controls, agencies should also establish policies and procedures over their established planning and performance management process to aid in ensuring the accuracy and consistency in reporting of performance information. A review of documents at the first four agencies to implement performance-based budgeting revealed that none of these agencies maintain comprehensive department-wide policies and procedures covering the data collection, data verification, and data reporting functions for their performance management systems. While some agencies maintain variations of a basic data collection plan which includes information such as the names of individuals responsible for collecting data for a particular performance measure, how that data was collected, the types of systems used to collect the data, and other relevant performance measure information, these plans are limited in their procedural guidance, are silent as to oversight to ensure compliance, and do not always reflect current practices.

Accurate, reliable, and valid performance data are vital to the success of a performance management initiative. If performance data are inaccurate, unreliable, or invalid, then any decisions made based on that data will also likely be amiss. In order to ensure that agency managers, legislators, and other stakeholders have the most accurate, reliable, and valid performance data, agencies should ensure that they have adequate controls over all information systems used to manage performance information. Additionally to ensure consistency in reporting accurate and reliable results, agencies should document their policies and procedures.

*The Reporting of Performance Information Needs to Be Improved to Make it Easier to Assess an Agency's Progress Toward Meeting Its Stated Goals and Objectives*

Effective communication is vital to the successful implementation of a performance measurement and performance management system. To be effective, performance information should provide a clear picture and an uncomplicated, straightforward assessment of an agency's progress toward its goals. While Tennessee agencies have a basic framework in place, improvements are needed to ensure that critical decisions, including resource allocation decisions, can be made from the strategic planning and performance information reported.

A stated objective of the Tennessee Governmental Accountability Act is to implement a system that will generate the information necessary for the public to be informed fully and for the General Assembly to make meaningful decisions about the allocation of scarce resources in meeting vital needs. This objective can only be accomplished if agency progress can be clearly discerned. Today, in the State of Tennessee, the documents prepared annually to communicate agency results statewide make it difficult to assess an agency's overall progress in relation to its goals, or to make meaningful resource allocation decisions.

The General Assembly's primary source for performance information is the two-volume *Agency Strategic Plans* document, which is F&A's compilation of five-year agency strategic plans and program performance measure information.

While the *Agency Strategic Plans* document does contain all required information outlined in the act, the reported program performance measure data only contain the actual performance measure results from the most recent fiscal year-end, an estimate for the current year, and a target for the upcoming year. This is the same format as the Budget Document, and while it works well for the Budget Document, it is not a practical tool for easily assessing progress in a performance management environment. The weakness is that it lacks historical information to quickly and adequately assess agency performance, make annual comparisons, or identify trends. This is an important tool which would have a practical application in budget hearings. Currently, to make any meaningful historical comparisons, one would need to manually review prior-year documents for each performance measure of interest and obtain actual results and targets. Additionally, there are few notations or footnotes to explain estimates or targets when these conflict with the stated standard.

The *Annual Program Performance Report* prepared by the Commissioner of Finance and Administration evaluates each state agency's compliance with its strategic plan and performance-based measure. The *Annual Program Performance Reports* are practical in that they identify all program performance measures by agency by program; they report the original "Target" established for each measure and the "Actual" fiscal year-end result; and they document any agency comments for goals materially missed. However, the following issues make this tool less valuable for decision-making: (1) program performance measures reported are often dated due to the changes to programs and/or performance measures over time, and are often significantly different from the current measures immediately in front of the Finance Committees; (2) the report does not contain any information on compliance with the strategic plan, only performance-based measures; and (3) there is no consistency in reporting of agency comments (there is a lack of clarity in what defines a "materially" missed measure that would require an agency to document comments).

#### *Departments Need Ongoing Coordinated Training*

Within each agency, the training provided relative to strategic planning and performance-based budgeting has varied but what has been provided has typically involved sending selected staff to seminars, "webinars," and one-on-one training between planning staff and management. The Department of Finance and Administration has provided guidance on performance measure development on an as-needed or as-requested basis through an assigned budget analyst. Also, F&A issues annual guidelines to assist agencies in developing their strategic plan and performance measures as required by the 2002 Accountability Act. These guidelines are very concise and limited in the instruction they provide to the departments.

Funding had been appropriated for departmental training but was reverted to the general fund as a part of a reserve taken to close fiscal year 2007-2008. The General Assembly appropriated \$500,000 in fiscal year 2004-2005 to be used for program evaluation and training. This funding went unspent, and per officials with the Department of Finance and Administration's Division of Budget, was held in Miscellaneous Appropriations and carried forward each subsequent fiscal year until it was reverted at June 30, 2008, as part of the reserve taken to close fiscal year 2007-2008. The reserve taking was authorized in the 2008 Appropriations Act (Public Acts of 2008, Chapter 1203, Section 67).

Performance-based budgeting requires agencies to adopt a new culture that emphasizes results rather than processes and outcomes rather than inputs. If this new culture is to be embraced across all state agencies, it is imperative that all managers and employees have access to ongoing training and technical assistance. The training needs to emphasize the continued benefits of strategic planning and performance measurement. Ideally, the Department of Finance and Administration should be working closely with each agency's budget office to ensure that appropriate training is being provided.

*Leadership Is Needed Throughout the Strategic Planning and Performance-Based Budgeting Process If Meaningful Budget Reform Is Going to Be Achieved*

If meaningful budget reform is going to be achieved as a result of the requirements of the Tennessee Governmental Accountability Act of 2002, then leadership is needed at all levels of state government. The theory behind performance-based budgeting (PBB) is that it provides legislators with a way to strengthen governmental accountability by linking budget decisions and government performance. If successful, performance-based budgeting offers policymakers increased program accountability and efficiency, increased knowledge about state services and programs, and improved communication with state departments and agencies. In order for performance-based budgeting to be successfully implemented, it is necessary for legislators to continue to clarify both the purpose and the expected results.

Auditors have attended both House and Senate budget hearings in an attempt to determine whether hearings for those agencies operating under performance-based budgeting guidelines were conducted any differently than those that have not yet entered the process. While we observed that there were a few questions asked about agency performance measures, by and large, the budget hearings for all agencies were conducted in the same manner. If performance-based budgeting is to succeed in Tennessee, it is imperative that the legislature begin proactively using the planning and performance information. At a minimum, this means asking agencies specific questions about the performance measures presented as well as providing feedback on measures that should or should not be included. Over time, this will enable state agencies to develop and present information that is useful and that can be relied on to make resource allocation decisions.

In addition to increased legislative involvement in the performance-based budgeting process, leadership is needed at the executive level. As the administrator of the strategic planning and performance-based budgeting initiative, Finance and Administration officials should take a proactive approach in assisting agencies to ensure that the plans and measures presented to the legislature provide the critical elements upon which to base budget allocation decisions.

*The Existing Strategic Planning and Performance-Based Budgeting Process Has Not Met the Legislative Intent of Constituting a New Approach to the Budgeting, Planning, and Accountability Process*

Section 9-4-5605, *Tennessee Code Annotated*, states that “it is the legislative intent that the requirements of the Tennessee Governmental Accountability Act of 2002 constitute a new approach to the budgeting, planning and accountability process, rather than an addition to existing procedures.” Personnel from many of the agencies we spoke with report that the performance-based budgeting process is useful, but it is not what drives budget decision-making within the departments. Agency personnel reported struggling with ways to improve the reported measures and the usefulness of the performance-based budgeting process itself when little to no guidance or feedback is provided when performance-based budgeting targets are or are not met. Thus far into the implementation of strategic planning and performance-based budgeting, there is no link between the performance-based budgeting plan and the state’s budget.

Conclusion

Tennessee has taken an ambitious step in attempting to reform the way it funds government programs and the way it holds agencies accountable for the results provided to citizens. The Tennessee Governmental Accountability Act of 2002 was intended to improve the state’s system for appropriating funding by requiring agencies to focus on the results or outcomes of their activities rather than on the activities themselves. Whether the act will result in increased accountability, improved public management, or increased knowledge about state programs and services on the part of policymakers remains to be seen. However, if performance-based budgeting is going to bring about “a new approach to the budgeting, planning, and accountability process” in Tennessee, then it is going to require leadership from all stakeholders in the process. Without executive and legislative guidance, leadership from top agency management, and buy-in from agency personnel at all levels, Tennessee’s strategic planning and performance-based budgeting process will result in little more than a planning document created to meet the statutory requirements of the act. As such, it will not meet the express legislative intent of the law to create a new approach to budgeting in Tennessee.

As budgetary resources continue to tighten, the ability for all stakeholders to determine the efficiency and effectiveness of state programs becomes even more critical. Clearly identified goals with quality performance measures are tools that can assist agency managers, the General Assembly, and other stakeholders in making critical strategic, operational, and budgetary

decisions. Agencies need to continue to review, revise, and improve their goals; strengthen their performance measures with a focus on outcomes; ensure that the results provided by those measures are valid, reliable, and accurate; and ensure targets established are challenging yet attainable.

**Table 6**

**Performance-Based Budgeting  
Executive Branch Agency Implementation  
FY 2004-2005 Through FY 2011-2012**

**FY 2004-2005**

Environment and Conservation  
Human Services  
Revenue  
Safety

**FY 2005-2006**

Agriculture  
Correction  
Economic and Community Development  
Finance and Administration  
Transportation

**FY 2006-2007 and FY 2007-2008**

No new state agencies under performance-based budgeting.

**FY 2008-2009**

Commerce and Insurance  
Education  
Financial Institutions  
General Services  
Labor and Workforce Development  
Military

**FY 2009-2010**

Board of Probation and Parole  
Health  
Human Resources  
Mental Health and Developmental Disabilities  
Tennessee Bureau of Investigation  
Tennessee Regulatory Authority  
Tennessee Rehabilitative Initiative in Correction (TRICOR)  
Tennessee Wildlife Resources Agency

**FY 2010-2011**

Advisory Commission on Intergovernmental Relations  
Aging and Disability  
Alcoholic Beverage Commission  
Arts Commission  
Children's Services  
Commission on Children and Youth  
Corrections Institute  
Health Services and Development Agency  
Human Rights Commission  
Intellectual Disabilities Services  
State Museum  
Tennessee Housing Development Agency  
Tourist Development  
Veterans Affairs

**FY 2011-2012**

Higher Education  
TennCare  
Cover Tennessee

## Overview of the Tennessee Governmental Accountability Act

The Governmental Accountability Act established the framework for planning and budget reform in Tennessee. The act requires administration and oversight of strategic planning by the Commissioner of Finance and Administration; preparation and execution of strategic plans by all state agencies, boards, and commissions; performance reviews by the Comptroller of the Treasury and the Governmental Accountability Commission; and plan review and utilization by the General Assembly in making resource allocation decisions. The following information highlights the key requirements of the act.

### Strategic Planning

Beginning July 1, 2003, each state agency subject to performance-based budgeting is required by the act to submit a strategic plan to the Commissioner of Finance and Administration for delivering the services and achieving the objectives required of it under the laws of the state and any federal program in which the state participates. Since that time, the Commissioner of F&A has required all state agencies to submit strategic plans annually, regardless of the agency's performance-based budgeting status. The strategic plans are agency plans which are prepared on a program-by-program basis based upon guidelines issued annually by the Department of Finance and Administration's Division of Budget.

The act specifically directs the Tennessee Higher Education Commission to submit a single strategic plan to the Commissioner of F&A for all higher education units, with advice from The University of Tennessee, the state university and community college system, and the Tennessee Student Assistance Corporation. The Administrative Office of the Courts is to prepare the plan for the Court System, including the District Attorneys General Conference, the District Public Defenders Conference, and the Office of the Post-Conviction Defender. The Joint Legislative Services Committee is to prepare a plan on behalf of the Legislative Department.

The act requires the Comptroller, Secretary of State, and Attorney General to submit their plans separately.

Agency strategic plans must include

- the statutory and constitutional objectives of the agency;
- the scope of services the agency is required to provide and the best means to provide those services;
- optional services the agency may provide, if resources permit, and the best means to provide those services;
- means of maximizing federal or other non-state sources of revenue;
- means of avoiding unnecessary costs and expenditures;
- means of addressing any change in objectives or services since the previous strategic plan;

- obstacles to meeting objectives and delivering services;
- means to overcoming obstacles; and
- future challenges and opportunities.

The act requires the Commissioner of Finance and Administration to consolidate the agency plans for transmittal to the Governor and General Assembly.

### Performance-Based Budgeting

Strategic plans, including program performance measures and standards, are to be submitted to the Governor and General Assembly by September 1 each year for the current fiscal year. To meet this requirement, staff with F&A's Division of Budget prepares the *Agency Strategic Plans* document, which is presented in two volumes. Volume 1, *Five Year Strategic Plans*, includes each agency's plan, along with agency-wide goals and performance measures focused on the most important priorities of the agency. Volume 2, *Program Performance Measures*, includes program-specific performance measures and standards for each of the agencies. Volumes 1 and 2 together contain the strategic planning information required by the Governmental Accountability Act.

Legislative review of strategic plans is a continuous process throughout the year. Pursuant to the act, the General Assembly has final approval of all strategic plans, performance measures, and standards through the general appropriations act.

To assist the General Assembly in its review process, the act requires the following:

1. An annual report on adjustments to current year performance standards and measures by the Commissioner of the Department of Finance and Administration, with a report to the Governor and the Senate and House Finance, Ways and Means Committees prior to consideration of the appropriations bill.
2. An annual program performance report by the Commissioner of F&A submitted to the Governor and Senate and House Finance, Ways and Means Committees evaluating each state agency's compliance with its strategic plan and performance measures. This report is to include agency comments.
3. An annual report by the Governmental Accountability Commission, which is charged with reviewing the program performance report submitted annually by the Commissioner of Finance and Administration. The commission is comprised of the Comptroller of the Treasury who serves as chairman, the Executive Director of the Fiscal Review Committee who serves as vice-chairman, and the Director of the Office of Legislative Budget Analysis who serves as secretary. The commission is to comment in writing on its review, and may make recommendations on the strategic plan, the actual performance of agencies participating in performance-based budgeting, the reasonableness of performance standards and measures recommended in the budget document or other strategic planning or program performance matter the commission deems appropriate.

The law also enumerates incentives and disincentives which the Commissioner of F&A may recommend to the Governor and the Senate and House Finance, Ways and Means Committees for potential inclusion in the appropriations bill.

The incentives may include but are not limited to (1) additional flexibility in budget management; (2) additional flexibility in salary rate and position management; (3) retention of up to 50% of unexpended and unencumbered balances of appropriations, excluding special categories and grants in aid, that may be used for non-recurring purposes including, but not limited to, lump-sum bonuses, employee training, or productivity enhancements, including technology and other improvements; and (4) additional funds to be used for, but not limited to, lump sum bonuses, employee training, or productivity enhancements, including technology improvements.

Disincentives may include but are not limited to (1) mandatory quarterly reports to the Governor on the agency's progress in meeting performance standards; (2) mandatory quarterly appearances before the Governor to report on the agency's progress in meeting performance standards; (3) elimination or restructuring of the program, which may include, but not be limited to, transfer of the program or outsourcing all or a portion of the program; (4) reduction of total positions for a program; (5) restriction on or reduction of the appropriation for the program; and (6) reduction of managerial salaries.

To date, there have not been any recommendations by the Commissioner of F&A to utilize any of these incentives or disincentives.

State agencies are responsible for tracking their performance results throughout the year. Agencies may request adjustments to the performance measures and standards annually based on changes in the program appropriations made by the General Assembly. These adjustments require the approval of the Commissioner of Finance and Administration, who must report these adjustments to the Senate and House Finance, Ways and Means Committees. State agencies may also submit changes to their performance measures and standards at any time during the fiscal year in which a state agency, by restraining order, injunction, consent decree, settlement, or any final judgment of a court, or by law or executive order, is required to modify its operations, or if the agency receives additional federal or other funding.

### Performance Reviews

Each state agency is subject to a performance review of its activities by the Comptroller of the Treasury. These reviews are to include such matters as the Comptroller deems appropriate related to the manner in which the entity is delivering its services and achieving its objectives including, but not limited to:

1. the efficient use of all state and federal resources and user fees;
2. additional non-state revenue or cost savings that the entity could achieve; and
3. the extent to which the entity has achieved the objectives of the strategic plan.

The Comptroller's Office, Division of State Audit, conducts performance reviews of strategic plans and program performance measures as part of performance audits conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29.

## **Policies and Procedures for Leases Require Changes**

### Background

Section 12-2-114 et seq., *Tennessee Code Annotated*, and State Building Commission policies and procedures based on these sections govern how the Department of Finance and Administration's Asset Management Section administers state leases. (The Asset Management Section is part of the department's Division of Real Property Administration.) Section 12-2-114 requires that

When it becomes necessary for any agency of the state to lease space, the Commissioner of Finance and Administration, through the Division of Real Property Management, shall prepare a general statement of such agency's space needs, and shall advertise such needs in a newspaper of general circulation in the city and/or county where the space is needed. The advertisement shall be run on at least one (1) occasion at least two (2) weeks before proposals are opened. The cost of such advertisement shall be borne by the state department or agency requesting the space.

Leasing transactions "involving new, succeeding, superseding leases or lease renewals," must be advertised. Section 12-2-114 allows for four exceptions to the advertising requirement:

- (1) Where the annual rental will be less than an amount to be specified by policy of the State Building Commission, the amount not to exceed \$25,000, or where the term of the lease will be one year or less;
- (2) Where property is owned by a governmental agency and leased to another governmental agency;
- (3) Where a supplemental agreement is made to an existing lease for additional space at a negotiated price without modifying the original lease term; or
- (4) Where the space required by the state department or agency, including institutions of higher education, has special and unique requirements as determined and approved by the State Building Commission.

As allowed by Section 12-2-114, the State Building Commission requires that all leases involving rent payments over \$8,500 per year be advertised. Section 12-2-115 requires that if

“any proposed lease of property by or to the state government or any agency, department, institution or office thereof is longer than five (5) years or if the consideration for any such lease amounts to more than seventy-five thousand dollars (\$75,000) per year or such other amount as determined by the state building commission, it shall first be submitted to and approved by the state building commission.” As allowed by Section 12-2-115, the State Building Commission requires its approval of leases longer than five years or where the annual rent exceeds \$40,000. Section 12-2-114 allows an agency to refuse the lowest bid if it concludes the space offered is unsuitable, upon approval of the Commissioner of Finance and Administration and the State Building Commission.

As of January 2010, the Asset Management Section managed 417 leases. The section has jurisdiction mostly over leases for general office space, general warehouse space, and some special facilities for executive and legislative branch agencies. The section does not have jurisdiction over leases involving the judicial branch, parks, or prisons unless leasing costs are covered by the Facilities Revolving Fund (FRF). FRF, as required by Section 9-4-901 et seq., charges each state agency its proportionate share of the cost of housing state agencies on a rentable square foot basis. FRF square foot rental rates are determined for properties in each county by Asset Management and the Division of Budget based on local rental costs.

We reviewed a random sample of 25 of the 417 leases to determine if the Asset Management Section is meeting all requirements regarding the advertising, bidding, and selection of leases. We did not find significant problems with how the section managed the leases based on this review. We also contacted facility officials with the five agencies with the most rental payments through leases managed by the Asset Management Section, as of November 2009. These agencies were the Departments of Human Services, Children’s Services, Environment and Conservation, and Safety, and the Board of Probation and Parole. None of these officials mentioned significant problems with how Asset Management administers leases.

We had concerns that extensions of current leases (called holdovers) might have an adverse financial impact on agencies as the owner of the property, or lessor, might charge a higher rent than that stipulated in the lease, as legal constraints against a rise in rent end with the official ending date of a lease. Both the Director of Asset Management and the officials of the five agencies we contacted stated that this was not a serious problem. Causes of holdovers include late submission of lease requests by agencies for new leases or renewals (which should be submitted at least a year in advance, according to an agency official), difficulties in predicting agency space requirements because of uncertain budgets, difficulties in finding suitable space, construction delays (e.g., caused by inclement weather), architectural delays, delays in Fire Marshal approval of designs, lack of Asset Management staff, and, in the current financial crisis, lessors finding it difficult to get loans to build or remodel facilities. We found two problems with policies and procedures relating to the administration of leases.

#### No Time Limits on Holdovers

The State Building Commission’s policies and procedures, *By-Laws, Policy and Procedure of the State Building Commission of Tennessee*, do not have time limits on how long

holdovers can be used for specific leases. The standard lease form, or instrument, also does not require any such time limits for holdovers. Without such time limits, a lease theoretically could be continued in perpetuity, bypassing the competitive bidding process required by Section 12-2-114. The State Building Commission should add a time limit on how long a holdover or holdovers should be used per lease, after consulting the Asset Management Section.

#### Need for Relocation of Requirement for State Building Commission Approval

The other problem is the misplacement of the following requirement in the commission's policies and procedures:

All leases and lease amendments where the State is the lessee with consideration of more than \$40,000 per year or a term of longer than five (5) years shall require State Building Commission approval, or approval by an authorized sub-committee thereof, in accordance with TCA 12-2-115. Additionally, such leases must be approved by the Attorney General.

This requirement is in the F section of Item 7.01, which pertains to higher education leases. According to the Director of Asset Management, the State Building Commission does require her section to adhere to this requirement for all leases. Item 7.03 of the policies and procedures implies the requirement applies to all leases: "any amendment to a lease which was not submitted and approved by the Commission because the term was less than five years or the consideration was less than \$40,000, but due to the amendment or the aggregate effect of amendments now exceed those limits, shall be submitted to the Commission for approval prior to the execution of the lease amendment." To clarify that all leases which involve rent over \$40,000 per year or are more than five years in duration are subject to State Building Commission review and approval, the commission should remove the requirement from the F section and make it a stand-alone section in Item 7.01.

#### **Surplus Real Property Disposal**

Section 12-2-112, *Tennessee Code Annotated*, gives the Department of Finance and Administration the authority to dispose of "any interest in surplus state real property" if the department meets several conditions, including

- transferring the property at no cost to any state agency which wants the property;
- notifying the House and Senate member or members from the district in which the property to be sold or conveyed is located at least 20 days prior to the agreement of sale or conveyance;
- having the property appraised by at least two independent, qualified appraisers, wholly disconnected from state government or any other legal governmental entity except as may otherwise be determined by the State Building Commission;

- if the surplus property has an average appraised value exceeding \$25,000, advertising the property no less than one time in a newspaper which is local with respect to the property to be sold and once in a newspaper in either Nashville, Memphis, Chattanooga or Knoxville, whichever is nearest by air (provided, that if one of these four cities is the location of the property to be sold, advertisement shall be made twice within a two-week period); and
- selling property of such value through the seal bid method, upon the approval of the Governor, the Attorney General and reporter, and the Commissioner of Finance and Administration.

Section 12-2-112 allows the Department of Finance and Administration to permit the negotiated sale or disposal of surplus real property without appraisals or advertising to any legal governmental body for a public use purpose, as the State Building Commission may deem in the best interest of the state. A state agency wanting to dispose of surplus real property must first submit a request to the department's Office of Real Estate Management using a Real Property Management Transaction Form (RPM 1). The State Building Commission must approve the request before the disposal of the property can proceed.

We conducted a review of all real property disposals for calendar years 2007 through 2009 by the Office of Real Estate Management that involved sales to private individuals or organizations or governments to determine if the office met all requirements of Section 12-2-112. Excluded from the review were 17 properties either donated or sold at a discount to local governments for the public welfare. The office used the method called "fee simple," where all rights to the property are conveyed to the new owner. We determined, based on this review, that the Office of Real Estate Management appears to be properly disposing of state surplus property through fee simple.

We contacted property management officials in the state agencies, aside from the Department of Finance and Administration, which had real property disposals of at least \$10,000 each during the three-year period of our review. These agencies were the Departments of the Military and Transportation, the Tennessee Board of Regents, and the University of Tennessee. None of these officials reported significant problems with how the Office of Real Estate Management disposes of surplus state real property.

### **State Health Plan Released in 2009**

We reviewed the department's compliance with state law requiring a state health plan and found that the first plan was released in 2009. In 2004, the General Assembly created the Division of Health Planning under Section 68-11-1625, *Tennessee Code Annotated*, and charged it with developing a state health plan that "shall guide the state in the development of health care programs and policies and in the allocation of health care resources in the state."

The Division of Health Planning developed the first edition of the State Health Plan (released in November 2009), which focuses on the public health status of Tennesseans and also

addresses the certificate of need process. The State Health Plan serves as the basic framework for addressing the healthcare needs of the state. The Tennessee State Health Plan was completed in November 2009 and states in its Key Principles that the purpose of the State Health Plan is to improve the health of Tennesseans.

#### The Five Principles for Achieving Better Health Stated in the Health Plan

The following principles are stated in the State Health Plan:

1. *The purpose of the State Health Plan is to improve the health of Tennesseans....* The State Health Plan will present Tennessee's current state of the following key determinants of health: nutrition and exercise; chronic conditions; mental health and substance abuse; preventive health care; and maternal and prenatal care. The description of the current status of our health determinants is intended to support an informed public discussion of how we as Tennesseans should work together to achieve our common goal of improving our health.
2. *Every citizen should have reasonable access to health care.* Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture.... The State Health Plan can provide standards for reasonable access and offer policy direction to improve access. In addition, the State of Tennessee currently seeks to expand access to health care through its Safety Net initiative, Cover Tennessee, and multiple other programs and services. The State Health Plan can serve a coordinating role to expand health care access through these efforts, increasing both the effectiveness and the efficiency of the state's resources.
3. *The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system....* A State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system, and to encourage innovation and competition. However, while competition can increase the efficiency of Tennessee's health care system, the State Health Plan must also consider the issue of ensuring that the health care industry is able to make essential health care services accessible to every person in Tennessee, regardless of ability to pay.
4. *Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers....* The State Health Plan adopts the definition of "high quality care" used by The Institute of Medicine of the National Academies, private nonprofit institutions providing science, technology, and health policy advice under a congressional charter. That definition of "high quality care" is care that is safe, effective, patient-centered, timely, efficient, and equitable.... The State Health Plan will define Tennessee's strategy for measuring and improving the quality of care our citizens receive.

5. *The state should support the development, recruitment, and retention of a sufficient and quality health care workforce....* The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the safety net system, the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding. At the time of publication of this document, the current economic recession, for a variety of reasons, has alleviated some of the nursing workforce shortage pressures.

### Certificate of Need Standards

According to the *State Health Plan*, “Tennessee’s Certificate of Need (CON) program seeks to deliver improvements in access, quality, and cost savings through orderly growth management of the state’s health care system. State law directs the Health Services and Development Agency (HSDA) to use the State Health Plan as guidance in issuing CONs.” The Certificate of Need process aligns itself with the plan’s Five Key Principles for Achieving Better Health. As stated in the State Health Plan, these key principles contribute to improving the CON process by requesting that previous issues mentioned be heard, such as workforce allocation and assurances of high-quality care. According to the Director of Health Planning, by developing specific standards and criteria that are tied to the Key Principles, the CON components and the health components of the State Health Plan mutually support each other. The State Health Plan contains the standards and criteria for the Position Emission Tomography Services (PET) and the Cardiac Catheterization Services.

During the audit, the auditors interviewed the Advisory Committee Members who have experience at the state and local level as well as being involved with major professional public health organizations. The director stated that “the plan is a continually developing document, that by statute (TCA § 68-11-1602(15) and 1625(a)), is to include clear statements of goals, objectives, criteria and standards to guide the development of health care programs administered or funded by the state of Tennessee through its departments, agencies or programs, and considered as guidance by the Health Services and Development Agency when issuing Certificate of Needs.”

A Blue Cross Blue Shield representative and advisory committee member said that the plan did a good job of balancing the certificate of need process and the improvement of the public health status of Tennesseans. A representative from National HealthCare Corporation noted that with the development of the health plan, the state is focused on the big picture of examining the relationships of citizens, providers, and existing services; the need for additional services; and, eventually, outcome data. Many of those interviewed feel that the new State Health Plan does a good job of balancing the certificate of need process with the improvement of the public health status of Tennesseans.

## **RESULTS OF OTHER AUDIT WORK**

The following topics, reviewed as part of our audit objectives, are included in this report to provide additional information on the programs and activities of the Department of Finance and Administration.

### **Individuals Are Screened to Determine Eligibility for State Health Insurance Benefits**

The Department of Finance and Administration (F&A) has an established process to screen individuals and their dependents for eligibility for state employee health benefit programs that appears to be adequate. Further, the department has developed a system that appears to be reasonably adequate in recovering dollars paid for benefits to ineligible individuals.

#### Eligibility Screening Process

F&A provides departments with guidelines detailing benefit enrollment time frames, as well as criteria identifying the type of employee who is eligible for benefits (i.e., full-time or part-time). However, it is the responsibility of the hiring agency to verify the eligibility of employees and their respective dependents. Specifically, each department is supposed to screen new hires to determine whether they are full-time, part-time, or other (i.e., contract). Agency human resource directors subsequently submit new employee application data to F&A which keeps this information in electronic files. However, according to F&A officials, it is ultimately the individual employee's responsibility to keep track and notify his or her respective department's human resource division of any change to their dependent's eligibility.

Full-time employees are eligible for benefits as are part-time employees who have been employed by the state for at least 24 months and work at least 1,450 hours in a fiscal year. Individuals in positions classified as temporary appointments, or performing services on a contractual basis, are not eligible for benefits.

For existing employees, the state has a period during which they may change their respective benefit plans. However, an existing employee who has a major family change (i.e., a birth or divorce), may change plans outside this period. New employees must enroll within a month of their hire date. If they fail to sign up during this period, they must wait for the annual change in benefit period to sign up to receive benefits. However, if they have a significant life event (similar to an existing employee), they may sign up for benefits beyond their first month of hire.

On a monthly basis F&A, also compares individuals receiving state health benefits with state vital records to determine if there has been a change in member status such as a death or divorce. While this process will detect any change in marital status for individuals divorced within Tennessee, it will not identify divorces granted in other states.

Before the summer of 2009, agencies were not required to have their staff submit documentation verifying the eligibility of their dependents. Rather, prior to this time frame, employees merely had to attest that their dependents were eligible to receive benefits. However, in an effort to identify and remove ineligible individuals receiving state benefits, beginning in July and concluding in November 2009, F&A required all employees to submit documentation verifying the eligibility of all individuals receiving state health benefits. Examples of acceptable documentation included birth certificates and marriage licenses. According to information the department presented to the state insurance committee, the subsequent action resulted in 4,035 ineligible dependents being dropped from the state plan. The financial impact resulted in the state saving approximately \$11.9 million in annual premium contributions including \$8.3 million in recurring state funds. The remaining balance of savings is federal funds. However, according to department officials, the loss of the state's contributions to plan premiums will likely result in a relatively small reduction in cash flow to the plans themselves.

F&A officials state that unless otherwise instructed by the state insurance committee, they do not plan to conduct another employee verification project. Since F&A currently requires all new employees to submit documentation demonstrating the eligibility of their dependents before they may receive insurance coverage and the 2009 verification process identified irregular cases for existing employees, there is no need for another verification round.

According to F&A officials, the majority of ineligible cases involved dependents who did not meet eligibility guidelines, such as children and ex-spouses of employees. F&A policy states that eligible dependent children may not exceed the age of 19 unless they are unmarried and full-time students in a college, school, or university. Once dependent children reach the age of 24, they are deemed ineligible for state benefits regardless of their academic standing. Ex-spouses are not eligible for state benefits. F&A staff assert that the majority of identified cases were the result of employees accidentally failing to remove ineligible dependents from their benefits and not intentional efforts to circumvent department eligibility rules. As part of the audit, we reviewed data used by the department to verify health benefit eligibility.

The new state Enterprise Resource Planning system (known as Project Edison) helps F&A identify individuals who become ineligible for benefits. Namely, the system flags employees' dependent children once they reach the age of 19. This notification is intended to require the employee to provide documentation proving that their dependent is attending school. The Edison system also flags dependent children once they reach the age of 24, the year they become ineligible for state health benefits under any circumstances.

## Recovery of the Cost of Benefits Received in Error

Department officials report that the changes made by the department in the summer of 2009 requiring greater proof of benefit eligibility have substantially reduced the risk of individuals receiving benefits improperly. When detected, the department requires employees and retirees to reimburse the state if they have received insurance benefits they were not eligible for. However, F&A officials concede that due to the vast number of individuals covered by state health benefits, identifying every possible occurrence is difficult.

## Amnesty Period

Beginning in July 2009 and extending to the later part of 2009, the state announced an “amnesty period” on claim recovery. The state insurance committee made the decision to provide an amnesty period in an effort to help identify and remove ineligible recipients from the system. It was believed that people would voluntarily come forward if they were granted amnesty without fear of having to repay the state for benefits to which they were not entitled. However, amnesty was only granted to those individuals who self-reported. If during the amnesty period, and without the assistance of the employees, the state identified individuals receiving benefits that they were not entitled to, the employees were liable for the cost of services that they or their dependents had not been entitled to receive. Once the amnesty period expired in late 2009, any identified cases have resulted in F&A seeking full restitution. However, department officials report that the department did not identify any examples of benefits being improperly obtained since the conclusion of the amnesty period. Further, they report that due to the difficulty in proving fraud, the department seldom attempts to prosecute individuals who received benefits despite being ineligible. Rather, they simply attempt to obtain reimbursement.

The department’s benefit application form requires applicants to confirm that all information is accurate and states that the applicant can lose insurance benefits if he or she provides false information and will have to reimburse the state.

## **Multiple Channels Exist for Recipients of State Healthcare Benefits to Communicate With the Department of Finance and Administration**

In the Department of Finance and Administration (F&A), the Benefits Administration Division receives information regarding customer satisfaction with the state’s health benefits program from multiple sources. Department officials report that the combination of these sources of information helps them manage services provided by the various carriers as well as to address any problems that might arise. The department also has an appeal process for customers not satisfied with benefits decisions. However, it appears that the department has not maximized its efforts to help carriers address customer concerns. Namely, the department did not work with the carriers as required by contract to develop corrective action plans to address problems identified in customer satisfaction surveys conducted by the carriers. (See finding 2.)

## Sources of Information Received

### *Satisfaction Surveys*

Per contract with the state, each of the six health insurance carriers is to annually conduct a customer satisfaction survey. Carriers that fail to reach their required satisfaction threshold are subject to a monetary penalty. Further, and again per contract, the respective carriers and the department are supposed to jointly develop an action plan to correct problems or deficiencies identified in the satisfaction surveys. However, we found that in neither instance where the carrier failed to reach its designated satisfaction threshold did the department work with the carrier to identify the problem and develop a corrective plan. See finding 2 for more discussion on this issue as well as for the results of the 2008 satisfaction surveys for the six carriers. Department officials conceded that they could not explain how they determined satisfaction survey targets that the various carriers were required to meet. Rather, they stated that with the exception of dental carriers, each of the health carriers is to be accredited by the National Committee for Quality Assurance (NCQA). The NCQA is a private nonprofit organization whose purpose is to improve healthcare quality, but the organization does not accredit dental carriers. Department officials report that the NCQA requires that accredited entities use specified surveys.

### *Call Centers*

Department officials stated that while they review the results of the annual satisfaction surveys, they do not rely only upon them to manage state health benefits. Rather, they reported that they attempt to be proactive in their management efforts, respond to issues as they arise, and closely monitor customer feedback from the department's call center to identify problems. Department officials also stated that the vast majority of concerns pertain to why a benefit is not covered by a particular health plan. As part of the audit, we reviewed the report that the department maintains documenting the number and type of issues received by the call center.

### *Meetings With Carriers*

To further their efforts to be proactive, department officials report that they routinely meet with representatives of the various carriers to discuss issues that have arisen.

## Appeals Processes

While department management stated that they seek to resolve customer concerns by working with the individual carriers, the department periodically is unable to resolve all concerns to the customer's satisfaction. Therefore, the department has an established process that allows customers to appeal benefit decisions. The initial step is for individuals with a concern to contact their respective insurance company claims administrator. If the concern is not resolved to their satisfaction, they request an appeal with F&A's Benefits Administration Division. Members have two years to file an appeal from the time of the initial claims decision. Following several layers of review by department staff, which could include being reviewed by medical consultants, a decision on the claims status is made. According to department officials, appeal decisions are generally reached within 60 days of an appeal being filed. They stated that the 60-day time

frame, while not a department policy or procedure, is an industry norm used by most insurance companies. Department officials further stated that the department only tracks customer appeals that reach F&A. As part of our audit work, we reviewed the report that F&A uses to track customer appeals.

## **Cover Tennessee Health Care Programs**

According to Section 56-7-3003, *Tennessee Code Annotated*, the department is authorized to establish the Cover Tennessee program to offer health benefits coverage to eligible individuals through contractors. The four programs under the Cover Tennessee umbrella are CoverTN, CoverKids, CoverRx, and AccessTN. CoverTN is a partnership between the state, employers and individuals that makes healthcare coverage affordable for the state's working uninsured. CoverKids offers free comprehensive health coverage to qualifying uninsured children in Tennessee, age 18 and younger. CoverRx offers affordable prescription drugs to Tennesseans who lack pharmacy coverage. AccessTN is comprehensive health insurance for adults who are uninsurable due to preexisting conditions.

The Cover Tennessee programs, except for CoverKids, are primarily funded by state dollars and are not eligible to receive federal monies because they are limited-benefit programs. In 2007, AccessTN received a \$1 million federal seed grant, but has not received any federal money since then. For fiscal year 2010, the following amounts were received in state and federal dollars:

- CoverTN received \$20,123,000 in state dollars;
- AccessTN received \$23,049,200 in state dollars;
- CoverRx received \$11,088,500 in state dollars; and
- CoverKids received \$28,956,100 in state dollars and \$86,754,600 in federal dollars.

The Cover Tennessee programs have contracts with the following insurance, eligibility, and dental carriers: BlueCross BlueShield of Tennessee; Policy Studies, Inc., Express Scripts; National Guardian/Doral Dental; and DentaQuest.

### Enrollment

Effective December 1, 2009, the department suspended new enrollment in CoverTN as a result of reaching budget capacity. Current members and participating businesses, as well as those who had been approved for coverage effective for later dates in calendar year of 2010, were unaffected by the suspension. CoverKids suspended enrollment in late calendar year of 2009 when membership reached the maximum that could be supported by the current budget. On March 1, 2010, the department reopened enrollment in CoverKids. Below is the member enrollment for the Cover Tennessee programs as of fiscal years 2008 and 2009, and fiscal year to date through January 2010, as stated in the enrollment reports prepared by the department. The

enrollment figures were calculated by counting prior period enrollment plus new enrollees for the period minus enrollees who dropped.

**Table 7**  
**Cover Tennessee Member Enrollment**  
**FY 2008, FY 2009, and FY 2010 Through January 2010**

<b>Program</b>	<b>FY 2008</b>	<b>FY 2009</b>	<b>July 2009- January 2010</b>
<b>CoverRx</b>	20,246	36,144	39,527
<b>AccessTN</b>	3,768	4,093	3,789
<b>CoverKids</b>	23,458	37,966	43,439
<b>CoverTN</b>	14,321	19,098	22,167

Source: Enrollment reports compiled by the department.

Grievance Reports

During the audit, the auditors reviewed the grievance reports generated by BlueCross Blue Shield of Tennessee and Express Scripts. As stated in the contract, the contractors are required to maintain a formal appeal procedure. According to the CoverKids assistant director, the contractor sends a monthly grievance report to the department. The program directors review the grievance reports once they are received. The grievance data reported obtained from the BlueCross Blue Shield reports are listed below.

**Table 8**  
**Grievances Resolved for Cover Tennessee**  
**Calendar Years 2007 – 2009\***

<b>Grievances Resolved for Cover Tennessee</b>			
<b>Calendar Years 2007 – 2009*</b>			
<b># of Grievances</b>			
<b>Group</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
CoverTN	19	349	84
AccessTN	34	106	21
CoverKids	3	53	28
<b>Total</b>	<b>56</b>	<b>508</b>	<b>133</b>

\*Cover Tennessee began in April 2007; data for 2007 covers April to December 2007.

## Customer Satisfaction

Similar to the grievance reports, the contractors prepare the customer satisfaction reports. BlueCross BlueShield of Tennessee conducts an annual survey to measure client satisfaction. Program effectiveness for CoverRx is measured via the contract performance guarantees, which Express Scripts reports quarterly. The independent research companies conduct surveys and use them to monitor the overall rating of the health plan, as well as members' perceptions of specific aspects of the health plan such as: health plan benefits, member services representatives, claims processing, network of providers, and care management programs. The department reviews the information provided by BlueCross BlueShield and Express Scripts to determine potential improvement areas. For example, the assistant director for CoverKids has used the information provided in the past to make adjustments to the application and to strengthen the messaging provided to the customer service representatives. Overall, the Cover Tennessee program directors are satisfied with the customer satisfaction information provided by the contractors. Based on the information provided, Express Scripts appears to have met its performance guarantee measures.

Based on our review of the customer satisfaction reports,

- 53% (455 customers) were very satisfied with the CoverKids health plan benefits;
- 44% (324 customers) rated the pharmacy benefits as excellent, and 45% (373 customers) rated the medical benefits offered by CoverKids as excellent; and
- 46% (357 customers) rated the timeliness and accuracy in processing claims as excellent.

Some of the negative comments on the surveys involved not having enough dental providers in close proximity and the increased amount of the co-pay.

## **Office of Inspector General**

The Office of Inspector General (OIG) was created by Governor Bredesen and the 104th General Assembly, effective July 1, 2004. Section 71-5-2505, *Tennessee Code Annotated*, authorizes the Office of Inspector General to investigate civil and criminal fraud and abuse of the TennCare program, or any other violations of state criminal law related to the operation of TennCare. Under that section, the office also investigates civil and criminal fraud and abuse, or any other violations of state criminal law, related to operation of any program created pursuant to AccessTN, CoverTN, and CoverKids. In addition, the Office of Inspector General no longer has access to the TennCare data to investigate alleged fraud, including alleged prescription drug diversion due to concerns by the Social Security Administration. However, TennCare carries out that function.

The Office of Inspector General is composed of three divisions: Program Integrity, Criminal Investigation, and Legal. The case information goes through a process that begins

when it is received by the Program Integrity Division. It is investigated first by Program Integrity, and then it is forwarded to the Criminal Investigation Division to be assigned to a special agent. The special agent will work with the Legal Division, in which the attorneys act as in-house counsel to ensure quality control of criminal prosecution. If a fraud investigation does not appear to be of criminal nature, attorneys review it for any civil prosecution/recovery.

The Office of Inspector General provides many opportunities for the public to report potential fraud cases, such as the OIG hotline, e-mail, the OIG website, fax, and other correspondence. The information received by OIG is sent to TennCare for verification to ensure the information presented warrants opening a case. For example, after going through the verification process, it may turn out that the person is no longer on TennCare. Providers will typically fax information when they suspect any fraudulent activity in regard to TennCare.

For fiscal year 2009 – 2010, the division received 128,267 cases, of which 124,145 have been closed. According to the Inspector General, cases are closed when there is inadequate information provided to investigate the complaint, the information has been researched and determined to be unfounded, the case was referred to another agency (as per appropriate jurisdiction), or the case was prosecuted by the OIG and closed. The division makes attempts to educate the public with posters describing steps to be taken in order to report fraud. The Cash for Tips and Doctor Shopping posters are distributed to licensed medical providers, law enforcement, district attorneys, state agencies, and other stakeholders although they are not required to post them. The media has also played a role in the increased number of calls received.

According to the Inspector General, the average amount of time to investigate a case depends on how long it takes to gather information and the workload of the District Attorney. From February 2005 to June 2010, the division recouped \$1.9 million of lost dollars due to fraud. Since 2005, the division also has made 1,240 arrests, 609 convictions, and 233 diversions (judicial diversion or pre-trial diversion). In some instances, multiple arrests are made involving the same person. OIG has no control over who is terminated from TennCare. The federal Centers for Medicare and Medicaid Services will not allow TennCare to terminate an enrollee's eligibility for one or more fraud arrests or convictions, and the Doctor Shopping Law will not change that. (Enrollees are terminated if they are sent to prison.) Doctor shopping as defined willingly going to different medical providers, with the intent to deceive, in search of a controlled substance prescription without disclosing to the provider the receipt of a prescription from another provider within a 30-day period, and either the clinical visit or the controlled substance was paid for by TennCare.

### **Office of e-Health Initiatives**

The Office of e-Health Initiatives was established in 2006. Its mission is to work toward upgrading Tennessee's health information technology in order to provide complete health information and improve the quality of patient care at the point of care.

## E-Health Advisory Council

The Office of e-Health was to serve as staff to the e-Health Advisory Council, which was created in April 2006 by executive order. The purpose of the advisory council was to coordinate e-Health activities for the state. According to the e-Health director, once ARRA funding became available, the need for having an advisory council was reduced. Consultants were brought in to figure out the best way to implement the initiatives, and it was decided that the council was no longer needed. The consultants interviewed stakeholders representing state government, insurance companies, providers, regional health organizations, etc. Stakeholders felt that a not-for-profit (NFP) would be better, and therefore, Health Information Partnership for Tennessee (HIP TN) was established in July 2009. Since the e-Health Advisory Council was established by executive order, the director stated the Governor had been notified of the stakeholders' decision to terminate the council. The e-Health Advisory Council's last meeting was on June 17, 2009.

## Health Information Partnership for Tennessee

Health Information Partnership for Tennessee (HIP TN) was created by the Advisory Council stakeholders. HIP TN is composed of nine board members, and its mission is "to improve the health of people served in Tennessee by using a public-private framework to coordinate and empower the sharing of appropriate health information through local and regional Health Information Exchanges." HIP TN will also provide this same service in areas not yet covered by an exchange, thereby improving quality, coordination of care, cost efficiency and public health.

The Office of e-Health Initiatives emphasizes the use of e-prescriptions and electronic medical records (EMR) as two forms of information exchange technology. The information on the e-Health systems will be interoperable and will allow exchange of information throughout the state and hopefully on the national level as well. The e-Health network is maintained by the state from a technical level. There is also a TennCare component that allows providers to verify a patient's enrollment in TennCare.

E-Health particularly targets rural providers and TennCare-specific providers. According to the director, there are some providers who are reluctant to adopt e-Health, due to concerns about implementing it into their workflow. QSource (an outside consulting firm) has offered training to providers in EMR. In the past, the Office of eHealth has awarded grants to QSource for various programs, services, and deliverables but does not currently have any active grants or contracts with them. According to the director of the Office of e-Health Initiatives, a preliminary survey revealed that statewide, 30% of providers use electronic medical records. Providers are responsible for setting up the system within their practice and most are waiting for the grants that will be available to assist with the cost/training. Statewide, not many providers are participating in electronic prescriptions; the number of providers participating is between 4-5%. Although this number seems significantly low, it has improved, according to the office's director.

## Additional Information

The Office of e-Health plans to use stimulus funds to contract with HIP to build the aforementioned information exchange. The Office of e-Health was awarded an \$11.7 million grant in February 2010 that will establish Health Information Technology Coordinator that will be responsible for aligning internal healthcare agencies' health information technology with external agencies (such as HIP TN).

One of the major obstacles e-Health is currently facing is creating policies for privacy and security. The not-for-profit HIP TN and many stakeholders are involved in helping to draft the policies.

## **Office of Shared Services Solutions**

The Office of Shared Services Solutions was created in July 2007 as a result of a study conducted by the F&A Office of Audit and Consulting Services. Its mission is to provide fiscal, procurement, and human resource support to small state agencies. Small agencies face special challenges as a result of limited staff including limited backup; difficulty specializing; difficulty staying current on a wide variety of issues; difficulty with segregation of duties; high error rates because of low volume on some complex transactions; and limited ability to attract, supervise, and retain specialized staff. Shared Services Solutions addresses those challenges by providing a team of experienced fiscal and human resources professionals.

The Office of Shared Services Solutions is moving toward self-sufficiency by obtaining enough contracts to cover its costs. The office bills for actual cost of the services. In 2009, office provided services to the following 17 agencies:

- Post Conviction Defender's Office
- Governor's Office
- Commission on Children and Youth
- Commission on Aging and Disability
- Alcoholic Beverage Commission
- Human Rights Commission
- Health Services and Development Agency
- Tennessee Rehabilitative Initiative in Correction (TRICOR)
- Tennessee Corrections Institute
- Tennessee Advisory Commission on Intergovernmental Relations
- Tennessee Housing Development Agency
- Arts Commission

- Tennessee State Museum
- Volunteer Tennessee
- Governor’s Office of Children’s Care Coordination
- Developmental Disabilities Council
- Office of Homeland Security

As a performance measure, the Office of Shared Service Solutions conducts customer satisfaction surveys and includes the results in the annual reports that are prepared for the board of client agency directors. The surveys are sent to the 17 agencies listed above. (The number of participants completing the surveys varies by agency.) For the quarter ending September 2010 surveys of 24 respondents indicated that 63.6% were delighted with the overall services they received from the office, 27.3% were satisfied, 9.1% had a few concerns, and 0% were dissatisfied. However, a couple of the surveys stated that the participants were dissatisfied with the reliability, timeliness, responsiveness, and Edison system transition support. The office follows up on negative comments. The survey also showed that 79.2% felt that the Shared Services team has helped them better focus on their core mission.

### **Capital Budget Process**

The Department of Finance and Administration is statutorily mandated to annually prepare and submit a budget document to the Governor under Section 4-3-1006, *Tennessee Code Annotated*. Further, Section 9-4-501 (b), *Tennessee Code Annotated*, requires the department to present proposals for capital projects by other departments. Capital projects consist of any the construction of new facilities and maintenance of existing facilities that will cost in excess of \$100,000. To facilitate this effort, F&A provides departments with general guidelines to follow in developing proposed capital projects requests. These steps include documenting the cost of projects including construction costs, disclosing fees associated with the state architect’s office, and providing justification for the need. F&A also provides the necessary forms for departments to prepare and submit their capital budget requests.

The development of a capital budget is a bottom-up process in that individual departments identify their project needs and their respective priority first and then present their capital project issues to F&A for review and consideration. Criteria considered by F&A staff include whether proposed projects address health and safety needs as well as what the proposed projects cost.

After their review, F&A staff prioritize and submit capital budget requests to the Governor for his consideration and possible inclusion into his general budget proposal to the state legislature. Some are eliminated by F&A staff during their review. The Governor subsequently considers and determines which of those capital projects are to be included in his budget. In addition to the list of proposed capital projects presented by F&A, the Governor has

the authority to include other capital projects in his general budget proposal that he deems necessary.

The Governor's budget is then submitted to the General Assembly for its consideration. The legislature subsequently identifies which projects to go forward with and the mechanism to fund the projects (bonds, general fund revenues, or a combination of the two). Similar to the Governor, the legislature has the authority to add capital projects that are deemed necessary.

Capital projects which have made it through this process are not authorized until they have completed one last step. Namely, the State Building Commission must approve all capital projects before they can proceed. The commission is composed of seven ex officio members: the Governor, the Secretary of State, the Comptroller of the Treasury, the State Treasurer, the Commissioner of Finance and Administration, the speakers of the Senate and the House of Representatives.

We reviewed F&A's capital budget instructions to departments, interviewed the state Budget Office Director and interviewed officials in seven departments who were responsible for submitting their respective department's requests for capital projects. Officials from the Department of Correction, the Tennessee Board of Regents, the Tennessee Department of Environment and Conservation, the Tennessee Department of Education, the Tennessee Department of Children's Services, the Department of Economic and Community Development, and the Tennessee Department of Transportation were interviewed to obtain their perspective on the capital budget process. Officials from six of the seven departments stated that they were generally satisfied with the process and only had a few logistical concerns. One of the seven, the Department of Environment and Conservation, expressed significant concerns with the capital budget process, in that F&A did not keep it adequately involved in the process once projects are approved in the capital budget.

## **Title VI and Other Information**

### Title VI

All programs or activities receiving federal financial assistance are prohibited by Title VI of the Civil Rights Act of 1964 from discriminating against participants or clients on the basis of race, color, or national origin. In response to a request from members of the Government Operations Committee, we compiled information concerning federal financial assistance received by the Department of Finance and Administration (F&A) and the agency's efforts to comply with Title VI requirements. The results of the information gathered are summarized below.

F&A carries out its responsibilities through its own administrative and program staff as well as through contract/grant programs. The department's contracts are representative of both "subrecipient" and "vendor" relationships. In those cases in which a contract (or grant) creates a "subrecipient" relationship as opposed to a "vendor" relationship (as defined by OMB Circular A-133), the contractor is deemed a subrecipient with unique obligations to the state and federal

government including compliance with Title VI requirements. Contractors reimbursed with federal funds are also subject to these requirements. Two program areas within F&A receive and administer funding from the federal government. The Office of Criminal Justice Programs and Volunteer Tennessee are both components of the Resource Development and Support Division and administer grant programs.

F&A received \$114,449,600 in federal financial assistance during fiscal year 2009. A breakdown of federal money received is as follows:

<b>Federal Funds</b>	
Cover Tennessee	\$86,754,600
Criminal Justice Programs	\$22,845,800
Electronic Health Initiative	\$675,000
Volunteer Tennessee	\$4,174,200
<b>Total Federal Funds</b>	<b><u>\$114,449,600</u></b>

In fiscal year 2000-2001, the Title VI coordination functions were added to the responsibilities of the Division of Resource Development and Support. The responsibilities of the individual designated as the Title VI coordinator include, but are not limited to, the following:

- developing and monitoring implementation of the F&A Title VI/Title IX compliance plan;
- coordinating periodic evaluations of all aspects of F&A activities to ensure programs and services are being conducted without discrimination on the basis of race, color, national origin, or gender;
- contributing to policy relating to nondiscrimination;
- ensuring proper notice is given to employees and outside parties regarding F&A's policy of nondiscrimination;
- coordinating pre- and post-award compliance reviews to ensure that all funds are disbursed and services are provided on an equal opportunity basis; and
- coordinating the review and investigation of complaints.

To help ensure compliance with Title VI provisions, each new F&A employee must attend a new hire orientation which includes discussion about Title VI. The department also provides each newly hired employee with an employee manual which contains the Title VI policy as well as the department's complaint process.

In addition to the new employee orientation, briefings and updates are provided to staff responsible for ensuring Title VI compliance and to key program and project management staff as part of regular in-service training. Further, whenever available, department staff also take advantage of training programs offered by other government agencies.

Department staff also provide subrecipient contractors support to ensure that they are in compliance with Title VI provisions. According to the F&A Title VI plan, contract provisions and Statements of Assurances are the primary resources the department provides subrecipients regarding Title VI. In addition, the Office of Criminal Justice Programs routinely offers an annual training for new and continuing subrecipients that covers state and federal requirements of grant management and Title VI.

The department’s Title VI plan lists its complaint procedures. A complaint may be filed internally with management of the subject division, the Director of Human Resources, the Deputy Commissioner for Operations, or the Commissioner. A complaint may also be filed externally with the Tennessee Human Rights Commission or with the Regional Division of the U.S. Office of Civil Rights. According to the department’s Title VI coordinator, the department has not received a Title VI complaint in the last several years.

Further, in accordance with the terms of all contracts, each subrecipient shall show proof of nondiscrimination and shall post notices of nondiscrimination. Proof of nondiscrimination may require documentation of standard complaint process for both subrecipient employees and subrecipient program beneficiaries.

Each department’s Division Executive is responsible for conducting division reviews of activities to ensure compliance with Title VI. In addition to standard contract monitoring, the divisions within F&A awarding grants are required to monitor annually a subset of their subrecipient contract population. Each affected division has program or fiscal staff dedicated to conducting this monitoring.

Employee Gender and Ethnicity

The table below details the breakdown of department staff (including staff of the Office for Information Resources) by gender and ethnicity.

**Department of Finance and Administration  
Staff Gender and Ethnicity by Job Position  
March 2010**

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Accountant 2	5	3	1	2	0	0	5	0
Accountant 3	6	10	0	4	0	0	12	0
Accountant/Auditor 1	4	3	0	0	0	0	7	0
Accounting Manager	3	8	0	0	0	0	11	0
Accounting Technician 1	7	13	1	3	0	0	15	1
Accounting Technician 2	4	20	2	3	0	0	19	0
Administrative Assistant 1	2	8	0	5	0	0	5	0
Administrative Assistant 3	0	1	0	0	0	0	1	0
Administrative Secretary	0	5	0	0	0	0	5	0
Administrative Services Assistant 2	3	15	0	4	1	0	13	0
Administrative Services Assistant 3	2	11	0	3	0	0	10	0

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Administrative Services Assistant 4	5	7	0	1	0	0	11	0
Administrative Services Assistant 5	1	7	0	0	0	0	8	0
Architect	7	0	0	1	0	0	6	0
Architect-State	1	0	0	0	0	0	1	0
Attorney 3	4	0	0	0	0	0	4	0
Attorney 4	1	0	0	0	0	0	1	0
Audit Director 1	1	0	0	0	0	0	1	0
Auditor 2	1	1	0	1	0	0	1	0
Auditor 3	0	1	0	0	0	0	1	0
Auditor 4	1	2	1	0	0	0	2	0
Budget Administrative Analyst 2	0	1	0	0	0	0	1	0
Budget Administrative Analyst 3	3	1	0	1	0	0	3	0
Budget Administrative Analyst 4	5	1	0	0	0	0	6	0
Budget Administrative Assistant Director	1	0	0	0	0	0	1	0
Budget Administrative Coordinator 1	2	2	0	0	0	0	4	0
Budget Administrative Coordinator 2	5	2	0	0	0	0	7	0
Budget Administrative Director	1	0	0	0	0	0	1	0
Budget Analyst Coordinator	1	0	0	0	0	0	1	0
Cabling Infrastructure Specialist 1	2	0	0	0	0	0	2	0
Cabling Infrastructure Specialist 2	3	1	0	0	0	0	4	0
Cash Management Director	0	1	0	0	0	0	1	0
Chief of Accounts	0	1	0	0	0	0	1	0
Chief of Information Systems	1	0	0	0	0	0	1	0
Clerk 1	0	2	0	1	0	0	1	0
Clerk 2	3	0	0	0	0	0	3	0
Clerk 3	1	3	0	2	0	0	2	0
Commissioner 3	1	0	0	0	0	0	1	0
Communications Systems Analyst 2	0	1	0	0	0	0	1	0
Communications Systems Analyst 3	0	1	0	1	0	0	0	0
Communications Systems Analyst 4	8	2	0	0	0	0	10	0
Computer Operations Manager 1	1	1	0	1	0	0	1	0
Computer Operations Manager 2	0	1	0	1	0	0	0	0
Computer Operations Manager 3	2	1	0	0	0	0	3	0
Computer Operations Manager 4	1	1	0	0	0	0	2	0
Database Administrator 2	0	1	0	0	0	0	1	0
Database Administrator 4	4	4	2	0	0	0	6	0
Deputy Commissioner 2	1	0	0	0	0	0	1	0
Employee Wellness Program Coordinator	0	1	0	0	0	0	1	0
Energy Management Administrator	1	0	0	0	0	0	1	0
Enterprise Resource Planning Consultant 1	5	12	2	2	0	0	12	1
Enterprise Resource Planning Consultant 2	5	14	1	3	0	0	15	0
Enterprise Resource Planning Manager	2	3	0	0	0	0	5	0

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Enterprise Resource Planning Module Lead	9	8	0	1	0	0	16	0
Enterprise Resource Planning Project Assistant Director	1	0	0	0	0	0	1	0
Enterprise Resource Planning Project Director	0	1	0	0	0	0	1	0
Executive Administrative Assistant 1	0	1	0	0	0	0	1	0
Executive Administrative Assistant 2	3	2	0	1	1	0	3	0
Executive Administrative Assistant 3	4	1	0	0	0	0	4	1
Executive Secretary 1	0	1	0	0	0	0	1	0
Finance and Administration Management Consultant 1	0	4	0	2	0	0	2	0
Finance and Administration Management Consultant 2	2	2	0	1	0	0	3	0
Finance and Administration Management Consultant 3	3	2	0	0	0	0	5	0
Finance and Administration-Fiscal Director 1	4	4	0	1	0	0	7	0
Finance and Administration-Fiscal Director 2	1	0	0	0	0	0	1	0
Finance and Administration-Fiscal Director 3	0	1	0	0	0	0	1	0
Finance and Administration Program Director 1	8	5	0	0	0	0	13	0
Finance and Administration Program Director 2	3	3	0	0	0	0	6	0
Finance and Administration Program Director 3	0	1	0	0	0	0	1	0
Facilities Construction Director	1	1	0	0	0	0	2	0
Facilities Construction Regional Administrator	3	2	0	1	0	0	4	0
Facilities Construction Specialist 3	1	1	0	1	0	0	1	0
Facilities Management Executive Director	0	1	0	0	0	0	1	0
Facilities Planning Specialist 2	0	6	0	1	0	0	5	0
Facilities Planning Specialist 3	1	2	0	1	0	0	2	0
Facilities Revolving Fund Director	1	0	0	0	0	0	1	0
Financial Director	1	0	0	0	0	0	1	0
Funds Coordinator	3	4	1	1	0	0	5	0
General Counsel 2	0	1	0	0	0	0	1	0
Geographic Information Systems Analyst 3	4	1	0	0	0	0	5	0
Geographic Information Systems Technician 2	0	2	0	0	0	0	2	0
Human Resources Analyst 1	0	1	0	0	0	0	1	0
Human Resources Analyst 2	0	2	0	0	0	0	2	0
Human Resources Analyst 3	0	3	0	0	0	0	3	0
Human Resources Manager 2	1	0	0	0	0	0	1	0
Information Resource Support Specialist 2	13	7	0	7	0	0	10	3

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Information Resource Support Specialist 3	5	0	0	1	0	0	4	0
Information Resource Support Specialist 4	6	6	0	2	0	0	10	0
Information Resource Support Specialist 5	0	3	0	0	0	0	3	0
Information Officer	0	1	0	0	0	0	1	0
Information Representative	1	0	0	0	0	0	1	0
Information Systems Analyst 2	1	0	0	0	0	0	1	0
Information Systems Analyst 3	2	3	0	0	0	0	4	1
Information Systems Analyst 4	6	3	0	4	0	0	5	0
Information Systems Analyst Supervisor	1	2	0	0	0	0	3	0
Information Systems Consultant	9	5	0	2	0	0	12	0
Information Systems Director 3	0	1	0	0	0	0	1	0
Information Systems Manager 2	0	1	0	0	0	0	1	0
Information Systems Manager 3	1	2	0	0	0	0	3	0
Information Systems Manager 4	4	2	1	0	0	0	5	0
Information Systems Specialist 2	0	1	0	0	0	0	1	0
Information Systems Specialist 3	1	1	0	0	0	0	2	0
Information Systems Specialist 4	1	4	0	1	0	0	4	0
Information Systems Technology Consultant	38	18	1	1	0	1	52	1
Information Systems Technology Manager	7	0	0	2	0	0	4	1
Insurance Benefits Analyst 1	7	13	0	8	0	0	12	0
Insurance Benefits Analyst 2	3	9	0	4	0	0	8	0
Insurance Benefits Analyst 3	1	7	0	2	0	0	6	0
Insurance Benefits Manager	0	6	0	1	0	0	5	0
Insurance Benefits Specialist	2	10	0	4	0	0	8	0
Internal Service Fund Specialist	0	2	0	0	0	0	2	0
Legal Assistant	0	1	0	0	0	0	1	0
Mainframe Computer Operator 2	8	4	0	6	0	0	6	0
Mainframe Computer Operator 3	3	0	0	0	0	0	3	0
Mainframe Computer Technician 1	6	5	0	4	0	0	7	0
Mainframe Computer Technician 2	4	2	0	3	0	0	3	0
Mechanical Engineer	0	1	0	0	0	0	1	0
Network Technical Specialist 3	2	0	0	0	0	0	2	0
Network Technical Specialist 4	2	0	0	0	0	0	2	0
Office of Information Resources Director 1	3	2	0	0	0	0	5	0
Office of Information Resources Director 2	2	1	0	0	0	0	3	0
Planning Analyst 2	0	2	0	1	0	0	1	0
Planning Analyst 4	5	9	0	2	0	0	12	0
Planning Analyst 5	4	7	0	2	0	0	9	0
Planning Analyst 6	1	0	0	0	0	0	1	0
Procurement Officer 2	1	0	0	0	0	0	1	0
Program Monitor 2	1	2	0	0	0	0	3	0
Program Monitor 3	0	1	0	0	0	0	1	0

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Programmer/Analyst 2	3	3	1	1	0	0	4	0
Programmer/Analyst 3	6	1	0	1	1	0	5	0
Programmer/Analyst 4	14	11	0	1	0	0	23	1
Property Utilization Manager 2	1	1	0	0	0	0	2	0
Public Health Educator 3	0	1	0	0	0	0	1	0
Public Health Nursing Consultant 1	1	2	0	1	0	0	2	0
Public Health Nursing Consultant 2	0	3	0	0	0	0	3	0
Public Health Nursing Consultant Manager	0	1	0	0	0	0	1	0
Real Estate Management Director	1	0	0	0	0	0	1	0
Real Property Agent 3	1	2	0	0	0	0	3	0
Real Property Agent 4	4	1	0	2	0	0	3	0
Statistical Research Specialist	2	0	0	0	0	0	2	0
Student Assistant	0	1	0	1	0	0	0	0
Systems Programmer 2	17	4	0	5	0	0	16	0
Systems Programmer 3	36	6	0	1	0	0	40	1
Systems Programmer 4	54	14	2	7	0	0	59	0
Telecom Manager	1	0	0	0	0	0	1	0
TennCare Assistant Inspector General	2	1	0	0	0	0	3	0
TennCare Field Investigator	10	1	0	3	0	0	8	0
TennCare Inspector General	0	1	0	0	0	0	1	0
Website Developer 2	1	1	0	0	0	0	2	0
<b>Total</b>	<b>476</b>	<b>435</b>	<b>16</b>	<b>130</b>	<b>3</b>	<b>1</b>	<b>750</b>	<b>11</b>

## Contracting Information

### **Department of Finance and Administration Professional Service Contractors/Grantees**

<b>Type of Contractor</b>	<b>Number of Contracts Per Type of Contractor</b>	<b>Total Amount Per Type of Contractor</b>
African American	22	\$6,899,411
Asian	1	669,861
Delegation	8	9,503,000
Female	183	40,610,337
Government	155	25,141,460
Not Minority Disadvantaged	181	1,706,632,142
Small Business	16	18,064,043
<b>GRAND TOTAL</b>	<u>566</u>	<u>\$1,807,520,254</u>

For greater detail on individual contracts, see the Department of Finance and Administration's Title VI plan.

### **Performance Measures Information**

As stated in the Tennessee Governmental Accountability Act of 2002, "accountability in program performance is vital to effective and efficient delivery of governmental services, and to maintain public confidence and trust in government." In accordance with this act, all executive branch agencies are required to submit annually to the Department of Finance and Administration a strategic plan and program performance measures. The department publishes the resulting information in two volumes of *Agency Strategic Plans: Volume 1 – Five-Year Strategic Plans* and *Volume 2 – Program Performance Measures*. Agencies were required to begin submitting performance-based budget requests according to a schedule developed by the department, beginning with three agencies in fiscal year 2005, with all executive-branch agencies included no later than fiscal year 2012. The Department of Finance and Administration began submitting performance-based budget requests effective for fiscal year 2006.

Detailed below are the Department of Finance and Administration's performance standards and performance measures, as reported in the September 2009 *Volume 2 – Program Performance Measures*. We gathered information from the department about how it collects and verifies the data in the measures, and its methods appear appropriate. For several measures, the department did not have written procedures for collecting and verifying data, but the measures are simple and do not require written procedures.

## Performance Standards and Measures

### Performance Standard-Division of Administration

Performance Standard 1 – Resolve help desk tickets for the areas of desktop support, security, and infrastructure services within five days of receipt.

Performance Measure 1 – Office of Shared Technology Services' percent of tickets resolved within five days.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
87%	90%	90%

### Performance Standard-Office for Information Resources

Performance Standard 1 – Availability of mainframe and distributed systems meets or exceeds industry standards on key infrastructure systems delivered.

Performance Measure 1 – Mainframe and distributed system availability for key infrastructure systems (Industry Standard 98%).

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
99.9%	99%	99%

Performance Standard 2 – Availability of networks meets or exceeds industry standards on key infrastructure systems delivered.

Performance Measure 2 – State network availability as measured by the percent of end sites meeting the monthly availability target of 99%.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
99%	99%	99%

### Performance Standard-Benefits Administration

Performance Standard 1 – In order to minimize plan administrative cost, maintain Benefits Administration spending for the public sector plans at a level no greater than one half of 1% of combined expenses for those plans.

Performance Measure 1 – Percent of Benefits Administration's administrative budget for the public sector plans as a percent of combined public sector plan expenses.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
.052%	.50%	.50%

### Performance Standard-Criminal Justice Programs

Performance Standard 1 – Provide services and reduce victimization for child victims of crime through child advocacy centers established across the state.

Performance Measure 1 – Number of child victims who receive services to reduce child victimization through child advocacy centers across the state.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
11,210	13,000	13,500

Performance Standard 2 – Train drug court managers in how to effectively initiate and implement drug courts across the state.

Performance Measure 2 – Number of drug court managers trained in how to initiate and manage drug courts across the state.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
310	325	325

**Performance Standard-Resource Development and Support**

Performance Standard 1 – Average days to complete Office of Contracts Review review of approved contracts.

Performance Measure 1 – Average days to complete Office of Contracts Review review of approved contracts.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
9	8	8

Performance Standard 2 – Average days to complete Office of Contracts Review review of approved requests for proposals.

Performance Measure 2 – Average days to complete Office of Contracts Review review for requests for proposals.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
6	8	8

**Performance Standard-Volunteer Tennessee**

Performance Standard 1 – Mobilize volunteer hours to meet community needs in education, environment, public safety, human needs, and homeland security.

Performance Measure 1 – Number of volunteer hours mobilized to meet community needs in education, environment, public safety, human needs, and homeland security.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
381,805	350,000	350,000

Performance Standard 2 – Train volunteer leaders and teachers in how to effectively mobilize volunteers through AmeriCorps and service-learning.

Performance Measure 2 – Number of volunteer leaders and teachers trained in how to effectively mobilize volunteers through AmeriCorps and service-learning.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
381	1,000	500

**Performance Standard-State Health Planning Division**

Performance Standard 1 – Develop and deploy data marts as part of a comprehensive health planning data warehouse to directly support the statutory responsibilities of the State Health Planning Division.

Performance Measure 1 – Number of health planning data marts to be achieved by each fiscal year.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
1.8	5	4

**Performance Standard-Enterprise Resource Planning**

Performance Standard 1 – Successfully implement the financials, procurement, and logistics phase of Edison (Phase 2).

Performance Measure 1 – The percent of financials, procurement, and logistics implemented by October 1, 2009.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
15%	100%	100%

**Performance Standard-Shared Services Solutions**

Performance Standard 1 – Meet or exceed 95% of annual customer service level agreement key targets for fiscal, human resource, and procurement service in the Division of Shared Services Solutions.

Performance Measure 1 – Percent of customer service level agreement key targets met or exceeded, including customer satisfaction, quality, and timeliness.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
93.3%	95%	95%

**Performance Standard-Electronic Health Initiative**

Performance Standard 1 – Develop and implement an overall strategy for the adoption and use of electronic medical records and create a plan to promote their use by all health-care stakeholders.

Performance Measure 1 – Percent of achievement of eHealth roadmap.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
15%	40%	40%

**Performance Standard-Division of Budget**

Performance Standard 1 – Earn the Government Finance Officers Association (GFOA) Distinguished Budget Presentation Award as an indicator of Budget Document quality.

Performance Measure 1 – GFOA Distinguished Budget Presentation Award received or not.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
Yes	Will Apply	Will Apply

Performance Standard 2 – In the next Budget Document, achieve 70% as the portion of program performance measures that are outcome measures (among the official performance-based budget agencies).

Performance Measure 2 – Percent of program performance measures that are outcome measures (among the official performance-based budget agencies).

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
70%	70%	70%

**Performance Standard-Division of Accounts**

Performance Standard 1 – Complete all tax filings by their deadlines.

Performance Measure 1 – Number of days after deadline that tax filings are made.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
0	0	0

Performance Standard 2 – The Comprehensive Annual Financial Report (CAFR) is completed and audited by December 31.

Performance Measure 2 – Number of days after December 31 that the CAFR is prepared and audited.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
Not Prepared Yet	0	0

**Performance Standard-Governor’s Office of State Planning and Policy**

Performance Standard 1 – Identify and develop specific policies that advance the Governor’s priorities and provide research and information that support these efforts.

Performance Measure 1 – Percent of policy projects completed on time.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
100%	100%	100%

**Performance Standard-Real Property Administration**

Performance Standard 1 – Design State Building Commission projects in a timely manner.

Performance Measure 1 – Percent of projects designed within original design schedule.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
76%	75%	80%

Performance Standard 2 – Complete projects within original budgets approved by State Building Commission.

Performance Measure 2 – Percent of projects completed within original construction budget.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
68%	80%	80%

**Performance Standard-TennCare Fraud and Abuse Prevention**

Performance Standard 1 – Pursue criminal arrests for TennCare fraud.

Performance Measure 1 – The number of criminal arrests for TennCare fraud in a fiscal year by the OIG.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
258	250	250

**Performance Standard-Cover Tennessee Health Care Programs**

Performance Standard 1 – Facilitate the provision of affordable, portable basic health-care coverage to employees of qualified small employers.

Performance Measure 1 – Number of employers enrolled in the CoverTN program.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
6,861	7,000	7,200

Performance Standard 2 – Facilitate the provision of affordable, portable basic health-care coverage to qualified working Tennesseans that are uninsured.

Performance Measure 2 – Number of enrolled individuals in the CoverTN program.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
18,632	22,000	22,000

**Performance Standard-AccessTN**

Performance Standard 1 – Facilitate the provision of comprehensive health-care coverage to uninsurable Tennesseans.

Performance Measure 1 – Number of enrollees in the AccessTN program.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
4,206	6,000	6,000

Performance Standard 2 – Offset the cost of premiums to low-income enrollees through the provision of premium assistance.

Performance Measure 2 – Percent of AccessTN enrollees provided with premium assistance.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
89.7%	75%	75%

**Performance Standard-CoverKids**

Performance Standard 1 – Facilitate the provision of comprehensive health-care coverage to uninsured Tennessee children, age 18 and younger, and maternity coverage for pregnant women.

Performance Measure 1 – Number of enrollees in the CoverKids program.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
36,858	41,000	45,000

Performance Standard 2 – Assure all carriers or insurers are accredited by either the Utilization Review Accreditation Committee (URAC) or the National Committee for Quality Assurance (NCQA).

Performance Measure 2 – Percent of carriers or insurers that meet URAC or NCQA accreditation standards.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
100%	100%	100%

**Performance Standard-CoverRx**

Performance Standard 1 – Facilitate access to basic and affordable medications for low-income Tennesseans without prescription drug coverage.

Performance Measure 1 – Number of enrollees in the CoverRx program.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
35,477	40,000	40,000

Performance Standard 2 – Assure all carriers or insurers are accredited by either the Utilization Review Accreditation Committee (URAC) or the National Committee for Quality Assurance (NCQA).

Performance Measure 2 – Percent of carriers or insurers that meet URAC or NCQA accreditation standards.

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
100%	100%	100%

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## OFFICE FOR INFORMATION RESOURCES

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### BACKGROUND

The Office for Information Resources (OIR) is part of the Division of Finance and Administration. The office manages the information needs of state government and is led by the Chief Information Officer.

#### Objectives

The objectives covered in this chapter were to

1. determine the adequacy of the disaster recovery guidance provided by the OIR, whether adequate resources have been assigned by OIR to assist agencies in disaster recovery planning, and whether state agencies with applications hosted at the State Data Center sufficiently understand what is necessary for successful restoration of agency applications;
2. determine whether OIR billing rates for services and equipment supplied to state agencies are reasonable and justifiable and whether it has adequate systems to prevent and correct billing errors;
3. review the information technology (IT) contract and project management process and identify any weaknesses and improvements needed in the process, particularly with time and cost management;
4. assess OIR's efforts to maintain security for the state's information resources;
5. determine the responsibilities of OIR and the Information Systems Council for project planning and development and assess whether these responsibilities are being fulfilled;
6. determine OIR's compliance with the Information Systems Council policy on open access to electronic information; and
7. determine the status of the new state data center and the continued use of the existing data center.

## Organization and Statutory Responsibilities

The Office for Information Resources (OIR) is responsible for providing direction, planning, resources, execution, and coordination for managing the information systems needs of the state. As a division within the Department of Finance and Administration, OIR provides services to clients that are primarily state agencies, departments, and commissions, although it also provides some services to federal and local governmental entities. OIR serves as staff to the Information Systems Council (ISC) and, under the ISC's guidance, provides technical direction, resources, and infrastructure to the state.

OIR has approximately 404 employees. The division is headed by a Chief Information Officer, who supervises a Deputy Chief Information Officer, Chief Technology Officer, as well as Directors of Administration; Security; Enterprise Architecture and Research; Technology Financial Management; and Research and Special Projects. (See organization chart on the following page.) OIR's sections, which provide services to state agencies, are described below.

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

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

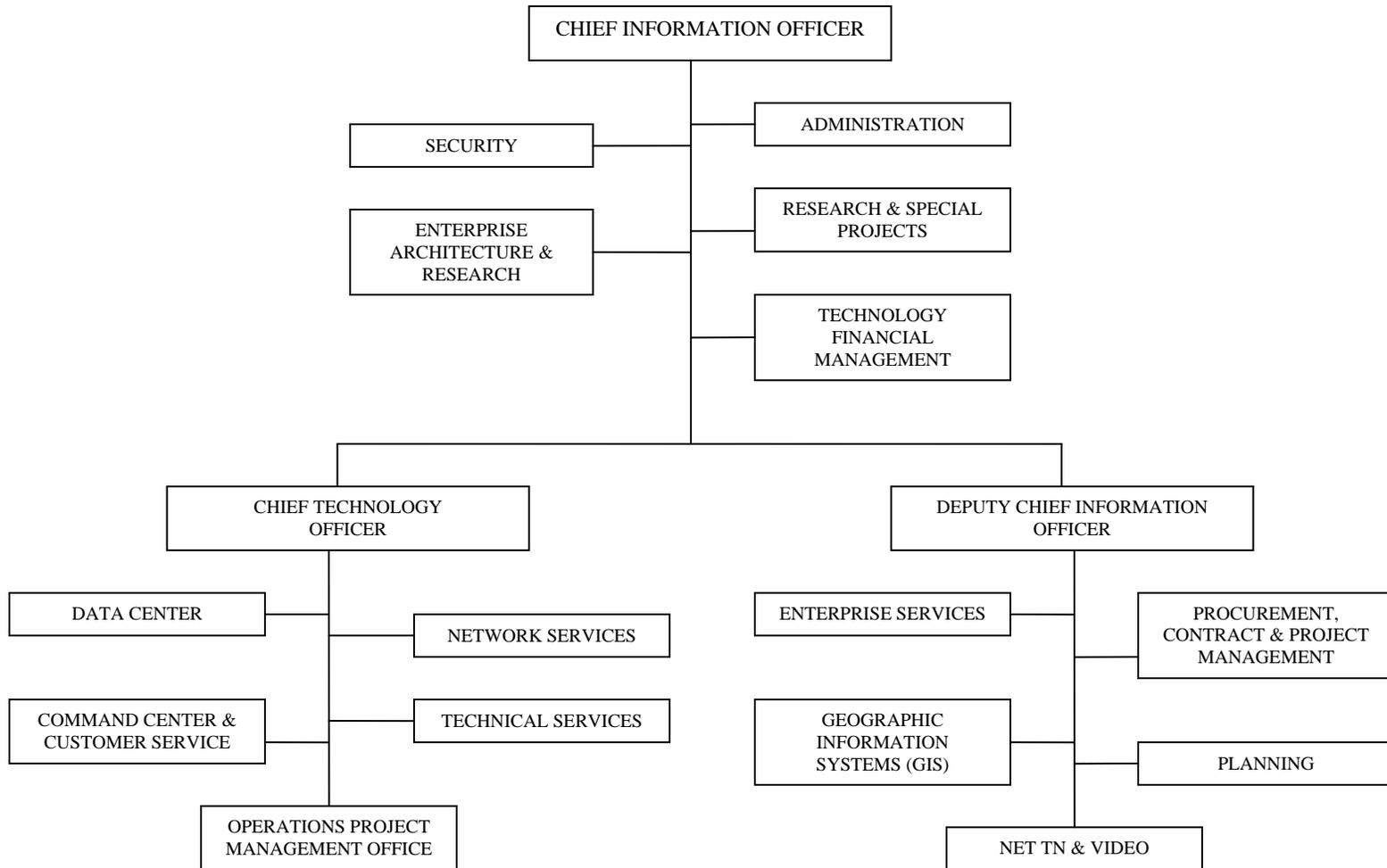
The *Data Center* operates around the clock and provides statewide hosting services for applications that run on the state's mainframe and distributed systems. In addition to hosting services, the data center provides data storage management and limited production and print services.

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

The *Operations Project Management Office* provides project management, change management, and disaster recovery support services.

*Network Services* handles the computer network infrastructure. The components supported include network security operations, server connectivity at the data center, and infrastructure hardware such as cabling, routers, and switches.

**DEPARTMENT OF FINANCE AND ADMINISTRATION  
OFFICE FOR INFORMATION RESOURCES  
ORGANIZATION CHART  
MARCH 2010**



*Technical Services* includes the management and operation of several technical areas including e-mail, directory services for managing the state eDirectory and Active Directory operations, voice, local area network management, end-point management, and cabling.

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

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

*Procurement, Contract and Project Management* provides support for IT commodities contracts, OIR services contracts, and OIR Endorsements. The Enterprise Project Management Office provides project management and business analysis support.

The *Planning* section serves as staff to the Information Technology Assessment and Budget Committee and provides support, guidance, and training in project plan development, development of 3-Year Information Systems Plans, and IT-related requisition review and approval. The Planning section also oversees OIR training for state employee computer training, scheduling, registration, billing, room rental, web-based training development, and special project delivery.

*NetTN and Video* is composed of NetTN and Video Services. NetTN is responsible for managing and overseeing the operations of the statewide network contract. Video Services provides a wide variety of services including audiovisual systems, digital media, media streaming solutions, and video conferencing.

## Revenues and Expenditures

According to the fiscal year 2010-11 Budget, the Office for Information Resources (OIR) had total expenditures of \$130,090,000 for the year ended June 30, 2010. Of this total, \$1,474,000 (1%) was funded through state appropriations, and the remaining \$128,616,000 (99%) was funded through billing agencies for services.

## FINDINGS

### **4. The Department of Finance and Administration’s Office for Information Resources has not met its obligations in providing disaster recovery guidance to state agencies as required by ISC Policy 9**

#### **Finding**

Pursuant to Information Systems Council (ISC) Policy 9, the Office for Information Resources (OIR) is responsible for overseeing the State of Tennessee’s disaster recovery program—including developing and recommending to agencies the standards, procedures, and guidelines necessary to ensure recovery capabilities for the state’s information systems—and for providing management and technical consulting support to agencies in fulfilling their disaster recovery roles. During our review, we found that OIR has not met its obligations in providing guidance as required by ISC Policy 9.

The wording of this finding does not identify specific vulnerabilities that could allow someone to exploit the state’s systems. Disclosing those vulnerabilities could present a potential security risk by providing readers with information that is confidential pursuant to Section 10-7-504(i), *Tennessee Code Annotated*. We provided the Office for Information Resources with detailed information regarding the specific vulnerabilities we identified as well as our recommendations for improvement.

#### **Recommendation**

The Chief Information Officer (CIO) over the Office for Information Resources should ensure that these conditions are remedied by the prompt development and implementation of effective controls (standards and procedures) to ensure compliance with stated policy. The CIO should ensure that risks associated with this finding are adequately identified and assessed in OIR’s documented risk assessment. The CIO should implement effective controls to ensure compliance with applicable requirements, assign staff to be responsible for ongoing monitoring of the risks and mitigating controls, and take action if deficiencies occur. The CIO should also take all other steps available to establish or improve any compensating controls until these conditions are remedied.

#### **Management’s Comment**

The department has provided us with a detailed comment to the finding; however it has been excluded from this report to prevent disclosing vulnerabilities that could present a potential security risk by providing readers with information that is confidential pursuant to Section 10-7-504(i), *Tennessee Code Annotated*.

**5. The Office for Information Resources procured an estimated \$1,000,000 of IT consulting services through an existing commodity contract, effectively bypassing non-competitive personal service contract rules**

**Finding**

The Office for Information Resources (OIR) used an existing server, hardware, and maintenance contract to procure \$999,500 in IT consulting services, which exceeded the limited provision for allowable professional services under the contract. These consulting services were procured in November 2009 to aid in the relocation of existing servers and the migration of applications from the current data center to the new data center. In entering into a non-competitive contract for professional services through a contract procured through the Department of General Services procurement rules, OIR officials were able to circumvent state law requiring notification of the Fiscal Review Committee, documented approval by the Commissioner of the Department of Finance and Administration, as well as rules for establishing a business case justification.

In Tennessee, the regulatory authority for the procurement of goods and services is split between the Department of General Services and F&A, respectively. Both authorities allow competitive and non-competitive procurement of goods and services. Section 12-4-109, *Tennessee Code Annotated*, charges F&A with the responsibility for establishing regulations for the procurement of personal, professional, and consulting services. Section 12-3-107, *Tennessee Code Annotated*, charges the Department of General Services with the responsibility for establishing procurement policies and procedures for the purchase, storage, delivery, and distribution of supplies, materials, and equipment. General Services' rules also allow state agencies to procure non-professional services such as maintenance and repair, as well as limited professional services, such as equipment support.

Rather than properly procuring IT consulting services through a personal, professional, and consulting services contract through F&A's procurement rules, OIR obtained these services through an existing contract that had been originally procured pursuant to the Department of General Services' purchasing rules. This contract was competitively awarded to GTSI Corporation on December 1, 2007, for the purpose of establishing "a restricted statewide contract to supply to the Office for Information Resources . . . the products and services relat[ed] to two 'types' of enterprise-level servers . . ." with limited provisions for professional services such as selection/design, installation, configuration, and other computer-related services incidental to these two types of servers.

Based on consultation with officials with the Comptroller of the Treasury, Office of Management Services, who reviewed and approved the contract, the professional services authorized under the contract were to be used for technical support and maintenance related to the purchase of equipment available through the contract to ensure that it integrates with the existing state network environment. However, in fact, the services procured were not associated with maintenance or purchase of equipment under the contract. Instead, these services were to

aid in the design of the relocation of existing servers and migration of applications from the current data center to the new data center.

We obtained a Statement of Work dated November 9, 2009, which outlines three specific deliverables the consultants were to provide:

- Application Interdependency Report;
- Hardware Inventory Report; and
- Risk Assessment Report.

#### Requirements for Notification of Fiscal Review and the Commissioner of Finance and Administration

Section 12-4-109(a)(1)(G), *Tennessee Code Annotated*, which applies to personal, professional, and consulting services contracts procured through Department of F&A procurement rules, requires all procurement requests for non-competitively awarded contracts to be filed with the Fiscal Review Committee and the Commissioner of Finance and Administration. Pursuant to this statute, state agencies must notify the Fiscal Review Committee of non-competitively awarded contracts with terms of more than one year, or non-competitive contracts which are renewable by either party, that extend beyond 12 months and exceed \$250,000. The Data Center Relocation Assessment and Design project was supposed to take eight months; however, as of December 2, 2010, after 13 months, the project is still ongoing. The project is estimated to cost \$999,500. For all other remaining non-competitively awarded personal, professional, and consulting service contracts, the Fiscal Review Committee must be notified following approval by the Commissioner of Finance and Administration.

#### Requirements for Business Case Justification

Additionally, Chapter 0620-3-3-.03(5)(b)1.(v) of F&A personal, professional, and consulting service contract rules require non-competitively awarded contract requests to specify “the justification for Non-Competitive Negotiation detailing sound, business reasoning why a competitive procurement of the given services is not appropriate and why Non-Competitive Negotiation is in the best interests of the state.” However, according to the Executive Director of Data Center Operations, who initiated and is the project manager for the Data Center Relocation Assessment and Design Project, OIR’s Chief Information Officer and Chief Technology Officer were involved in the decision to procure consulting services through the existing GTSI contract, although there is no written documentation of the approval or justification to use the GTSI contract over a professional service contract.

OIR’s Procurement, Contract and Project Management Section periodically determines the applicability of procurement rules when the initiator of services, typically an OIR director, contacts the office with questions; however, the Director of Procurement, Contract and Project Management stated that neither he nor his staff were aware of this particular project and that they

were not contacted by the Executive Director of the Data Center, or OIR's Chief Information Officer to consult on the applicability of procurement rules for this engagement.

The legislature through Section 4-3-5504, *Tennessee Code Annotated*, charged the Information Systems Council (ISC) with the responsibility for the development of procurement policy for "telecommunications, computer, or computer-related equipment or services." Per this statute, while the role of the council in establishing such policy is not to include the administrative or day-to-day operations of the procurement process, "it is the legislative intent that the Information Systems Council, in establishing procurement policy . . . select the purchasing method for a procurement that will produce the lowest and best overall costs to the state." However, none of the current ISC policies address purchasing method selection.

Agency officials' failure to properly designate projects under the proper procurement rules bypasses essential oversight by the Department of Finance and Administration, the Comptroller of the Treasury, and the Fiscal Review Committee. This lack of oversight, particularly when there is no written business case justification for the contract, increases the risks of fraud, waste, and abuse, and therefore is not in the best interests of the state.

### **Recommendation**

The Chief Information Officer should ensure that OIR properly designates all projects under the appropriate procurement rules. The Chief Information Officer should review and evaluate OIR's procurement policies and practices to ensure that project purchasing decisions incorporate the expertise of OIR procurement officials working in conjunction with officials from the Department of General Services' Purchasing Division and Finance and Administration's Office of Contracts Review.

The General Assembly passed legislation in 2010 to combine the procurement regulatory authority between the Department of Finance and Administration and the Department of General Services into a new Procurement Commission. We recommend that any new or existing entity charged with procurement regulatory authority for the state consider the risks associated with the procurement of personal, professional, and consulting services under the current rules of the Department of General Services, in the development and promulgation of any new rules, particularly those risks noted in this report.

The General Assembly may wish to consider revising Section 12-4-109(a)(1)(G), *Tennessee Code Annotated*, [Transferred to §4-56-106 effective October 1, 2011.] to ensure that the Fiscal Review Committee receives notification of procurement of all non-competitive personal, professional, and consulting services regardless of whether the services were purchased through a personal, professional, and consulting services contract or an existing General Services contract. If the General Assembly's intent is to house all procurement regulatory authority for the state within the new Procurement Commission, we recommend that Section 4-3-5504, *Tennessee Code Annotated*, pertaining to the legislative intent of ISC policymaking authority over telecommunications, computer, or computer-related equipment or services, be reviewed to

determine its relevance. At a minimum, OIR management, as staff to the ISC, should assist the ISC in drafting procurement policy to comply with the legislative intent of Section 4-3-5504.

### **Management's Comment**

We concur. The Chief Information Officer and his management team regret this inappropriate use of an existing commodity contract and are taking immediate actions to ensure that this type of action does not happen in the future.

The Office for Information Resources (OIR) was not attempting to avoid review of this purchase by the Fiscal Review Committee or the Commissioner of the Department of Finance and Administration. OIR was simply seeking the best approach to purchase the necessary services to move and re-install a group of highly complex software applications and associated hardware, which are essential to the day-to-day operation of state government (such as TennCare, Edison, etc.) from the current data center to the new data center.

As the Comptroller points out, the GTSI contract under which OIR purchased these services provided for the “technical support and maintenance related to the purchase of equipment available through the contract to ensure that it integrates with the existing state network.”

Currently, in the data center there are over 400 SUN Microsystems servers accounting for over two-thirds of the existing base of servers in the center. The SUN servers are currently purchased under state contract with GTSI, which also provides for a catalog of services related to the maintenance of these servers. Under this contract, any SUN server moved must be done by a SUN certified vendor; otherwise, SUN requires the server to be recertified or void the maintenance agreement. GTSI is a SUN-certified vendor. It is estimated that using an uncertified vendor would cost the state in excess of \$1.2 million to recertify.

In order to successfully accomplish this move, there has to be an inventory and diagram for every software application and associated hardware system currently operating in the data center including how each system connects to each other. The complexity and interdependent nature of the software applications and associated hardware developed by the state on SUN servers maintained by GTSI makes their involvement critical to the success of the move.

The state contract with GTSI provides for “[p]rofessional services for selection/design, installation, integration, optimization, clustering, configuration, load balancing, implementation, and security, within the state’s environment/infrastructure, including its enterprise/security/telecommunications networks, including Hewlett-Packard Openview Management Software of these systems and appliances and this equipment and software.” While this language seemed broad enough to accommodate the procurement of these services, OIR does not contract for these type services very often. In retrospect, the relocation of existing servers should have been purchased as a professional service under the Department of Finance and Administration’s rules.

In order to avoid this in the future, the Director of Procurement and Contract Management is instituting a new process for the review and approval of the use of all existing contracts. Any Statement of Work (SOW) must be approved by either the Chief Technology Officer (CTO) or the Deputy Chief Information Officer (CIO). The required approval is determined by the line authority of the particular division for which the SOW has been developed. Before the SOW can proceed, the senior management position for the non-involved division of OIR (either the CTO or Deputy CIO) must sign off on the procurement. These approvals will be formalized and will be kept in an electronic file. This additional step ensures a system of “checks and balances.”

In addition, the Director of Procurement and Contract Management will conduct a training session for all members of the OIR Leadership Team. That training will clearly discuss the types of contracts and conditions under which they may be utilized. The review and approval process will be included in that training.

OIR management will ensure that all processes and procedures are followed and that all non-competitive procurements are reviewed by the Fiscal Review Committee as appropriate in accordance with applicable laws, policies, and procedures.

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**6. The Department of Finance and Administration’s Office for Information Resources is not sufficiently ensuring that information security risks are remediated adequately and timely in select cases**

**Finding**

Information Systems Council (ISC) Policy 13 charges the Office for Information Resources (OIR) with managing and securing the state’s network infrastructure “to ensure the reliability, integrity, availability, and confidentiality of the operations of government and those it serves.” We found weaknesses with regard to the adequacy and timeliness with which OIR coordinates with state agencies to resolve select information security risks.

The wording of this finding does not identify specific vulnerabilities that could allow someone to exploit the state’s systems. Disclosing those vulnerabilities could present a potential security risk by providing readers with information that is confidential pursuant to Section 10-7-504(i), *Tennessee Code Annotated*. We provided the Office for Information Resources with detailed information regarding the specific vulnerabilities we identified as well as our recommendations for improvement.

## **Recommendation**

OIR's Chief Information Security Officer (CISO) should ensure that state agency IT officials adequately and promptly correct information system security risks. The CISO should ensure that these conditions are remedied by the prompt development and implementation of effective controls (standards and procedures) to ensure compliance with stated policy. The CISO should ensure that risks associated with this finding are adequately identified and assessed in OIR's documented risk assessment. The CISO should implement effective controls to ensure compliance with applicable requirements, assign staff to be responsible for ongoing monitoring of the risks and mitigating controls, and take action if deficiencies occur. The CISO should also take all other steps available to establish or improve any compensating controls until these conditions are remedied.

OIR's Chief Information Officer should also provide the Information Systems Council with periodic updates regarding information security risks and the status of OIR and agency remediation efforts.

## **Management's Comment**

The Office for Information Resources concurs that the remediation phases of the information security risks reviewed by the Comptroller take too long to complete. However, it should be noted that all of these select information security risk cases are mitigated through additional security controls. The Office for Information Resources has taken action to remediate and/or mitigate all of the identified information security risks reviewed by the Comptroller.

Certain conditions such as agency budget, program priorities and/or procurement cycles push remediation beyond our target date. For those instances, OIR will continue to mitigate the risks through additional security controls as well as introduce more strict policy requiring formal agency escalation and notification. Where agencies appear unable or unwilling to address information security risks, OIR will ensure that agency management is well informed of their decision through inter-office memorandums.

[Management's comment to the full finding has been edited in this report to prevent disclosing vulnerabilities that could present a potential security risk by providing readers with information that is confidential pursuant to Section 10-7-504(i), *Tennessee Code Annotated*. Every effort has been made to preserve the substance of management's comment.]

## **7. The Office for Information Resources has developed cost models for its services but lacks adequate documentation for rate reviews, analysis, and approval**

### **Finding**

In the 2004 performance audit of the Office for Information Resources (OIR), we found that management could not provide documentation to support and justify rates charged to state agencies for information technology services and equipment. OIR management concurred with the finding and commented that “the annual rate review process will be adequately documented, a cost model will support new rates, rate adjustments will be adequately documented and documentation of rate approval and review by upper management will be maintained.” Our current audit of OIR, which included a review of the rate setting process, and rate adjustments over the prior three years, revealed that while management maintains written rate setting procedures, as well as cost models to support rates accounting for approximately 95% of OIR’s revenues, the department still lacks adequate documentation to support rate reviews, rate analysis, and the review and approval of rates by upper management.

Under the current rate setting procedures, OIR division directors collaborate with the OIR financial manager to prepare four-year-recovery cost models. The models are to account for all costs, which depending upon the service may include amortized hardware and software costs, annual hardware and software maintenance fees, licensing fees, loaded labor rates (e.g., salary, benefits, direct and indirect overhead), and other direct costs. Rates for most services are calculated based the four-year projected cost of service, and estimates of volume/usage. Once division directors finalize cost models and rates, OIR’s financial manager conducts a final review and submits the rates to the senior management team for approval. Approved rates are made available to agencies through an electronic catalog of services.

OIR’s financial manager stated that cost models are reviewed and updated every three years. However, the cost model review process is not formally documented and there are no written procedures for cost model review. We reviewed 12 cost models, and of the 12, one had not been reviewed in three years (since February 2007); another model for determining 2010 “Open View” network monitoring service rates, while dated May 9, 2007, was based on fiscal-year-to-date 2005 cost and expenditure assumptions. Additionally, for five cost models we reviewed, while the assumptions appeared reasonable, each lacked adequate documentation within the model to support all assumptions, particularly with regard to general operating expenses, overhead, and working capital allowances.

In addition to cost model reviews, the OIR financial manager monitors revenues and expenditures by major service category throughout the year for cost recovery. Rates are adjusted annually as determined necessary by management. Although OIR’s financial manager maintains documentation substantiating specific rate adjustments, there is no documentation to support the overall review and analysis of rates. Under this process, it is possible for the department to meet

its objective of breaking even with regard to revenues and expenditures, with individual rates for services varying significantly in terms of percent of cost recovery. Based on OIR's fiscal year 2007 through fiscal year 2009 "Results of Operations" documents, which are used by OIR's financial manager to track the percent of cost recovery by major service category, the percent of cost recovery for services ranged from 9% to 281% in fiscal year 2007, 30% to 139% in fiscal year 2008, and 1% to 145% in fiscal year 2009.

Additionally, as was noted in the 2004 performance audit, we found no documented policies or procedures for rate analysis or adjustment; nor do OIR officials maintain documentation to verify the review and approval of rates by upper management.

For accounting and reporting purposes, OIR operates as an internal service fund, which by definition, is a fund used to account for the financing of goods or services provided by one department or agency to other departments or agencies on a cost-reimbursement basis. Documentation is critical because all or parts of OIR bills are passed on to federal granting agencies providing funding to state agencies. OMB Circular A-87, which establishes the principles for determining allowable costs, and which applies to central services activities, requires that costs be adequately documented. Additionally, without documentation to support the entire rate setting process, including rate review and analysis, OIR management will not be able to adequately and fully justify all rates.

### **Recommendation**

Upper management, in consultation with the financial manager, should continue their efforts to formalize the rate setting process by adequately documenting its cost model and rate reviews, rate analysis, and review and approval of rates by upper management.

### **Management's Comment**

We concur. OIR will further document the process for rate reviews, analyses, and approvals. It is important to note, however, that OIR goes to great lengths to ensure that rates charged to agencies for IT services are fair, reasonable and consistent with federal guidelines. As the report points out: 1) OIR has written policies for preparing cost models and implementing new rates; 2) cost models exist for 95% of OIR's revenues; 3) of the twelve cost models reviewed, only "one had not been reviewed in 3 years..." OIR also requires management approval for all new rates and rate changes. Finally, OIR periodically benchmarks its rates with IT rates in the private sector to further ensure that its rates and costs are equitable.

**8. The Office for Information Resources, which serves as staff to the Information Systems Council (ISC), lacks written guidelines for ISC policy review and information systems project reporting**

**Finding**

Statutorily created in 1994, the Information Systems Council (ISC) is the governing body for information technology in Tennessee. Section 4-3-5503, *Tennessee Code Annotated*, directs the Office for Information Resources (OIR) to serve as staff to the ISC. In this role, OIR assists the council with its statutorily defined duties and responsibilities, which include developing policy guidelines for the management of the state's information systems and reviewing the effectiveness and efficiency with which the state's information systems network is managed. Other duties resulting from OIR's staff role to the Information Systems Council include the review and approval of agency information systems plans, review of information technology procurements, and the establishment of statewide information technology standards.

ISC Policy Review

According to OIR management, OIR is responsible for assisting the ISC in its review of ISC policies and recommending necessary revisions; however, OIR lacks written guidelines for policy review. During our review, we observed that six of the nine ISC policies (67%) had not been revised since 2004; two (22%) were revised in December 2009 but had not previously been revised since 2004; and one (11%) was approved by the ISC in March 2007, with no other documented revision.

In addition to the specific policy, ISC Information Resource Policies contain objectives and implementation requirements for both OIR, state agencies, and, where applicable, individual users. It is critical, given the ever-changing nature of the information technology environment, that all of these policy components be frequently reviewed to ensure compliance, and that revisions are recommended as necessary.

We interviewed OIR management to assess OIR's compliance with the seven implementation requirements delineated in ISC Policy 12—"Open Access to Electronic Information"—and determined that out of the seven requirements, three were not implemented as required by the policy. Two of the requirements pertained to the development and maintenance of the Tennessee Information Locator System (TILS), which was to be an inventory system for state information systems holdings; however OIR's Chief Information Officer and Deputy Chief Information Officer had no knowledge of TILS, or whether the system ever existed. They added that the policy requirement pre-dated the Internet, and stated that this requirement had been accomplished indirectly through the use of Internet search engines. Additionally, OIR management did not maintain established pricing guidelines for creating and providing online access to public records, or for copying electronic files containing public records, as required by the policy, and at the time of our review, had not given consideration to the pricing authorities

delegated to the Office of Open Records Counsel in 2008, through Section 8-4-604(a)(1), *Tennessee Code Annotated*, relative to the establishment of pricing guidelines for public records.

In November 2009, during our audit, OIR did review ISC Information Systems Resource Policy 12 and proposed recommendations for revision to the ISC. The revised policy was approved by the ISC at the December 2009 meeting.

Periodic review of ISC policies aids in ensuring that OIR fulfills its statutory responsibilities as staff to the ISC and supports the council in its duty to establish policy guidelines for the management of the state's information systems.

### Information Technology Project Reporting

OIR also lacks documented guidance for determining which information systems projects to report to the Information Systems Council.

ISC Policy 7 requires that an Information Systems Plan (ISP) be prepared annually by each state agency, and that OIR administer the planning and review process. Under the planning process, state agencies develop an Information Systems Plan using a three-year planning horizon. An internal agency advisory committee within each state agency reviews and authorizes its agency's plan. Agencies submit their approved plans to OIR, at which point the plans undergo an extensive review by a committee of senior management from OIR and the Department of Finance and Administration's Division of Budget. ISC Policy 7 does not mandate that OIR report specific project requests to the ISC; however, it states that "major technology requests may be presented."

While OIR does report to the ISC on the status of some major projects, OIR officials maintain no documented guidance or criteria to define a major project. According to ISC minutes from December 6, 2006, and December 2, 2009, OIR officials updated the council on the status of nine information system technology projects and provided annual overviews of the three-year ISP. According to OIR management, the annual ISP overviews address plan highlights and are not project-specific. There are approximately 800 information systems projects in the statewide plan for the 2010-2012 planning cycle.

Without guidelines to assess major projects, there is the risk that costly, high-risk, or failing information systems projects may never be reported to the ISC, which is charged with overseeing information technology for the state.

### **Recommendation**

As staff to the Information Systems Council, OIR management in consultation with ISC members should establish written guidelines for the review of ISC policies. These guidelines should both address the timeliness of review and establish a process for assessing compliance with the policy, policy objectives, and implementation requirements.

OIR management should also draft written guidelines (in consultation with the ISC) for defining major information systems projects for the purpose of reporting to the ISC, taking into account factors such as the complexity of each project, total funding, project size, and risks to the state.

### **Management's Comment**

We concur. ISC policies are designed to provide broad guidance. As such, the policy statement itself tends to be technology neutral and therefore the need to change the policy statement on a regular basis is rare. With that said, management does concur that written guidelines concerning the ISC policy review process are warranted. Those guidelines are under development and will be discussed with the ISC at its next meeting.

We also concur that there are currently no written guidelines that set criteria for determining which specific information systems will be reviewed in depth by the ISC. As stated in the audit, the ISC does review selected major information systems projects. While not selected by formal criteria, these projects tend to be the most complex, high-profile, and high-dollar projects in the state. In addition, the ISC receives a copy of the Statewide Plan annually. Further, the ISC receives a briefing concerning the results of the review of the agencies' information systems plans annually. Proposed guidelines concerning criteria for information systems project review by the ISC will be developed and presented to the ISC during 2011.

### **OBSERVATIONS AND COMMENTS**

The topics discussed below did not warrant a finding but are included in this report because of their effect on the operations of the Office for Information Resources (OIR) and on the citizens of Tennessee.

#### **The Office for Information Resources Has Taken Steps to Improve Its Billing System, but LAN/WAN Billing Continues to Rely on Accurate Agency Self-Reporting**

The March 2004 performance audit of OIR found OIR's billing system to be "weak and inadequate for project management." The finding noted two issues: (1) that the accuracy of OIR's billing system, particularly for local area network (LAN)/wide area network (WAN) services, relied on communication between OIR staff and billed agencies regularly reconciling bills and agencies responding accurately when asked about their billable services; and (2) that OIR's billing system was "confusing in nature, difficult to reconcile, and fragmented, making it difficult for state agencies to reconcile and manage technology projects." The audit recommended that OIR management work with agencies to determine ways agencies can receive the necessary billing information needed to properly reconcile, track, and manage technology projects, as well as work with agencies to ensure billing accuracy.

During our current review, we determined that OIR management has taken steps to improve its billing system to provide state agencies with billing information needed to reconcile, track, and manage OIR billings. This includes providing state agencies with consolidated billing reports, which combine OIR billings within a single document, and posting OIR services and costs in an online catalog of services for rate verification. LAN/WAN billings, however, continue to rely on regular communication between OIR staff, as well as on state agencies routinely reconciling OIR billing and self-reporting changes.

### LAN/WAN Billing

Under the current LAN/WAN billing process, agencies are billed monthly for LAN/WAN service based on the number of nodes (network workstations/connections, i.e., computer, network printer, etc.) tracked and on file with OIR. OIR staff track node counts in an electronic spreadsheet which is manually updated by state agencies through shared folders, as well as updated by OIR staff throughout the month to reflect agency-reported changes coordinated through LAN administrators. They also track new and discontinued connections agencies have entered through the division's REMEDY system. Billing Services in the Department of Finance and Administration (F&A) collects the LAN/WAN billing information from OIR monthly and distributes billing statements detailing LAN/WAN charges on the first of each month. Agencies have until the 10<sup>th</sup> of each month to review the statements and notify OIR officials of any discrepancies.

During our review, we interviewed state Information Technology (IT) directors responsible for overseeing OIR billings at three state agencies. While none of the IT directors interviewed reported significant OIR billing issues in the past three years, each reported periodic billing issues with regard to the accuracy of node counts in LAN/WAN billing statements. Agencies reported that in many of these cases, however, LAN/WAN billing problems were not the result of an OIR error, but rather involved failure by agency staff to self-report LAN/WAN service changes to OIR (i.e., discontinuation in the use of a node).

OIR's LAN Management Services Section operates with 33 LAN administrators that provide LAN service and support to the state's consolidated Executive Branch agencies. According to the Manager of LAN Management Services, LAN administrators are responsible for working with these agencies to resolve node count discrepancies, and perform limited node verification. However, for non-Executive Branch agencies, there is no OIR oversight of self-reported node counts.

As was noted in the 2004 audit, OIR does not have the electronic capability to validate all node connections for all state departments billed for OIR services, and therefore must continue to rely on state agencies, working with OIR staff, including OIR's Division of LAN Management Services, to reconcile node counts and self-report billing discrepancies.

## **OIR Has Implemented a Project Management System to Prevent Problems Such as That of the MARS Contract, Which Was Terminated in January 2008**

The Office for Information Resources' Procurement, Contract and Project Management Division provides project management services to state agencies, as requested, on IT projects with an initial cost of \$100,000 or more, on IT projects that involve multiple agencies, and on projects where the state's Information Technology Assessment and Budget Review Committee requests an OIR project manager be assigned. Examples of projects managed by OIR project managers include the Multi-Agency Regulatory System (MARS), Vision Integration Platform (VIP), the Tennessee Family and Child Tracking System (TFACTS), and the state e-Health initiative.

To assess the effectiveness and efficiency of OIR's project management processes, specifically with regard to cost and time management, we interviewed OIR's Director of Contract, Procurement and Project Management regarding OIR's project management process and reviewed case logs maintained by the division for all state-terminated information technology projects over the past five years, which included only the Multi-Agency Regulatory System (MARS) project. Based on our review, we determined that OIR has a newly instituted project management process that appears reasonably effective at assisting agencies in controlling project cost and time overruns, as well as a management team that is committed to industry best practices, and adhering to the standards established by the Project Management Institute, a globally recognized association for project management. However, project management weaknesses noted in OIR's oversight of the MARS contract, as well as contract deficiencies, contributed to three years of project delays, before OIR's Chief Information Officer terminated the contract for vendor noncompliance in January 2009.

### Multi-Agency Regulatory System (MARS)

In September 2005, OIR entered into a \$4.8 million five-year contract with Systems Automation Corporation for the "My License Office" product, for what was to become the Multi-Agency Regulatory System (MARS). This system was intended to support four state agencies in managing licensing data—the Departments of Commerce and Insurance, Education, Financial Institutions, and Health—and was to replace the existing licensing system known as the Regulatory Board System (RBS).

The original project timeline called for the full implementation of MARS within the Department of Health by October 2006 and implementation within the remaining three departments by December 2006. However, at the time of project termination in January 2009, only the Department of Education had a partially implemented version of the MARS system.

MARS' case log reflects that OIR officials, staff within the four implementing agencies, and the vendor made repeated attempts through frequent status reports, executive-level steering committee meetings, conversations, and e-mails to remedy issues hindering its success. Impediments included inadequate staffing by the vendor beyond contractual requirements and missed target dates by the vendor. Failure to implement a fully functional system pursuant to the

terms of the contract led OIR’s Chief Information Officer, with the approval of the Commissioner of Finance and Administration, to terminate the contract for cause in January 2009. Termination occurred only after an unsuccessful final attempt by department officials to change the scope of the project to a full system implementation only for the Department of Education.

Based on State of Tennessee Accounting and Reporting System (STARS) data as of March 31, 2010, expenditures on the MARS contract totaled \$1.74 million, which included the cost of OIR staff time and direct payments to the vendor. The total expenditures by agency are broken down as follows:

**Table 9**  
**Multi-Agency Regulatory System (MARS)**  
**Total Expenditures by Agency**

Agency	Total Expenditures
Department of Commerce & Insurance	\$ 595,054
Department of Education	503,887
Department of Health	575,253
Department of Financial Institutions	75,107
	<b>\$1,749,301</b>

As of November 2010, Systems Automation had filed a claim with the Claims Commission (March 2009) stating that the state had predetermined sometime around July 2008, for matters related to the budget and other reasons, that F&A did not want to continue the project. F&A denied the allegation and filed a counterclaim to recover the costs that were incurred by agencies over the period. The case is currently being handled by the Office of the Attorney General.

As to each state agency’s plan to replace what it did not receive through MARS, the Department of Education is collaborating with OIR officials to develop a “MARS-like” system; the Department of Financial Institutions has purchased code from the State of North Carolina to implement a similar system for that department; and officials with the Department of Health and the Department of Commerce and Insurance have issued new requests for proposal for systems for their respective departments.

MARS - Lessons Learned

According to OIR’s Director of Procurement, Contract and Project Management, for OIR-managed IT contracts in effect prior to 2006, which included the MARS contract, the primary method for controlling time overruns was limited to managing each project through regular status reports. The department allowed delinquent projects to continue as long as the vendor continued

to show reasonable effort in continuing and progressing with the project, and as long as other parties to the contract were in agreement to continue.

Since 2006, OIR officials have assisted state agencies in implementing several changes to new IT request for proposals (RFPs) and enhanced its internal project management processes. Some of the major changes include:

- strengthening requests for proposal, and thereby state IT contracts, by entering into performance-based contracts which clarify expectations, provide clear performance metrics, and identify consequences for failure to meet objectives. (TFACTS and the new state portal contract are two examples of performance-based contracts);
- inserting industry standard plans into each contract and managing the project to those plans;
- collaborating with state agencies on IT contracts to include independent quality assurance reviews where determined appropriate;
- assigning only certified Project Management Professionals or Associate Project Management Professionals to each project;
- providing training classes to agency staff on project management, business analysis, and business process reengineering; and
- implementing end-of-phase gate reviews, to review the adequacy of all deliverables at the conclusion of each project phase, before proceeding to the next phase of the project.

With the recently instituted improvements to OIR's contract and project management operations, we recommend that OIR staff continue to monitor and evaluate these newly developed project management operations to ensure that they effectively minimize information technology project cost and time overruns.

## **RESULTS OF OTHER AUDIT WORK**

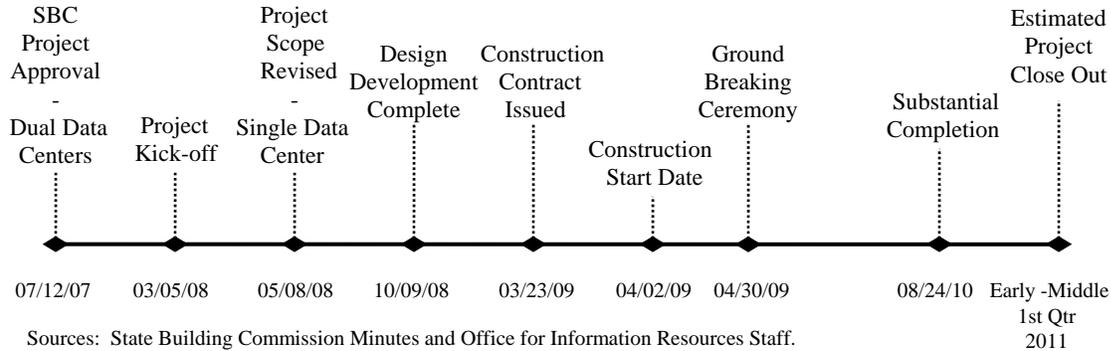
### **Frequency of Information Systems Council Meetings Has Improved**

The March 2004 performance audit found that the Information Systems Council (ISC) met only twice in the two and a half years following its March 2001 meeting. The audit recommended that the ISC meet regularly several times each year and noted that the General Assembly may wish to consider amending Section 4-3-5501, *Tennessee Code Annotated*, to require regular meetings by the ISC.

According to Information Systems Council minutes, the ISC met ten times between December 6, 2006, and December 2, 2009. There are currently no statutory meeting requirements for the ISC.

## Status of the New Data Center Project – Tennessee South Service Center

The state’s new information technology data center, Tennessee South Service Center, was substantially completed on August 24, 2010, 16 months following ground-breaking, and approximately one month ahead of schedule. Since that time, OIR officials have progressed with laying the foundation of the IT infrastructure, including installing equipment, servers, cabling, data lines, and other critical components. The following timeline depicts the overall project schedule:



The Tennessee South Service Center location ranked second of seven sites considered for the project in a 2007 IBM Corporation consulting evaluation. The data center is certified by the Uptime Institute, an industry leader in data center education, research, and education, as a Tier III facility, which is defined as a facility that minimizes downtime through the use of resilient systems. Some of the major features and highlights of the new data center include

- 48,350 total square feet with 15,000 square feet of raised floor space;
- a 17-person office capacity;
- state-of-the-art post-9/11 security features;
- entirely redundant building mechanical infrastructure;
- hardened construction
  - tested to withstand F3 (severe) tornado pressure loads, and
  - seismic rated to withstand moderate level earthquakes;
- several “green” and energy saving components; and
- data replication ability with Tennessee North Service Center.

The total cost to construct and equip the new Tennessee South Service Center is estimated at \$60.4 million—\$36.2 million for construction and \$24.2 million for non-construction and equipment costs. OIR has expended \$33.9 million of the \$44 million budgeted on the construction phase to-date, and \$15 million of the \$24 million budgeted for non-construction and equipment costs through June 30, 2010.

Dual Data Centers Approved – A Single Data Center Constructed. The fiscal year 2007-2008 budget included \$44 million in approved capital appropriations—\$5 million from the Facilities Revolving Fund and \$39 million in bonds—for the construction of two new data centers. At that time, it was anticipated that the state would replace the existing 70,000 sq. ft. Tennessee North Service Center with two 35,000 sq. ft. data centers. The \$44 million estimate was based on a February 2007 IBM Corporation consulting evaluation which developed the first level conceptual architecture, timeline, site evaluation, and project budget. The consultant’s estimated project construction budget varied by site and ranged from \$17.8 million to \$25.9 million for each facility.

In May 2008, OIR officials requested and obtained approval from the State Building Commission to revise the scope of the project from two data centers to a single data center. OIR officials stated that the request was made because of the escalation in construction supply costs (i.e., copper and steel) and other technology-related costs since the original estimates were developed. While the scope of the project was revised from two data centers to one data center, there was no change to the project’s \$44 million capital budget.

Status of the Downtown Data Center – Tennessee North Service Center. Over the past four years, significant attention has been given to the location and structural condition of the state’s 22-year-old Tennessee North Service Center. OIR officials reported that the downtown data center is structurally sound, and that with planned improvements, OIR will be able expand its useful life until budgetary conditions will allow for the construction of a second facility.

With respect to the impact that the May 2010 flooding had on the downtown data center, OIR management reported that there was no damage to the building or equipment, and that no surface water entered the facility. However, flood waters did rise to a level that affected the pump that provides water to the chillers, which forced a partial shutdown of the data center for approximately 1.5 hours.

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## BUREAU OF TENNCARE

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### BACKGROUND

TennCare is the State of Tennessee's Medicaid program that provides healthcare for 1.2 million Tennesseans.

#### Objectives

The objectives covered in this chapter were to

1. review and assess TennCare's processes for monitoring compliance of Managed Care Organizations (MCOs) with contract requirements;
2. review and assess TennCare's effort to ensure its MCOs are offering quality healthcare to enrollees;
3. review and assess the efficiency of the credentialing process for TennCare providers;
4. assess the pharmacy program's systems for measuring effectiveness of services and the controls in place to maintain acceptable levels of care while also preventing fraud and abuse of medications;
5. assess the adequacy of TennCare resources to monitor the Pharmacy Benefits Manager (PBM) contract and the adequacy of the PBM's system to process claims timely and efficiently;
6. review TennCare's disease management program and assess TennCare's efforts to monitor the MCOs' provision of disease management services;
7. review the process for denying services and tracking MCOs' denial of services;
8. assess compliance with provider network requirements and completeness and accuracy of provider and enrollee files, and to examine pharmacy claims to identify any trends that may indicate problems;
9. review the process for promulgating public necessity rules and determine whether TennCare has used the process appropriately;
10. review Long Term Care staff's monitoring plans for the CHOICES program, both prior to and after implementation;
11. summarize the CHOICES program's "single point of entry" system, focusing on how it will assist applicants and their families and efforts to ensure a continuum of care; and
12. review Long Term Care staff's actions to assess the adequacy of services available under the CHOICES program, in order to reduce the need for more expensive services.

## History and Statutory Responsibilities

On January 1, 1994, pursuant to an executive order signed by Governor Ned McWherter, Tennessee withdrew from the federal Medicaid program to implement a new type of healthcare plan called TennCare. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), granted Tennessee approval to implement a demonstration project under Section 1115 of the Social Security Act. Under this new plan, the state extended healthcare coverage not only to Medicaid-eligible Tennesseans, but also to uninsured and uninsurable persons, using a managed care system. In 2005, TennCare underwent dramatic reform to control its escalating costs. Benefits were reduced and many uninsured and uninsurable individuals were disenrolled. (Children who were uninsured or uninsurable were able to keep their coverage, as long as they met certain financial requirements.) The Bureau of TennCare, within the Department of Finance and Administration, is responsible for administering the program. The waiver has been extended numerous times and is currently extended through June 30, 2013. The bureau receives its statutory authority from Title 71, Chapter 5, Part 1, *Tennessee Code Annotated*.

The Bureau of TennCare is headed by the Deputy Commissioner. He has 12 executive-level offices that report directly to him. See the organization chart on page 90. The bureau had 379 employees as of March 31, 2010. As of this same date, there were seven contractors employing approximately 300 individuals that were housed in TennCare's building. As of December 15, 2009, TennCare had 1,185,634 enrollees, consisting of 733,974 children (birth through 20 years) and 451,660 adults (21 years and older).

TennCare's main mission is to pay for the provision of medical services to eligible Tennesseans. Its functions are broken down into four program areas: TennCare Administration, TennCare Services, Medicare Crossover Services, and Long Term Care Services.

### *TennCare Administration*

TennCare Administration is responsible for the daily operations of the TennCare program. This area includes the fiscal division, information technology, and oversight of the managed care contractors, including the pharmacy and dental benefits managers. Other services include policy and planning, legal, long-term care, and program integrity.

### *TennCare Services*

TennCare Services is responsible for funding healthcare and mental health services to its enrollees. Title XIX of the Social Security Act requires states to provide services to all mandatory Medicaid categories as well as some optional categories. The bureau has contracts with managed care organizations (MCOs), a dental benefits manager, and a pharmacy benefits manager to provide these services, and various state agencies to provide care to its enrollees. In 2006, TennCare went through a competitive bid process to find new MCOs to serve its enrollees—two MCOs per grand region. The bureau also contracts with TennCare Select, which operates on a statewide basis and serves special populations (e.g., children in the Department of Children’s Services’ custody). The MCOs, with the exception of TennCare Select, operate at full risk. On April 1, 2007, AmeriChoice and Amerigroup began serving the Middle Tennessee Grand Region; AmeriChoice and BlueCross BlueShield began serving West Tennessee on November 1, 2008, and East Tennessee on January 1, 2009. All MCOs now provide both integrated medical and mental health services, and they are accredited by the National Committee for Quality Assurance.

### *Medicare Crossover Services*

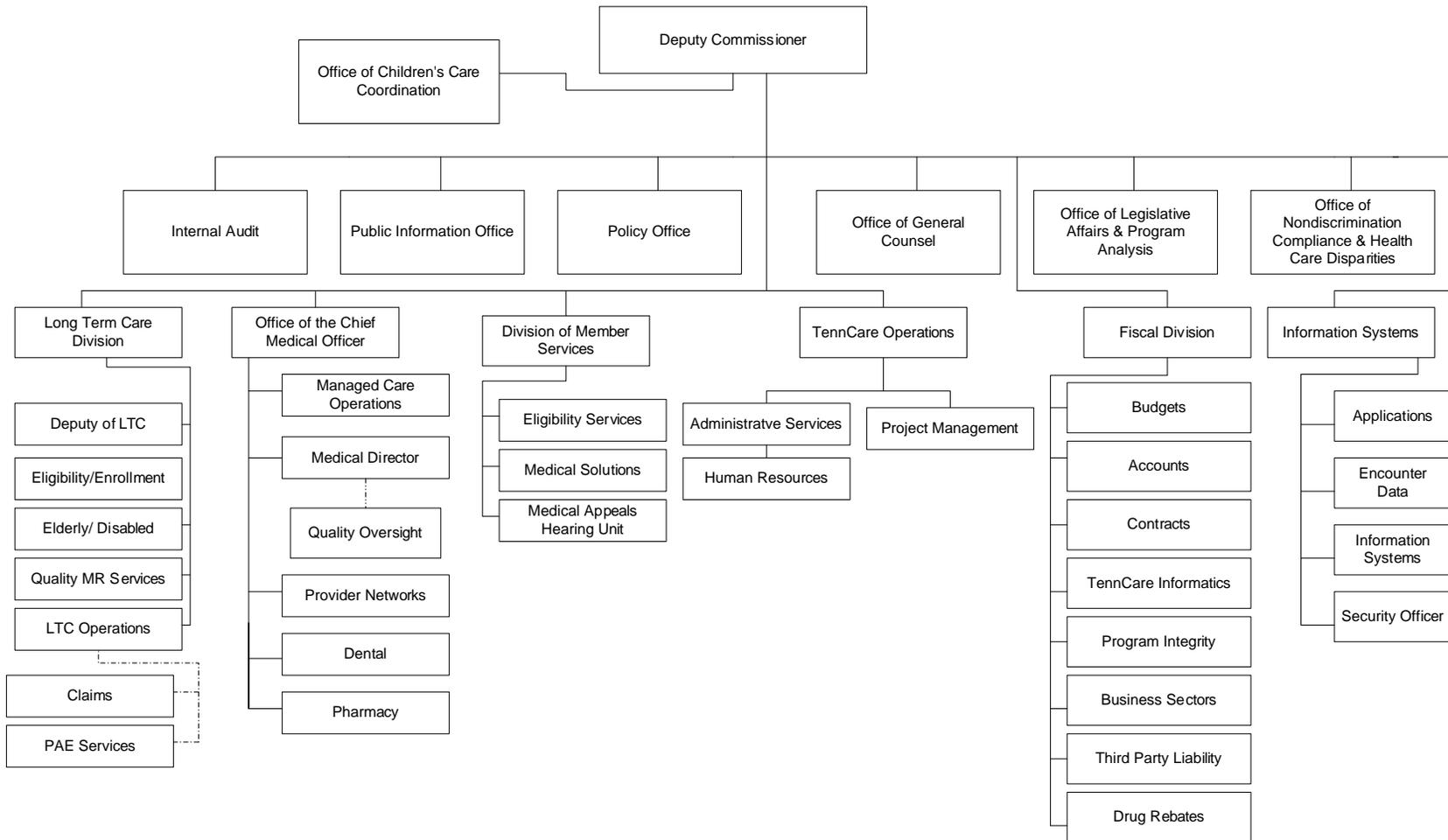
TennCare pays the premium for certain low-income enrollees who are also enrolled in Medicare. After Medicare has paid its portion of the claims, it submits these “crossover claims” to TennCare to process the portion of the claim for which the enrollee would otherwise be responsible. The claims are processed in accordance with TennCare policy pertaining to crossover claims.

### *Long Term Care Services*

The Bureau of TennCare’s Division of Long Term Care is responsible for programs that provide medical and non-medical long-term care. This care includes assistance with the activities of daily living and can be provided at home, in the community, or in institutional settings, such as nursing facilities or intermediate care facilities for persons with mental retardation (ICFs/MR)

TennCare offers two types of home and community-based services to individuals who are Medicaid eligible. These services are obtained through waivers approved by CMS. The first type serves individuals with intellectual disabilities who meet the requirements for admission into an intermediate care facility for persons with mental retardation (ICF/MR). The Department of Finance and Administration’s Division of Intellectual Disabilities Services is the operating agency for the waivers for the intellectually disabled. (Effective January 15, 2011, the new Department of Intellectual and Developmental Disabilities assumed this responsibility.) The second type serves elderly or disabled adults who meet level-of-care criteria for nursing facility (NF) services. With the implementation of the Long-Term Care Community Choices Act of 2008, the services which had been offered to persons who met criteria for Level I NF (formerly referred to as Intermediate Care Facility) services through a Section 1915(c) waiver have been integrated into the managed care delivery system via an amendment to TennCare’s Section 1115 demonstration waiver, and now offer an alternative to persons who may qualify for Level II NF (formerly referred to as Skilled Nursing Facility) services as well.

# Bureau of TennCare Organizational Chart



## TennCare Pharmacy Advisory Committee

The TennCare Pharmacy Advisory Committee was formed in 2003 pursuant to Section 71-5-2401, *Tennessee Code Annotated*. The statute created an entity that would review drugs and drug classes for recommendation to the Preferred Drug List to govern state expenditures for prescription drugs for the TennCare program. Pursuant to the statute, the committee has 15 members: 12 are practicing pharmacists and physicians in Tennessee, one is an advocate, and 2 are representatives from TennCare. The practicing pharmacists and physicians are nominated by medical groups in different areas of expertise. Nine of the members are appointed by the Governor, two by the Speaker of the House, and two by the Speaker of the Senate, depending on which position is being filled. The two members who are TennCare representatives, the Chief Medical Officer and the Pharmacy Director, are ex officio members who do not have a vote.

As of February 2010, seven Pharmacy Advisory Committee members were female and eight were male. Thirteen members were Caucasian, and two were African American. Two members practice in West Tennessee, nine members practice in Middle Tennessee, and four members practice in East Tennessee. Three of the appointed members' terms had expired; however, the members have continued to serve and attend meetings. See page 110 for additional information regarding the committee and the results of audit work performed.

## CHOICES Program

Because of concerns that Tennessee's current long-term-care system was fragmented and heavily dependent on costly institutional care, and that persons needing long-term care had few choices concerning the types and provision of such care, the General Assembly passed the Long-Term Care Community Choices Act of 2008 (codified in Section 71, *Tennessee Code Annotated*). The act restructures the long-term-care system and expands access to more cost-effective home and community-based services for persons who are elderly and/or have physical disabilities.

Parts of the act required federal waiver authority before implementation could proceed, and the Centers for Medicare and Medicaid Services (CMS) approved TennCare's application for the CHOICES waiver in July 2009. The Division of Long Term Care in the Bureau of TennCare is responsible for implementing plans, policies, and procedures for the CHOICES waiver that will expand the scope of services of the Managed Care Organizations (MCOs) currently contracting with TennCare to include a range of alternatives for those enrollees who need long-term care. See page 123 for information on TennCare's activities in preparation for CHOICES implementation.

The CHOICES program was implemented in Middle Tennessee on March 1, 2010. Implementation in East and West Tennessee occurred on August 1, 2010.

Table 10 details the CHOICES program target groups.

**Table 10**  
**CHOICES Target Groups\***

<b>Group</b>	<b>Description</b>	<b>Medicaid Eligible</b>	<b>Enrollment Capped?</b>
1	Persons who are receiving Medicaid-reimbursed care in a nursing facility	Yes.	No.
2	Persons age 65 and older and adults age 21 and older with physical disabilities who meet nursing facility (NF) level of care, need home and community based services (HCBS) as an alternative to NF care, and who would qualify as Supplemental Security Income (SSI) recipients or in the institutional category by virtue of receiving HCBS	Yes, as SSI recipients or in the institutional category by virtue of receiving HCBS.	Yes, at the state's discretion, but enrollment must be at least 6,000.
3	Persons age 65 and older and adults age 21 and older with physical disabilities who do not meet NF level of care but who, in the absence of HCBS, are "at risk" of institutionalization	Yes.	Yes, at the state's discretion but not less than 10% of the enrollment cap for Target Group 2. (Group 3 is on hold until January 2011 due to the requirements of the American Recovery and Reinvestment Act of 2009.)

\* According to Division of Long Term Care management as of January 2011, while the state has approval to establish Target Group 3, Group 3 has not yet been implemented due to CMS interpretations of Maintenance of Effort provisions set forth in the American Recovery and Reinvestment Act and now the Affordable Care Act.

Other TennCare-Related Work Conducted

In addition to the work conducted as part of this performance audit of the Department of Finance and Administration, two other sections within the Division of State Audit routinely conduct TennCare-related reviews. As part of its audit of the state's major federal programs, the division's Financial and Compliance section conducts an audit of TennCare annually to determine the bureau's compliance with the requirements of applicable laws, regulations, contracts, and grants. Any reportable areas of noncompliance are detailed in the section's annual audit report, the *Single Audit of the State of Tennessee*. (These reports are available on the Comptroller of the Treasury's website at [www.comptroller1.state.tn.us/RA\\_SA/](http://www.comptroller1.state.tn.us/RA_SA/).)

Under an agreement with the Department of Finance and Administration, the TennCare Section of the Division of State Audit performs examinations of nursing homes and Intermediate Care Mental Retardation facilities that participate in the Medicaid Program, and performs certain

rate-setting functions. (The examination reports are available on the Comptroller of the Treasury’s website at [www.comptroller1.state.tn.us/RA\\_SA/](http://www.comptroller1.state.tn.us/RA_SA/).) The section also assists the Department of Commerce and Insurance in conducting examinations of TennCare’s Managed Care Contractors that provide services to TennCare enrollees. (These examinations are available on the Department of Commerce and Insurance’s website.) In addition, the section monitors all aspects of compliance with the Grier Consent Decree, which sets federal court requirements related to TennCare enrollee grievances and appeals. The section submits quarterly reports, which are provided to TennCare, the federal court, and other interested parties. The reports address areas including compliance with specific rules concerning appeals, special provisions pertaining to pharmacy services, and requirements concerning public notice and operation of a call center for appeals. (These reports are available upon request.)

Revenues and Expenditures

**Statement of Revenues and Expenditures  
Revenues by Source  
For the Fiscal Year Ending June 30, 2009**

<b>Source</b>	<b>Amount*</b>	<b>Percent of Total</b>
State	\$2,005,065,550	27.54%
Federal**	4,743,016,864	65.14%
Federal – Certified Public Expenditures	267,700,320	3.68%
Pharmacy Drug Rebates	264,121,215	3.63%
Premiums	0	0%
Other Funding	892,121	.01%
<b>Total Revenue</b>	<b>\$7,280,796,070</b>	<b>100.00%</b>

\* These amounts include funding for the Governor’s Office of Children’s Care Coordination (GOCCC). Although the office is administratively linked to TennCare, it is not part of TennCare’s core operations.

\*\* The federal percentage in the tables represents an enhanced match period.

**Statement of Revenues and Expenditures  
Expenditures by Program  
For the Fiscal Year Ending June 30, 2009**

<b>Account*</b>	<b>Amount</b>	<b>Percent of Total</b>
Administration	\$ 256,946,309	3.53%
TennCare Services	4,985,985,327	68.55%
Waiver and Crossover Services	960,469,003	13.20%
Long Term Care Services	1,070,355,025	14.72%
<b>Total Expenditures</b>	<b>\$7,273,755,664**</b>	<b>100.00%</b>

\*TennCare’s program area descriptions have changed, so the program areas listed in this table do not match the current program descriptions on pages 88-89.

\*\* If we include \$7,040,404 in GOCCC expenditures, the total comes to \$7,280,796,068.

**Budget and Anticipated Revenues  
For the Fiscal Year Ending June 30, 2010**

Source	Amount*	Percent of Total
State	\$1,970,063,300	26%
Federal**	5,424,674,800	71%
Other	231,269,900	3%
<b>Total Revenue</b>	<b>\$7,626,008,000</b>	<b>100%</b>

\* This budget does not include GOCCC.

\*\* The federal percentage in the tables represents an enhanced match period.

**FINDINGS**

- 9. TennCare has not been consistent in properly assessing or timely collecting and recording liquidated damages against its Managed Care Contractors, and failed to ensure that a liquidated damages provision in one of its contracts was consistent with the Grier Consent Decree, resulting in a loss of revenue**

**Finding**

When the Managed Care Contractors (MCCs) fail to perform in accordance with the terms and provisions of their contract, TennCare may assess liquidated damages against the organization. (The term “MCC” encompasses both the Managed Care Organizations and various fee-for-service contractors.) Monetary damages for noncompliance and failure to achieve certain performance measures are outlined within each MCC contract. Failure to properly assess and timely collect and record liquidated damages could result in the loss of significant revenue for TennCare. During the course of the audit, we obtained from TennCare management a description of the process for monitoring the MCCs’ compliance with contract requirements and performed a file review of a sample of liquidated damages assessed from May 2009 through November 2009. (We chose this time period for our review because the database that tracks damages has only been in operation since early 2009.) We found that although TennCare was assessing damages and was appropriately notifying the MCCs of the liquidated damages being assessed, it was not properly assessing or timely collecting and recording damages in all cases. The deficiencies we identified are detailed below.

Within TennCare, either the Office of Contract Compliance and Performance (OCCP) or the “business owner” of the contract calculates the amount of liquidated damages to assess against the MCC, depending on the type of noncompliance. (The “business owner” is the division or program area within TennCare where contracts originate.) Once the liquidated damages amount is determined, the OCCP notifies the MCC by official letter of the sanction. To process the sanction, OCCP provides Fiscal Services with a copy of the letter to recoup the sanction. According to management, the MCCs are not billed separately for the liquidated damages; the amounts are deducted from their next payment.

During the file review testwork, we found that 11 of 102 liquidated damages payments tested (11%), totaling \$6,562.36, were either not recouped from the contractor and recorded in a timely manner or not recouped at all. Two of 11 liquidated damages were recorded between two and nine months after they were assessed. The total for these two items came to \$3,562.36. According to TennCare management, the normal liquidated damages recoupment time should be approximately 30 days. Nine of these 11 liquidated damages still had not been recouped when we completed our testwork in March 2010. Further review and discussion with TennCare management found that the failure to recoup these nine liquidated damages occurred for one of two reasons:

- For one of the liquidated damages (\$500), the sanction letter written by OCCP apparently was not received by Fiscal Services. Management in Fiscal Services could not determine if they ever received the sanction letter from the OCCP. (Damages were recouped on May 19, 2010.)
- For eight of the liquidated damages not recouped (\$2,500), it appeared the liquidated damages were overlooked and not recouped by Fiscal Services at the time the original MCC assessment letter was sent from the OCCP. According to TennCare management, there was a lack of controls in place to record when sanction letters are received in Fiscal Services. Furthermore, employee turnover within the OCCP and Fiscal Services appeared to hinder the recoupment of the liquidated damages. (Damages were recouped between April 19 and June 4, 2010.)

In addition, for 7 of the 102 liquidated damages payments tested, Fiscal Services was waiting for a payment to a “Run Out” MCO (no longer contracted with TennCare but still submitting invoices for services rendered through the end of their contract) to be processed in order to deduct the recoupment from that payment. We examined these sanctions in TennCare’s interChange system. It appeared the liquidated damages were correctly entered into the system; however, the recoupment had not processed. Fiscal Services management stated this group of liquidated damages was assessed to “Run-out Managed Care Organizations (MCOs).” In this instance, Fiscal Services entered an accounts receivable but had not yet received an invoice from the MCO to initiate the capture and processing of the liquidated damages (still outstanding as of early December 2010).

TennCare management has assigned an employee independent of the liquidated damages recoupment process to maintain a logbook of the liquidated damages information. Information contained in the logbook includes the date the MCC sanction letter was received in Fiscal Services, the date of recoupment, and the voucher and Financial Change Request (FCR) number. In addition, the MCC liquidated damages assessment letter is being sent from the OCCP to several employees within Fiscal Services rather than just the employees processing the liquidated damages recoupment.

In addition, during the file review, we found that 5 of 102 liquidated damages files tested (5%) were not properly assessed by TennCare. Each of the five discrepancies involved SXC Health Solutions Corporation (SXC), TennCare’s Pharmacy Benefits Manager since October 2008. From review of the liquidated damages files, it appeared that SXC was incorrectly

assessed \$100 for each “Defective Notice of Adverse Action” sanction rather than the \$500 that other MCCs were being assessed for the same type of sanction. According to TennCare management, SXC was being assessed damages of \$100 since this amount was stated in SXC’s contract. However, the federal court has ordered, under the Grier Consent Decree, that damages of no less than \$500 will be imposed for defective notices after October 15, 2000. Therefore, for the five files that were part of our file review, TennCare assessed SXC liquidated damages totaling \$500 whereas the correct assessment amount should have totaled \$2,500. Further review of all liquidated damages assessed from May 2009 through November 2009 identified an additional 106 “defective notice” damages assessed to SXC at the \$100 level rather than the required \$500. For the 111 assessments, SXC was assessed \$11,100 in liquidated damages instead of the correct amount of \$55,500—a \$44,400 difference.

According to TennCare management, TennCare was not aware there was a discrepancy between the liquidated damages amount outlined in the contract with SXC and the liquidated damages amount specified within the Grier Consent Decree. To address the discrepancy relating to the SXC contract, TennCare drafted an amendment to the Pharmacy Benefit Manager contract with SXC that will correct the liquidated damages amount to \$500 per occurrence. On June 2, 2010, the Tennessee General Assembly’s Fiscal Review Committee voted to pass the portion of the amendment of the SXC contract relating to this matter. On July 18, 2010, this amendment went into effect.

### **Recommendation**

The Director of Managed Care Operations and the Chief Financial Officer should work together to develop policies and procedures to adequately monitor the Managed Care Contractors’ compliance with contract requirements as they relate to properly assessing, collecting, and recording liquidated damages. In addition, the Chief Financial Officer should evaluate the newly implemented internal controls within Fiscal Services to ensure all liquidated damages are being received and processed from the Office of Contract Compliance and Performance. He should continually evaluate these controls to ensure they are working effectively and efficiently. Finally, TennCare management and its Office of General Counsel should improve the process for ensuring that contract terms are consistent with requirements set forth by external entities such as the federal courts.

### **Management’s Comment**

We concur that the process of communicating and collecting the assessments of liquidated damages during the audit period needed improvement (\$6,562.36). To that end, the Office of Contract Compliance and Performance (OCCP) made significant staffing changes in April 2010. OCCP also implemented a new automated tracking system for liquidated damages effective October 2010. In addition, Fiscal Services has created an independent log of liquidated damages to track the date of receipt in Fiscal Services to the date of recoupment. Fiscal staff will also submit a weekly report to management detailing the status of any open assessments. These

additional steps should greatly strengthen the internal controls over communicating, recording, and collections of liquidated damages. The questioned amounts were ultimately recouped by June 2010.

We concur that the liquidated damages portion of the SXC contract required an amendment. This discrepancy was corrected with an executed amendment effective July 18, 2010.

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## **10. Problems within TennCare's provider database and filing system weaken the functionality of enrollment administration and oversight**

### **Finding**

TennCare's management information system, known as interChange, was implemented in 2004. It is an all-inclusive system that contains enrollee, claims, and provider information, among numerous other things. At the time of implementation, much of the information in interChange was transferred from the previous system, including all data relating to providers who offered services to TennCare enrollees. There is an abundance of decades-old files which remain in interChange that are inactive or missing required information; and many files specifically lack the proper attributes for searchability. In addition, TennCare lacks a mechanism to accurately measure and track provider enrollment processing times for all providers, specifically those providers who are not required to sign a contract.

During the audit, we interviewed TennCare management to determine the process a provider must go through in order to enroll in TennCare as a fee-for-service or a managed care provider. We also interviewed management at the managed care contractors to determine what their enrollment processes were. We requested from TennCare's management a list of all active providers, whether they were fee-for-service providers or were part of any managed care network, or both.

Based on the interviews and review of policies, the process to enroll as a provider is as follows:

1. obtain a National Provider Identifier (NPI), a ten-digit identifier required under HIPAA (Health Insurance Portability and Accountability Act);
2. obtain a Medicare number if appropriate;
3. obtain a TennCare Identification number; and
4. enroll with a Managed Care Contractor (MCC).

In addition, according to TennCare Policy PRO 09-001, Enrollment & Disenrollment of Providers in TennCare Managed Care, all providers, whether they receive payment directly from

a managed care contractor or TennCare, must be enrolled by TennCare. According to management, the system for collecting and filing the information used to determine provider eligibility and assign a Medicaid number is completely paper-based, and the large number of paper-based files that are maintained create opportunities for documents to be misfiled. Management stated that TennCare recently completed business process modeling activities with its Medicaid Management Information System (MMIS) contractor to lay the groundwork for developing a computerized provider enrollment process.

Using provider information located in TennCare's interChange database, auditors randomly selected a sample of 563 out of a population of 37,510 contracted TennCare providers. We also selected a sample of 125 of a population of 954 providers who contract with the Division of Intellectual Disability Services (DIDS) to provide services to individuals enrolled in the Home and Community Based Services waivers for the mentally retarded and developmentally disabled. Auditors planned to calculate TennCare enrollment processing times by using TennCare application receipt dates (or the date the provider signed the application if the application was not stamped as received) and contract execution dates (the date of the last signature on the contract). Providers that sign contracts include long-term-care nursing facilities, intermediate care facilities for persons with mental retardation, hospitals, and Home and Community Based Services (HCBS) providers, including those who serve DIDS participants. All other providers (if applicable) sign provider participation agreements, which are included with the provider application. Providers submit applications to TennCare to receive a Medicaid ID so they can serve TennCare enrollees and receive payments. The applications also allow TennCare to comply with Title 42, Chapter 455, Subpart B, of the *Code of Federal Regulations* (CFR). According to 42 CFR 455.104, "The Medicaid agency must require each disclosing entity [i.e., Medicaid providers] to disclose . . . the name and address of each person with an ownership or control interest in the disclosing entity . . . in which the disclosing entity has direct or indirect ownership of 5 percent or more." Furthermore, section 455.106 also requires the provider to ". . . disclose to the Medicaid agency the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid . . ."

The initial provider sample yielded 38 files for which auditors could determine the processing time from the submittal of an application to the signing of a TennCare contract. The 38 files do not include MCO network providers that were part of the original sample. (See the Appendix on page 149 for additional information regarding the results of the initial file review, including information on files processed by the MCOs, SXC, DentaQuest, and DIDS.) For the providers whose file was complete, we calculated TennCare's processing time. TennCare operates under an internal guideline of 15 days for enrollment processing. Based on the provider files with calculable processing times, 17 of 38 sampled files (45%) exceeded the 15-day window, and the average total processing time was 28.67 days.

Following the initial file review, 239 of the previously sampled provider files were determined to be missing varying amounts of required documentation, or they could not be located at all. A secondary request prompted TennCare personnel to conduct a more thorough search for the files in question, as well as using different file-identifying criteria and linking

related provider numbers. During the file review process, TennCare management informed us that some providers who work in group settings are not required to sign a contract; instead, they sign provider participation agreements at the time of application. Auditors found a total of 88 providers from the sample which were only required to sign participation agreements and were excluded from the calculation of processing times.

Based on our discussion with management, it appears that the provider file database contains inactive files because TennCare provider numbers were issued with no expiration date and no requirement for the provider to periodically reapply for continued enrollment in the program. The addresses included in the sample population were the “pay to” addresses, yet the folders are filed by their “service location” address. For most providers, each address would have its own provider number, resulting in providers with multiple identification numbers. This is the reason management wanted to look for the files again. However, we should note that TennCare no longer issues multiple provider numbers; more recently enrolled providers have only one provider number, and in interChange the different provider numbers are linked. Once the provider files were located, the files were checked for an application, a provider agreement, and an NPI number assignment. Provider enrollment processing times were not able to be calculated for any provider that is not required to sign a contract.

A summary of the missing documentation is detailed below.

**Missing Documentation Identified During the TennCare File Review**

<b>No applications</b>	<b>76</b>
<b>No contracts but have an application on file</b>	<b>4</b>
<b>No applications or contracts on file</b>	<b>2</b>
<b>No signature on contract</b>	<b>2</b>
<b>No folder on file</b>	<b>19</b>

**Recommendation**

The Deputy Commissioner should ensure the provider database in interChange is purged of all non-active provider files. This would include reconciling files with missing or fragmented documentation; eliminating system-generated reporting; replacing documentation for missing files; and developing a uniform and reliable numbering and filing system. For any provider contained in interChange who does not have a file on site, the Deputy Commissioner should insist these providers reenroll. TennCare should also develop policies and procedures detailing processing times and instituting a periodic reenrollment process similar to what the MCCs have in place.

Additionally, TennCare should consider adopting a web-based application and enrollment system, one that could better track the application process, monitor processing lengths, keep track of required documentation, and ensure consistency for all providers during the enrollment and application process.

## Management's Comment

We concur in part. We agree that interChange includes inactive provider files and that in some cases one or more of the various forms a provider must fill out prior to enrolling in TennCare were incomplete or missing in the paper files maintained at the Bureau. We also agree that we have lacked a systematic mechanism to track provider enrollment processing times. We believe these problems stem from two distinct issues. First, up until now, with limited exceptions, when a provider enrolled in TennCare he/she was enrolled indefinitely. TennCare provider numbers were issued with no expiration date and no requirement for the provider to periodically reapply for continued enrollment in the program. As a result, provider numbers associated with providers who may no longer see TennCare patients still exist in our system along with those of active providers. Second, TennCare's process to issue provider numbers has consisted of an entirely manual process based on submission of paper applications and the use of an outdated paper-based filing system with opportunities for documents to be misplaced and an inability to systematically track processing times.

While we agree that there are clear opportunities to improve the provider enrollment process, we do not believe that the current process has placed us at risk for paying ineligible providers because there are several checks and balances built into the current process that guard against such errors. For example, a provider who completes TennCare's application process and is issued a Medicaid provider number cannot be paid through the fee-for-service system on a cross over claim unless the provider has also successfully completed the federally administered process to obtain a Medicare number. In fact, fee-for-service cross over claims are not processed by TennCare until they have been submitted and processed by Medicare. Similarly, after being issued a Medicaid number, managed care providers must go through a separate credentialing process conducted by the managed care organization (MCO) prior to becoming a provider in the MCO network. The managed care organization credentialing process is reviewed by the National Committee for Quality Assurance (NCQA) as a part of the NCQA accreditation process in order to assure quality standards are met. TennCare also has an ongoing process by which we receive information concerning newly sanctioned and disciplined providers and take action to assure such providers are removed from any applicable network.

Nevertheless, TennCare has begun making extensive changes to the provider enrollment process in order to improve our ability to manage the data and our internal procedures. These changes were initiated last summer with reorganization of the Provider Enrollment Unit under new management. We have since identified all enrolled providers with no claims activity during the last 18 months. We intend to terminate the enrollment of these providers unless an MCC is in the process of contracting with such a provider. A list of these providers has been sent to the MCCs so that they can advise us of any provider who should not be terminated due to a pending contract. Following receipt of responses from the MCCs, we will proceed to terminate the applicable providers.

For the remaining active providers, we are pursuing a two-pronged approach to updating their files. For individual providers, we identified the CAQH Universal Provider Datasource as a computerized process to maintain current information in our system. We are currently in the

process of securing a contract with CAQH for this purpose. The CAQH Universal Provider Datasource online system requires providers to update their status at least three times annually. The incentive for providers to utilize this service is that there is no cost to the provider and they need only update their profile in one place for any and all healthcare organizations utilizing the CAQH system. All TennCare MCOs currently offer CAQH as one acceptable method for a provider to submit credentialing material. Once the contract with CAQH is in place we will require all individual providers to reenroll with the TennCare program via CAQH and to update their status with CAQH on an ongoing basis, per CAQH protocol. In addition, all new individual providers will be directed to the CAQH process for initial enrollment with TennCare.

For non-individual providers, we have begun a process, by provider type (e.g., hospitals, group practices, home health agencies, DME companies, etc.), of sequentially requiring providers to reenroll with TennCare, thereby creating the opportunity to update provider files. We began this process with hospitals. Reenrollment of in-state hospitals has been completed. Out-of-state hospitals that did not respond to our written request to reenroll have been divided into two groups. The first group contains out-of-state hospitals where claims activity during the last 18 months was identified. We will ask our MCC partners to review this listing of out-of-state hospitals to determine if they have interest in maintaining any of these providers in their networks. The MCCs will be asked to assist with obtaining reenrollment materials from any such hospitals. Enrollment of the remaining out-of-state hospitals will be terminated.

The second non-individual provider type selected to undergo this reenrollment process is dental provider groups. Reenrollment packets were mailed to dental provider groups on 12/21/2010 with system data on file pre-populated on the forms. Once the initial reenrollment of all non-individual provider types has been completed, we will move to an every three year cycle for reenrollment of these providers. The enrollment/reenrollment of non-individual providers will continue as a manual process in the short term. As a longer term solution for non-individual providers we are considering a system that uses bar code technology to assist in tracking receipt of application materials, electronic filing of such materials, and verification of data by Provider Enrollment staff. We will also continue to explore the possibility of a web-based portal where providers could file their documents electronically.

As a part of the process of redesigning the provider enrollment process, we have also reevaluated the information which must be collected from the provider and are eliminating the previously required contract between the Bureau and certain provider types since many of the providers previously paid directly by the Bureau are now paid through the MCOs. Providers participating in MCO networks would, of course, still enter into provider agreements with the MCOs.

We offer the following information to assist in clarifying the portion of the audit finding (third and fourth paragraphs) that attempts to describe the process to enroll as a TennCare provider. Provider enrollment in TennCare refers to the process of applying for and obtaining a TennCare provider number. Contracting with a Managed Care Contractor is an option for a provider after they obtain a TennCare number, but some providers enroll in TennCare for the sole

purpose of receiving cross over payments. These providers do not attempt to contract with an MCC.

With regard to the data in the Appendix on page 149, please note that adherence to the 30-day standard is monitored by the External Quality Review Organization (EQRO) and all three MCOs were found to be in compliance during the most recent EQRO review in 2010. We would also point out that TennCare did not attempt to verify the DentaQuest credentialing processing time reported in the finding since DentaQuest is no longer under contract with TennCare and there was no provider application processing time standard included in the DentaQuest contract. However, the contract with the new TennCare dental benefits manager, Delta, does include a 30-day provider application processing time standard.

With regard to the DIDD processing times, as noted in the Appendix on page 149, there are currently no specified time frames within which an MR waiver provider application must be processed. Thus, this is not a matter of noncompliance. The primary reason for lengthier processing times has been receipt of incomplete applications. Many applications received at DIDD are incomplete and require a great deal of information and/or clarification from the applicant in order to approve (or deny) the application. It may take weeks or even months for providers to submit missing or incorrect information. These delays are attributable not to DIDD, but rather to the applicant. It is also worth noting that DIDD experienced turnover in the position responsible for processing provider applications numerous times during the period reviewed (2005 to 2009).

To help address delays attributable to incomplete applications, the current provider application policy is being revised to reflect that applications must be complete in order to be accepted and processed. Applications will be reviewed upon receipt, with incomplete applications returned to the provider. The provider will be responsible for completing the application and resubmitting for processing. In addition, in the FY 2012 contract with DIDD, TennCare will include specific time frames for review and approval (or denial).

## **OBSERVATIONS AND COMMENTS**

In addition to the work described above in the audit findings, we also performed the work discussed below in order to meet our audit objectives (see page 87). Our conclusions in the areas described below did not warrant a finding but are included in this report because of their effect on the operations of the bureau and on the citizens of Tennessee.

### **Quality of Care**

TennCare relies, in large part, on a system of reports and deliverables associated with its quality and utilization management programs to monitor and ensure the quality of care offered by its Managed Care Organizations (MCOs). (See page 89 for a description of the MCOs and the regions of the state they serve.) To assess what TennCare is doing to ensure that quality

healthcare is being provided to its enrollees, we reviewed contracts, interviewed TennCare management, and reviewed numerous quality-related reports. (Also see page 116 for auditors' review of denied services.) We examined the reports submitted by the MCOs and by QSource (TennCare's External Quality Review Organization), to ensure the reports contained the required content and were submitted to TennCare in a timely manner. Although we found some minor problems with timely submission of reports by the MCOs, overall the required reports were submitted and contained the required information, and TennCare appeared to have an appropriate process in place to monitor the quality of care.

### Required Reports

Each of TennCare's four Managed Care Organizations must, according to their contractor risk agreements (contracts), have "a Quality Management/Quality Improvement (QM/QI) program that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals." A major aspect of the MCOs' QM/QI programs is being accredited by the National Committee for Quality Assurance (NCQA). The MCOs are to use "current NCQA Standards and Guidelines" in developing their QM/QI programs. (The NCQA is a private not-for-profit organization dedicated to improving healthcare quality.) The MCOs are also expected to have Utilization Management (UM) programs (which focus on the appropriate settings for services, over-/under-utilization, and approval of services) and are closely interrelated to QM/QI programs.

The contracts for TennCare's MCOs state that the MCOs must provide annual and quarterly reports regarding their QM/QI and UM programs. In addition, as part of the requirement that all of the MCOs be accredited by the NCQA, the MCOs must submit documentation related to their attaining and maintaining accreditation.

TennCare also requires reports related to quality or utilization management from QSource, its External Quality Review Organization, including the following:

1. annual External Quality Review Reports;
2. annual reports on each MCO's compliance with Early and Periodic Screening Diagnosis and Treatment requirements;
3. annual comparative analysis of MCOs' HEDIS (Healthcare Effectiveness Data and Information Set) and CAHPS (Consumer Assessment of Health Providers and Systems) results;
4. annual evaluation of each MCO's Performance Improvement Projects; and
5. annual validation of each MCO's Performance Measures.

QSource's work largely addresses the Centers for Medicare and Medicaid Services' mandates, miscellaneous legal requirements, and some clinical standards in the MCOs' contracts that are not monitored by the NCQA.

## Auditors' Review of Reports and the Process

As a part of our audit work, we reviewed quality and utilization management reports from TennCare's current MCOs dating back to the start of the contractor risk agreements and from QSource for all reports submitted from January 2007, to the most current reports as of October 23, 2009. (Since the first of the current MCOs began services on April 1, 2008, the only reports that came before this date were for TennCare Select.) The required reports were submitted to TennCare's Quality Oversight Division and appeared to include all of the necessary content. We did find 12 reports that were not submitted timely by the MCOs. The majority of the 12 came from Amerigroup, with eight reports, two of them relating to NCQA accreditation (see below). AmeriChoice for Middle Tennessee submitted two reports late, as did BlueCross BlueShield, one for West Tennessee and one for East Tennessee. According to TennCare management, they assessed liquidated damages of \$6,900 for Amerigroup, excluding the two NCQA-related reports; \$200 for AmeriChoice Middle; \$700 for BlueCare West; and \$100 for BlueCare East. All reports submitted by QSource were submitted timely.

Only Amerigroup had to provide all of the NCQA accreditation-related deliverables because all of the other MCOs were accredited before the start of their contracts or before their first deliverable deadline. Amerigroup failed to meet some of the early deliverable deadlines, but after TennCare staff stressed the importance of this timeline to the MCO and assessed liquidated damages totaling \$38,500, Amerigroup met every other deadline and has since been accredited. Aside from offering an overall certification of quality, requiring NCQA accreditation also means that the MCOs must comply with the committee's standards for quality and utilization management programs. The annual quality and utilization management program descriptions, work plans, and evaluations are, therefore, reviewed primarily for compliance with NCQA standards and best practices. (As a part of its audits, the NCQA also reviews the health plans' quality and utilization management programs.) A similar approach is used for monitoring the Performance Improvement Projects (PIPs), which are a part of the QM/QI programs. In this case, the health plans reports are expected to show that Centers for Medicare and Medicaid Services protocols have been followed. QSource also selects one of the PIPs, checks the validity of the project, and, as referenced above, issues a report on the results.

While also required for NCQA accreditation, the HEDIS (Healthcare Effectiveness Data and Information Set) and CAHPS (Consumer Assessment of Health Providers and Systems) scores for the MCOs are heavily relied upon by TennCare. (HEDIS scores measure performance on various dimensions of care and services, and CAHPS scores show the results of standardized surveys of patient experiences with their healthcare.) The MCOs contract with NCQA-certified third-party vendors to prepare score reports on their behalf. Additionally, QSource's Performance Measures Validations attest that the MCOs' information submissions "were prepared according to the HEDIS Technical Specifications and present fairly, in all material respects, the organization's performance" and/or that the plan "is able to report HEDIS rates." While there are no minimum HEDIS or CAHPS score requirements, the contents of these reports have major implications for the MCOs since eight of the nine pay-for-performance incentive payments available to them are for HEDIS scores. More specifically, the MCOs are entitled to a "\$.03 PMPM [per member per month] payment" for either a "significant improvement . . .

defined using NCQA’s minimum effect size change methodology” (in the case of HEDIS physical health scores) or scoring “at or above the 75th national Medicaid percentile, as calculated by NCQA” (in the case of HEDIS behavioral health scores). QSource prepares its Comparative Report on MCOs’ HEDIS and CAHPS Results based on TennCare’s expected information needs, and the report is TennCare’s primary tool for reviewing and analyzing these scores. Since TennCare’s use of these scores goes beyond the QSource analysis, however, the Quality Oversight Division often prepares other reports based directly on the original HEDIS/CAHPS score reports.

According to TennCare management, the emphasis in quality management programs is on making efforts to improve quality and not on reaching a certain end (or penalizing the plans if this fails to happen). Therefore, staff in TennCare’s Quality Oversight Division review related reports primarily to ensure that the required standards are being met and that the data presented are accurate. However, if staff note significant problems, the MCOs are contacted to develop corrective action plans (which must be approved by TennCare), and updates are required three months into the plan to see if goals are being met.

## **Pharmacy Program**

The Pharmacy Division is responsible for overseeing TennCare’s pharmacy services and monitoring its Pharmacy Benefits Manager, SXC Health Solutions Corporation (SXC). We reviewed information pertaining to the division, to understand the pharmacy program’s systems for measuring effectiveness of services and the controls in place to maintain acceptable levels of care while also preventing fraud and abuse of medications and ensuring that costs are contained at a reasonable level. Our review of the systems and controls in place is detailed below. (Also see page 108 for the results of our review of certain SXC contract requirements and TennCare’s monitoring of its Pharmacy Benefits Manager.) Based on our limited review, TennCare appears to have reasonable systems and controls in place to help control pharmacy costs, maintain acceptable levels of pharmacy-related care, and identify potential fraud and abuse of medications.

## **Benefit Limits**

In 2005, TennCare underwent reform, which included disenrolling individuals and cutting benefits, in order to curb increases in TennCare spending. One of those benefit cuts limited the number of prescriptions adult enrollees can receive per month. Prior to 2005, there was no limit on the number of prescriptions adult enrollees could receive. Enrollees are now allowed five prescriptions (typically 31-day supplies) per month, two of which may be brand name. These limits are intended to help prevent fraud and abuse as well as control costs. Children are exempt from limits on the prescriptions they receive because of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements. Federal EPSDT regulation prohibits the imposition of limits on medically necessary covered benefits for enrollees under the age of 21.

Although enrollees are supposed to be limited to five prescriptions per month, this limit can be exceeded in two ways: the Auto-Exemption list and the Attestation list. The Auto-

Exemption list provides medications for common chronic conditions and medications used specifically in the treatment of certain serious medical conditions where multi-drug therapy is the norm. The drugs on this list do not count toward the prescription limit. The Attestation list provides for drugs that are needed on an urgent basis to prevent a serious adverse health outcome. For example, a patient who has a condition like diabetes or high blood pressure may have reached his benefit limit addressing this condition; if this person contracted a serious infection that could result in hospitalization if left untreated, he could be prescribed an antibiotic through the attestation process. For a patient to receive a prescription from the Attestation list, the prescriber must fill out a form listing all the medications that the patient is taking, describing why all the current medications are necessary, and explaining why the medicine that is being attested is necessary (e.g., an enrollee who broke a leg and needs antibiotics and pain medicine during recovery).

### Preferred Drug List and Prescribed Medications Requiring Further Review

TennCare uses a Preferred Drug List (PDL), which consists of generic and preferred brand drugs that are effective but the least costly. The Pharmacy Advisory Committee, composed of medical professionals from across the state, determines which drugs will be placed on the list, subject to approval by TennCare. New drugs being released into the market and new studies on the efficacy of drugs currently in use may trigger a change to the PDL. (See pages 91 and 110 for additional information on the committee.)

Drugs that are prescribed but are not on the PDL or are subject to other constraints (e.g., may only be used if other preferred drugs have been tried and have not been effective in treating the patient) must go through the prior authorization process in order to be approved. (This process begins with a phone call to the SXC Clinical Call Center, where the call center representative asks a series of questions based on set criteria for the particular drug involved and requests certain information from the prescribing doctor.) To further help prevent prescription abuse and ensure that patients get the appropriate type and amount of medication, point-of-sale edits are in place at the pharmacy level, triggering additional review before the pharmacy provides the medication. Some examples of such edits include the following:

- Therapeutic duplicates, where drugs from the same class are being prescribed. (An acceptable explanation for this situation might be that an enrollee was on one type of hypertension medication but then became tolerant to the drug, and the physician prescribed a different medication in the same class with a higher efficacy. If the enrollee filled the prescription before finishing the current prescription, the new medication would produce a therapeutic duplication edit.)
- Early refills, where the enrollee may seek a refill before the entire supply of the prescription is gone. (This situation might occur if, for example, an enrollee is taking a medication at a low dose but that dose is no longer sufficient to alleviate the symptoms. The doctor might prescribe a higher dose, such as double the amount the patient is currently taking. In doing so, the enrollee would run out of the current prescription at a faster rate, causing the patient to need an early refill.)

- Valid dates of service, which ensure the patient is filling the prescription within 90 days of the prescription being written.
- Drug-to-gender interactions, where the drug would not be prescribed for the other gender (e.g., birth control would only be prescribed for women).
- Drug-to-drug interactions, where a drug being prescribed may have an adverse effect on the patient when combined with one of the medications the patient is already taking.

### Drug Utilization Review Programs

Drug Utilization Review programs are required by federal law to improve patient safety and care, as well as to reduce overall drug costs. SXC is required by contract to provide a Prospective Drug Utilization Review system that applies TennCare-approved edits to all claims (see examples of such edits above). SXC must also implement a Retrospective Drug Utilization Review Program providing analyses that detail patient and prescriber trends, and identify potential quality-of-care problems and/or potential fraud and abuse. SXC submits reports (many of which relate to drug utilization) to TennCare, documenting its work required under the contract. These reports include information on pharmacies, enrollees, prescribers, drug costs, and prescribed drugs. SXC also submits reports concerning the Call Center, claims that were reversed, and ad hoc reports. The reports have information about the top-used drugs, the top-prescribing physicians, the top-filling pharmacies, and prior authorization approval time. Our review of required reports determined that SXC has fulfilled the current reports requirements. However, some of the required reports had not been generated at the inception of the audit because of SXC personnel issues (i.e., SXC had a difficult time finding a qualified person for the data analyst position responsible for these reports). Once the issues were resolved, TennCare began to set deadlines for any additional reports. In December 2009, TennCare set specific deadlines for eight reports that had not previously been submitted. The deadlines were between December 7, 2009, and January 6, 2010. Two of the eight reports were submitted late, resulting in liquidated damages being assessed.

As part of the Retrospective Drug Utilization Review Program, SXC also works with TennCare's Drug Utilization Review Board, which is composed of persons with medical or pharmacy expertise and provides program oversight and advice regarding provider education initiatives and current and proposed point-of-sale edits. TennCare receives quarterly reports showing trends in prescribing habits, as well as other patient and prescriber trends that could indicate potential fraud. The trends reported cover utilization, broken down by adults and children, as well as total population utilization. The reports also show which point-of-sale edits were used during the quarter, with most being compared to the same quarter in the previous year. These reports help TennCare ensure it is tracking the drugs that are the most widely prescribed and used, as well as the enrollees, prescribers, and pharmacies with the most activity. Instances reported may include prescribers frequently writing prescriptions for non-preferred drugs; over- and underutilization; drug-to-drug interactions; duplications; and patients who, over a 90-day period, use multiple pharmacies to fill their prescriptions, have numerous prescriptions, and have prescriptions written by multiple providers. In addition, targeting drugs on the Auto-Exemption

list, prescribers are notified regarding patients who appear to be in noncompliance with their prescriptions. Prescribers are then surveyed regarding the usefulness of the notice of potential noncompliance by a patient. If the surveys indicate a particular type of notification was useful, the program will keep that notification type to be used again later.

## **Pharmacy Contract Monitoring**

In addition to reviewing the pharmacy program, we also looked at SXC's contractual responsibilities regarding staffing and credentials, fraud and abuse, and system efficiencies; as well as TennCare's efforts to monitor SXC, its Pharmacy Benefits Manager (PBM). We reviewed TennCare's contract with SXC and related information, and also interviewed and obtained documentation from TennCare management, in order to assess the PBM's actions to meet its contractual responsibilities in the areas outlined above, and the adequacy of TennCare resources to monitor the PBM contract. We identified several areas of concern (discussed below); however, overall, SXC had the required number of qualified, appropriately trained staff and had the required policies and systems in place for mitigating the risk of fraud and abuse and processing claims. TennCare's Pharmacy Division has limited resources and two vacant positions, but the division does appear to have an appropriate monitoring system in place.

### Issues Related to SXC's Staffing and Credentials and TennCare Pharmacy Staff Resources

According to Section A.9 of SXC's contract, "the Contractor shall have total responsibility for hiring and management of any and all Contractor staff as determined necessary to perform the services in accordance with the terms of this contract and shall provide a proposed staffing plan for review and approval by TennCare." We interviewed TennCare management to determine if the obligations of the contract concerning staffing were being met. There are 11 positions outlined in the contract that must be maintained by SXC staff. We obtained and reviewed SXC staff's credentials, its staff training plan, and its course descriptions and found no problems other than the issue discussed below.

Section A.9.1(a) of the contract states that SXC shall provide to TennCare documentation verifying that all staff employed by SXC or employed as a subcontractor are licensed to practice in their area of specialty. The documentation is due on September 15<sup>th</sup> of each year of the contract. SXC must also provide TennCare with copies of resumes and job descriptions for all persons employed under the contract. However, our review found that TennCare did not ensure the documentation verifying the SXC staff's licensure to practice in their area of specialty was received. This information was not obtained by TennCare until after the auditor requested (in February 2010) to see that documentation. According to Pharmacy Division management, the person responsible for ensuring SXC complies with this requirement left employment in June 2009, and TennCare has been unable to hire someone in her place because of the hiring freeze. The contract also details the establishment of a Drug Utilization Review Board (DUR). (Also see page 107.) We verified the qualifications of the DUR board members by reviewing their license profiles on the Tennessee Department of Health's License Verification website.

In addition, we examined TennCare's Pharmacy Division's staffing levels. The division is headed by a director, who reports to the Chief Medical Officer. Including the director, there are eight positions dedicated to pharmacy operations. The other positions include

- one Associate Director, Pharmacy Operations;
- one Associate Director, Pharmacy Clinical Services;
- one Statistical Research Specialist;
- one Pharmacy Program Manager;
- two Managed Care Operators; and
- one Administrative Services Assistant.

According to management, the Associate Director, Pharmacy Operations, was hired in August 2009, after the position had been vacant for over a year. The Associate Director, Pharmacy Clinical Services, position was held by the current director until May 2009, and has been vacant since then. The Pharmacy Program Manager position has been vacant since June 2009. The director stated the current economic conditions have led to the vacant positions remaining unfilled.

#### Fraud and Abuse

Section A.4.9 of SXC's contract states that, "the Contractor shall develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards for the prevention, detection and reporting of incidents of potential fraud and abuse by members, providers, subcontractors and the Contractor." SXC has developed and submitted documentation outlining a Corporate Compliance Program and a Medicaid Fraud and Abuse Plan outlining actions to mitigate the risk of fraud and abuse. (See pages 106-107 for a description of the point-of-sale edits and Drug Utilization Review programs in place to help improve care and prevent prescription abuse.) The contract also states that "the Contractor shall designate a Compliance Officer and a Compliance Committee, accountable to senior management, to coordinate with TennCare and other state agencies on any fraud or abuse case." The committee keeps an internal compliance log of various compliance issues which are worked and tracked by the departments to which they relate. We reviewed a compliance log report that covered March 2009 to July 2009. We also obtained and reviewed SXC's October 2009 *Medicaid Fraud and Abuse Annual Report*. This report outlines fraud and abuse issues, and TennCare's and SXC's response to the issues. According to management, TennCare has reviewed SXC's fraud policies and believes that the policies were sufficient, but TennCare believes that further work is needed in a few areas concerning the pharmacy audits (see below). TennCare is working with SXC to develop better processes in fraud reporting. TennCare management provided, and we reviewed, revised policies and procedures relating to SXC's fraud and abuse work.

## System Efficiency

According to Section A.2.2.1(c) of SXC's contract, "the Contractor shall have in place a . . . claims processing system capable of accepting and processing claims submitted electronically." Claims processing guidelines are further outlined in the contract. Some penalties have been assessed by TennCare for noncompliance with claims processing procedures. TennCare monitors SXC by reviewing the batch claims processing reports it receives from the contractor.

The contract also states that SXC must have a Business Continuity and Contingency plan and have backup procedures in place in case of unexpected downtime. The system is supposed to be tested six times per year. We reviewed SXC's disaster recovery plan and obtained the system testing dates for the audit period. SXC also hired an independent audit firm to conduct a Statement on Auditing Standards (SAS) No. 70 audit of its system for the period October 1, 2008, through September 30, 2009. We reviewed this report, which included testing of backup procedures.

There is also a systematic audit process that identifies claims errors which, from October 2008 through April 2010, was performed by one of SXC's contractors, Prudent Rx. Prudent Rx generated a report of these errors and sent it to TennCare. TennCare decides what claims errors should be recouped and has a list of rules for when SXC should recoup claims. According to TennCare management, they believe these processes catch most claims errors. As of May 2010, Prudent Rx was no longer providing this function. SXC will conduct the audits in-house using the revised audit procedures discussed above, and the audit findings will be reported to the Compliance Committee.

## **TennCare Pharmacy Advisory Committee**

The TennCare Pharmacy Advisory Committee was created by Chapter 350, Public Acts of 2003, to review drugs and drug classes for recommendation to TennCare's Preferred Drug List (PDL), and thereby assist TennCare in its efforts to control pharmacy program expenditures. The committee initially reviewed all classes of drugs to establish the Preferred Drug List. (TennCare does, however, have the ultimate authority to approve or deny placing a drug on the Preferred Drug List.) Since then, the committee reviews new classes of drugs or re-reviews the current classes, ensuring that each class is reviewed every two years. To assess committee activities and compliance with requirements, auditors reviewed the statute and the committee's bylaws, interviewed management, and reviewed meeting minutes for February 2006 through February 2010. The results of our assessment are detailed below.

### Committee Members Do Not Receive Rebate Information from TennCare Management When Reviewing Drugs for Inclusion on the Preferred Drug List

When reviewing drugs, the committee is supposed to consider the drug's therapeutic information, such as efficacy and side effects, as well as cost information, ensuring that

TennCare is using cost-effective drugs. The committee conducts its reviews using clinical data but does not receive access to rebate (i.e., net cost) information they are entitled (by statute) to use. The committee does receive general information concerning the pre-rebate cost of drugs. According to Section 71-5-2404 (c)(2), *Tennessee Code Annotated*, “The committee may receive written studies, data and information relative to the cost-effectiveness of drugs being considered for placement on the preferred drug list.” In addition, Section 71-5-197, states,

Notwithstanding any other law to the contrary, all information and documents containing trade secrets, proprietary information, rebate amounts for individual drugs or individual manufacturers, percent of rebate for individual drugs or individual manufacturers, and manufacturer’s pricing that are contained in records of the TennCare bureau, the state of Tennessee and its agents shall be confidential and shall not be a public record. . . . Nothing in this subsection . . . shall be construed to prohibit the TennCare bureau and the state of Tennessee from disclosing the information covered by this subsection . . . to members of the state TennCare pharmacy advisory committee, who shall be deemed agents of the state of Tennessee. . . .

According to TennCare’s Pharmacy Director, during 2003, the year the committee began meeting, members were receiving the rebate information. The committee lost access to this information soon after TennCare began its contract with First Health, the Pharmacy Benefits Manager at that time, on the basis that the confidentiality statements in the contract prohibited TennCare from sharing the rebate information with the committee. (The First Health contract began on January 1, 2004, and ended on September 30, 2008). The TennCare Pharmacy Advisory Committee members still do not have access to the rebate information because of similar language in the contract with TennCare’s current Pharmacy Benefits Manager, SXC Health Solutions Corporation (SXC).

To ensure confidentiality, Section VIII of the bylaws states, “All information that constitutes trade secrets, proprietary information, rebate amounts for individual drugs or individual manufacturers, percent of rebate for individual drugs or individual manufacturers, and manufacturer’s pricing that members are privy to as a result of their membership on the TennCare Pharmacy Advisory Committee that has not been discussed in a public forum is also considered confidential.” Members will also (according to the bylaws) sign Confidentiality Agreements to protect such information. During the opening statements of each committee meeting, the chairman states that the agreements have been signed. However, when we asked the Pharmacy Director for copies of the signed agreements, we received signed copies from 2003. No agreements have been signed during the intervening years. The Deputy Commissioner should require committee members to sign agreements annually as required under the bylaws or, if he believes such agreements are unnecessary, he should work with TennCare staff and committee members to revise the bylaws to remove the requirement and to revise statements made by the chairman regarding confidentiality at the beginning of each meeting.

Further discussion with TennCare management revealed an additional explanation for not sharing the rebate information. Section VIII of the bylaws states, “Confidentiality also includes

sharing pricing information on any of the products reviewed for the preferred drug list.” TennCare management’s understanding of “sharing pricing information” is TennCare’s price before the rebates. However, this same section also clearly states that the members are “privity to” rebate information. TennCare management also stated that they are not obligated to provide the rebate information to the committee, just that the statutory language (Section 71-5-197(d), *Tennessee Code Annotated*) states that nothing prevents TennCare from sharing the rebate information. TennCare management asserted that sharing the rebate information would hinder the committee’s effectiveness. TennCare management depends on the committee for clinical expertise and recommendations. They want to know which drugs within a class are superior, with better efficacy or safety; inferior, with less efficacy or safety; and which are comparable, with similar efficacy and safety (and can then be considered therapeutic alternatives). TennCare management also consults the committee about how many people and what populations will be affected if a drug or class of drugs is removed from the PDL. TennCare management believes the rebate information is not necessary for the information they want the committee to provide.

#### Committee Member Absences from the Quarterly Meetings Are Not Documented Sufficiently to Determine Compliance With Attendance Requirements

Because of the committee’s importance in providing input regarding drugs to be included on TennCare’s Preferred Drug List, it is imperative that appointed members attend the quarterly meetings. (See page 91 for a description of the committee’s membership.) According to Section 71-5-2402, *Tennessee Code Annotated*:

A state TennCare pharmacy advisory committee member shall be removed by the commissioner of finance and administration from the committee for any of the following causes:

- (1) Absence from two (2) consecutive meetings without contacting the chair or the vice chair with a satisfactory explanation;
- (2) Absence from three (3) meetings in a single year without contacting the chair or the vice chair with a satisfactory explanation . . .

Based on our review of meeting minutes and interviews with TennCare management and the committee chairman, it appears that the committee members who are going to be absent have not been contacting either the chairman or the vice chairman. The members are also required to submit explanations for their absences, but no official record is kept as to whether they had an explanation and whether the chairman or the vice chairman deemed the explanations satisfactory justification for the absences.

According to TennCare management, SXC (TennCare’s Pharmacy Benefits Manager) performs the administrative work for the committee. One of the tasks that SXC performs is to determine the likely attendance (and the likelihood of a quorum) for each meeting by calling the members to see if they will be able to attend the meeting. The Pharmacy Director stated the list of attendees is then forwarded to her to give to the chairman or vice chairman, or SXC staff gives

the list directly to the chairman or vice chairman. No official record is kept of the excuses. The chairman, who is the former vice chairman, stated he has never received excuses from the members since the inception of the committee. For further clarification, we contacted the SXC representative who maintains the list of attendees. She confirms the attendance of the members and provided auditors with copies of her footnotes concerning the absence of members for the November 2009 and February 2010 meetings. However, she does not forward this information to the chairman or vice chairman, although she stated she will usually send the number of members attending to the TennCare Pharmacy Director, occasionally stating who will be absent.

According to the Pharmacy Director, there have been no significant problems with any particular committee member absences, except in the case of the former cardiologist member. This member served on the committee from August 2006 until July 2009. He came to one meeting and never attended again during the rest of his term. The committee tried to have him replaced, but the nominating body for his seat (the Tennessee Chapter of the American College of Cardiology) said they did not have anyone else to nominate. Our review of meeting minutes for fiscal years 2007 through the first half of fiscal year 2010 found some additional instances of members missing consecutive meetings or multiple meetings in a year. However, with the information available for meetings prior to August 2009, we could not determine if the members would qualify for removal (i.e., if they failed to provide committee officers with satisfactory explanations for their absences). For the three meetings taking place from August 2009 to February 2010, five members appeared to have valid excuses for the November 2009 meeting, and two members appeared to have valid excuses for the February 2010 meeting. Despite the absences, the committee had a quorum for all meetings reviewed.

The Director of Pharmacy should develop a method to properly document attendance at the TennCare Pharmacy Advisory Committee meetings. If TennCare management prefers that SXC maintain responsibility for confirming meeting attendance, SXC staff should document absences and explanations, and report those to the chairman, vice chairman, and the Director of Pharmacy. Otherwise, management could inform committee members to directly contact either the chairman or the vice chairman if they are going to be absent. Actual meeting absences and any excuses for those absences should be consistently documented, either in the meeting minutes or in other documentation maintained by either the chairman of the committee or an SXC representative.

#### A Newly Created Subcommittee Does Not Fully Comply With Statutory Requirements

Chapter 509, Public Acts of 2009, amended Section 71-5-2401, *Tennessee Code Annotated*, creating a subcommittee of the TennCare Pharmacy Advisory Committee to review additions and deletions to the Auto-Exemption list (a list of drugs that do not count toward an enrollee's prescription benefit limits). Specifically, Section 71-5-2401 states:

The TennCare pharmacy advisory committee shall have recommendation authority over any new proposed deletions or additions to drugs currently on the TennCare Bureau's auto-exemption list. It is the legislative intent that, insofar as practical, the TennCare Bureau shall have the benefit of the committee's

recommendations prior to deleting or adding a drug from the autoexemption list . . . . The pharmacy advisory committee shall establish a special review subcommittee comprised of practicing medical specialists and medical faculty members of institutions of higher learning with expertise in the usage and prescribing of the medications under review to provide expert advice on such new proposed changes. Any such subcommittee shall be appointed by the chairman in consultation with members of the pharmacy advisory committee . . . .

Based on auditors' review of subcommittee-related activities thus far, however, subcommittee membership does not fully comply with statute, and approved policies appear to conflict with legislative intent.

To determine compliance with statutory requirements, we examined the composition of the subcommittee as well as any policies it approved to carry out the subcommittee's responsibilities. The committee first discussed the subcommittee during the August 2009 meeting where it addressed the need for the subcommittee. The chairman (a practicing pharmacist) and four additional committee members (two other practicing pharmacists and two practicing doctors) volunteered to be on the subcommittee, and a date was set for the first meeting to occur before the November 2009 committee meeting. However, the subcommittee actually met for the first time on February 18, 2010. Although the statute requires the subcommittee to have practicing medical specialists and medical faculty members of institutions of higher learning, auditors' review of the composition of the subcommittee found that no medical faculty member from an institution of higher learning was on the subcommittee. (TennCare management later provided information that one of the two medical specialists on the subcommittee also serves as faculty at an institution of higher learning.) During the subcommittee's first meeting, it approved several policies, one of which states that if the subcommittee desires additional information on a certain topic, it will extend an invitation to a medical specialist or a medical faculty member to attend the meeting or provide written feedback. The chairman of the subcommittee stated that adding a specialist as a regular member would be of little use when the specialist would only be interested in his or her area of expertise.

In addition, the subcommittee approved policies that appear not to fulfill the statute's intent that TennCare have the benefit of the committee's recommendations prior to deleting or adding a drug from the Auto-Exemption list. Adopted policies provide for TennCare to make additions to the Auto-Exemption list without seeking prior recommendations from the subcommittee. In the case of additions to existing categories of the list, TennCare will notify the subcommittee at the next committee meeting that a change has been made. If TennCare adds a new category to the list, the subcommittee will make recommendations, but only after the change has been made. (In cases of deletions of an agent [a specific drug] or category from the list, the subcommittee will make recommendations prior to any deletion.)

## **TennCare’s Disease Management Program and Related Monitoring of the MCOs**

Chapter 931, Public Acts of 2006, required that TennCare adopt a disease management program “designed to improve care to and reduce overall expenditures for TennCare beneficiaries with chronic illnesses.” The bureau’s program is carried out by the MCOs it contracts with to provide services to enrollees. (See page 89 for a description of the MCOs and when their current contracts began.) Our audit objective was to review the program developed and TennCare’s efforts to monitor the current MCOs’ compliance with contract requirements regarding disease management. Overall, it appears that TennCare is appropriately monitoring the MCOs’ disease management activities and that the MCOs are meeting their contractual obligations relating to disease management. However, because of the relatively short period of time for which data are available under the current MCO contracts and because TennCare (in consultation with the MCOs) has only recently approved a standard set of measures of program effectiveness, we could not draw conclusions regarding the relative effectiveness of the MCOs’ disease management efforts.

The MCOs are required by contract to have the following disease management programs: maternity care management (in particular, high-risk obstetrics), diabetes, congestive heart failure, asthma, coronary artery disease, chronic obstructive pulmonary disease, bipolar disorder, major depression, schizophrenia, and obesity. The MCOs submit reports quarterly and annually to TennCare. They also submit program descriptions annually. TennCare developed specific criteria for the reports. Information to be provided includes numbers of participants in each program, how participants for a program are identified, frequency and type of interventions, and multiple performance measures.

Our review, which included reports from current MCOs for 2007 through the second quarter of 2009, found that the MCOs have been submitting timely reports and program descriptions that include all the contractually required material, or if items were missing, had issued clarification responses that included the missing information. After receiving the reports, TennCare staff read through the reports and then send clarification questions for items that were not covered in enough detail or are unclear. In addition, TennCare conducts on-site visits to the MCOs. According to management, TennCare has not assessed any liquidated damages relating to disease management.

TennCare’s disease management program staff stated that the biggest challenge for the program has been developing standardized report forms, definitions, and report criteria. Originally, it was very difficult to get standard data and measures of effectiveness from each of the MCOs. In April 2009, however, TennCare finalized 11 measures of success, and all of the plans agreed to them. Under the newly refined system, 2008 figures will serve as a baseline year for comparative purposes. The measures are as follows:

1. Member’s satisfaction with disease management program
2. Member’s improved quality of life
3. Patient adherence to treatment plan

4. Provider adherence to clinical practice guidelines
5. Effectiveness of care measure
6. In-patient hospitalization per 1000: enrolled
7. In-patient hospitalization per 1000: managed population
8. In-patient readmission per 1000: enrolled
9. In-patient readmission per 1000: managed population
10. Emergency room utilization per 1000: enrolled
11. Emergency room utilization per 1000: managed population

### **Analysis of the Process for Denying Services**

According to TennCare Rules 1200-13-13-.04(1)(a)1 and 1200-13-14-.04(1)(a)1, “Any and all medically necessary services may require prior authorization or approval by the [Managed Care Contractor] MCC, except where prohibited by law.” The Bureau of TennCare relies on its Managed Care Organizations (MCOs) to determine what services will require prior authorization, and, therefore, they have considerable authority as to which services are denied. However, prior authorization is not required for emergency department services or the screening under the Early and Periodic Screening Diagnosis and Treatment program offered to persons under age 21. (See page 89 for a description of the MCOs and when their current contracts began.) Our objective during this audit was to review the process for denying services and tracking MCOs’ denial of services. We also reviewed a sample of denials by one MCO to determine if the required procedures were followed.

The MCOs’ requirements with regard to prior authorizations are detailed in their contracts. First, they must “have in place, and follow, written policies and procedures for processing requests for initial and continuing prior authorizations of services.” It is further stated that these policies and procedures must be developed in accordance with TennCare rules and regulations. In effect, these procedures are shaped by TennCare Rule 1200-13-16, regarding medical necessity, and standards issued by the National Committee for Quality Assurance, a national organization that accredits health plans. According to Rule 1200-13-16-.05(1), the following criteria must be met for a service to be considered medically necessary:

- (a) It must be recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing within the scope of his or her license who is treating the enrollee;
- (b) It must be required in order to diagnose or treat an enrollee’s medical condition;
- (c) It must be safe and effective;
- (d) It must not be experimental or investigational; and

- (e) It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition.

Next, the MCOs are required to “document and communicate the reasons for each denial of a prior authorization request in a manner sufficient for the provider and member to understand the denial and decide about requesting reconsideration of or appealing the decision.” The *Grier* Consent Decree prescribes exact stipulations concerning how enrollees should be notified of denials. Finally, as required by their contract, the MCOs are to elicit “pertinent medical history information from the treating health care provider(s), as needed, for purposes of making medical necessity determinations.” The MCOs must also submit to TennCare quarterly Prior Authorization Reports using a report template contained within the contract that lists the number of appeals received, processed, approved, denied, and denied by reason, broken out by major service types. Separate grids must be completed for children and adults.

According to TennCare management, the MCOs do not require prior authorizations for any more services than they perceive to be necessary since reviewing extra requests would be very costly from an administrative standpoint. The services requiring prior authorization change over time, but the focus is typically on procedures that are high cost or are likely to be abused. Moreover, since MCOs are now back at full risk, they have a stronger incentive to keep enrollees as healthy as possible (i.e., they have little incentive to deny enrollees necessary medical care). (For several years beginning in 2002, TennCare implemented a stabilization plan under which the state assumed all financial risk for the program and paid the MCOs an administrative fee. In 2007, TennCare began phasing in new contracts under which the MCOs accept full financial risk to participate in the program and are paid set monthly rates, or capitated payments, to manage and deliver care to TennCare enrollees.)

All of the current MCOs have submitted the Prior Authorization Reports as required by their contracts. According to TennCare management, these reports are reviewed to identify trends and outliers with attention to major changes in a specific plan as compared to prior history, and to any significant differences across plans. We examined the Prior Authorization Reports for the second quarter of calendar year 2007 through the second quarter of calendar year 2009 to determine denial trends and frequency. In some cases, the total number of denials and the sum of denials broken down by reason did not match. TennCare management stated that this was likely because they had not given clear instructions to the MCOs concerning how to complete the report.

Based on our analysis of the data on the Prior Authorization Reports, we decided to conduct an additional review of denied services by AmeriChoice for the Middle grand region (because AmeriChoice had the highest frequency of denials). We interviewed key management personnel at AmeriChoice and reviewed a random sample of 100 requests for services that AmeriChoice denied from April 1, 2008, to June 30, 2009. We examined each denial for the following elements: consideration of pertinent medical history; review by an appropriate medical professional; and reference to an applicable clinical criteria or TennCare Rule.

AmeriChoice management's description of the MCO's prior authorization process appeared to meet all of the contractual requirements listed above. Our review of services they denied found that none in our sample lacked any of the necessary elements. The enrollee's medical history was reviewed and considered, except in some instances where the necessary clinical information was not provided with the request. All denials were made by appropriate and licensed medical staff. Finally, references to applicable clinical guidelines and/or TennCare Rules were included in all decisions except for some of the aforementioned requests where necessary clinical information was not provided. We did identify 3 of 100 denials that were not made within the 14-day time limit required in TennCare Rules 1200-13-13-.11(1)(b)2 and 1200-13-14-.11(1)(b)2, which state,

An MCC [managed care contractor] must notify an enrollee of its decision in response to a request by or on behalf of an enrollee for medical or related services within fourteen (14) days of the request for prior authorization, or as expeditiously as the enrollee's health condition requires. If the request for prior authorization is denied, the MCC shall provide a written notice to the enrollee.

None of these decisions, however, were made outside of 21 days, which would have resulted in "automatic authorization of the requested service[s]" according to TennCare Rules 1200-13-13-.11(7)(a) and 1200-13-14-.11(7)(a). No other deficiencies were noted in our review.

Of the 100 denials we reviewed, 88 were made for medical necessity reasons; the remaining 12 were made because the requests were for non-covered services. Of the services requested, 35 were for inpatient admissions, 17 were for home health aide and/or private duty nursing care, and the remaining 48 were for other miscellaneous services, which varied widely. As far as diagnosis, chronic obstructive pulmonary disease appeared 11 times in our sample; backache, 9 times; diabetes, 8 times; and pneumonia, 5 times. The remaining diagnoses varied widely.

Looking at the requesting providers, 40 were general or family practitioners; 24 were internists; and the remaining 36 were various other specialists. Most of the enrollees whose denials we reviewed were adults; 66 were classified as enrolled in the "Medicaid Adults 21 and over" category; 18 were "Dual eligibles," or persons with both Medicare and Medicaid coverage; 11 were "Medicaid Children under 21"; and 5 were Home and Community Based Services waiver participants.

While reviewing the denials, we also examined the resulting decision. There were 2 of 100 denials that were overturned as a result of an internal appeal or after being reconsidered by the MCO's medical staff. At least one of these reversals was directly attributable to new information submitted when the provider asked the MCO to reconsider its decision. Of the remaining 98 that were not overturned at the MCO level, the enrollees for 10 of them filed a medical appeal at TennCare. Of these ten appeals, six were successful. Three were attributable to new information that came to light during the appeals process. One denial was overturned by the MCO's Chief Medical Officer prior to the appeal hearing. At the hearing level, one appeal was successful because TennCare's independent medical expert determined that the requested

service was medically necessary, and another one was overturned by the administrative law judge. Although we found some minor problems with timely notification of denials, overall AmeriChoice appears to be meeting its obligation as it relates to denied services.

## **Provider Networks**

Our audit objective regarding the MCO networks was to assess compliance with provider network requirements and completeness and accuracy of provider and enrollee files, and to examine pharmacy claims to identify any trends that may indicate problems. When considering provider network requirements, we focused on one MCO, Amerigroup. (See page 89 for a description of the MCOs and the regions of the state they serve.) We chose Amerigroup because the MCO had lost Hospital Corporation of America's services as the result of a contract dispute, and we wanted to see the effect on Amerigroup's ability to meet provider network requirements. We interviewed TennCare management and reviewed documentation relating to TennCare's monitoring of Amerigroup's provider network.

### Access Requirements

Since April 2007, Amerigroup has provided services to the Middle Grand Region, which includes the counties included in Upper Cumberland, Mid-Cumberland, Davidson, and South Central Tennessee Community Services Agencies (CSAs). According to TennCare, as of February 28, 2010, this MCO served 187,764 recipients in the following counties: Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, and Wilson.

According to Amerigroup's contract (also known as a contractor risk agreement, or CRA), Amerigroup is responsible for providing TennCare enrollees with physical health and behavioral health services as medically necessary (as defined in Section 71-5-144, *Tennessee Code Annotated*). Amerigroup is responsible for providing "available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis." At a minimum, this includes

- a primary care physician or extender,
- specialty care and emergency care,
- hospitals,
- general dental services,
- general optometry services,
- pharmacy services, and

- lab and x-ray services.

The terms and conditions for access are measured in distance and time for both urban and rural areas. For urban areas, distance and transport time to a primary care provider should not exceed 20 miles or 30 minutes. For rural areas, distance and transport time to a primary care provider should not exceed 30 miles or 30 minutes. However, for rural areas where the time and distance for residents to access services are typically greater, the standard access time and distance for that community will apply, after justification and documentation for the exception has been provided to TennCare.

Amerigroup is required to send in provider enrollment files by the 5<sup>th</sup> of each month. Each quarter, TennCare performs a GeoAccess analysis in order to ensure the proper services are provided in accordance with the contract agreement. If deficiencies are identified, Amerigroup has 30 days to present a Corrective Action Plan which details the intended course of action to resolve the deficiencies. Failure to submit the requested Corrective Action Plan within the time allowed may result in an assessment of liquidated damages in the amount of \$500 per calendar day for each day the Corrective Action Plan is not completed or complied with as required in the CRA.

Although Amerigroup was unable to reach a compromise with Hospital Corporation of America (HCA), and lost HCA's services upon the expiration of its contract, Amerigroup has still met the access requirements as specified in the contract with TennCare.

Quarterly telephone surveys are also conducted to determine the accuracy of provider data that are submitted to the Bureau of TennCare by Amerigroup. QSource is the External Quality Review Organization contracted to conduct telephone surveys for TennCare. Once QSource receives the provider data from TennCare, a statistically valid sample size is determined for Amerigroup based on the universe of providers in its network. The validation process consists of accuracy of provider telephone numbers; addresses; contract status; provider specialty; availability of services to children under 21; availability of services to adults 21 and over; primary care services; and prenatal services.

According to its contract, Amerigroup is required to achieve a 90% accuracy rating for all data elements reported on its enrollment file as it relates to Provider Listing Accuracy. In 2009, TennCare assessed \$85,000 in liquidated damages because of Amerigroup's failure to achieve a 90% accuracy rate. The most common inaccuracies involved provider addresses and telephone numbers—these fields were below 90% accuracy all four quarters.

### TennCare Enrollee File

The enrollee file obtained from TennCare on June 11, 2010, contained the MCO each enrollee is assigned to as well as the enrollees' contact information. According to TennCare management, enrollee addresses come from different sources (Social Security Administration, Tennessee Department of Health, and Tennessee Department of Human Services [DHS]), and considering the extensive verification processes each agency has in place, TennCare deems the

information reliable. TennCare loads the enrollee's mailing address as the base address, and this is the address used to send correspondence.

With the many different ways addresses can be presented, both DHS and TennCare have invested in an application called Finalist, which corrects addresses based on the standards used by the United States Postal Service. For example, it corrects abbreviations as well as cities so that they read correctly. However, auditors found that some addresses listed were invalid addresses. Though Finalist is an application used across the state, each entity sets its own rules as far as options for corrections. Once TennCare receives the addresses from DHS, they are run through Finalist. However, if Finalist cannot find a match, TennCare loads the address exactly as it comes from DHS since DHS is responsible for validating enrollee addresses.

MCOs may learn of address changes, and they will report them to TennCare, but the information is not loaded in the system as a base address; instead, the address is saved. Because of the many processes involved on the enrollee's part to change an address, the base address is not changed until the proper steps have been taken. For example, an SSI recipient must report a change of address to the Social Security Administration, and a Medicaid recipient who was determined eligible by DHS must report a change of address to DHS within 10 days of the change. According to Section 71-5-110, *Tennessee Code Annotated*, TennCare Standard recipients are permitted 30 days to change their address.

### Pharmacy Claims

To identify trends that might indicate problems, we obtained pharmacy claims from TennCare for the quarter ending December 31, 2009. Our initial testwork was to include a data analysis of enrollees who filled prescriptions at pharmacies that were an unusually long distance from their homes, using geo-coding software. However, during the geo-coding process it appeared a large number of enrollees were living out of state, which resulted in prescriptions being filled unusually long distances from their home as well as some being filled out of state. After learning the addresses loaded into TennCare's interChange system were mailing addresses, and not physical addresses, we decided that examining home addresses versus pharmacy location would skew the results of the analysis. Instead, we chose to look into the narcotics and pharmacy claims for controlled substances.

Auditors obtained TennCare reports on the top prescribers and users of narcotics, as well as the top narcotic-dispensing pharmacies. TennCare has implemented a lock-in program that limits enrollees receiving multiple controlled substances and high doses to one pharmacy. TennCare believes the use of a single pharmacy for all prescriptions will mitigate the risk associated with multiple providers and high doses of controlled substances. Enrollees who have been locked into a single pharmacy but still exhibit inappropriate utilization of narcotics will be required to obtain prior authorization for controlled substances.

The purpose of pharmacy lock-in and controlled substance prior authorization is to enhance patient safety and reduce the potential fraud and abuse associated with use of high doses of controlled substances. TennCare believes that use of multiple controlled substances, multiple

pharmacies, multiple prescribers, and/or high-volume providers of controlled substances places enrollees at increased risk.

After analyzing pharmacy data, we noted some concerns. For example, the data revealed there was a physician with an expired license writing prescriptions, a physician on probation for substance abuse writing prescriptions for controlled substances, and what appeared to be a chiropractor writing prescriptions for controlled substances. The Director of Pharmacy was able to provide adequate explanations for each of these instances. The only concern that turned out to be a potential issue was the instance where it appeared a chiropractor was writing prescriptions for narcotics/controlled substances with no DEA (Drug Enforcement Agency) number listed. It turned out the prescriber was listed under the wrong NPI (National Provider Identifier) number, which made those narcotics and controlled substance prescriptions appear to be written by a chiropractor. TennCare is currently working with SXC to put a block in the system so if a pharmacy accidentally submits an NPI for an individual who does not have prescriptive authority (such as a chiropractor), the claim will be rejected.

As part of auditors' follow-up regarding the above concern, we confirmed that prescribers must have a DEA number in order to write prescriptions for controlled substances, and we conducted additional audit work. We pulled pharmacy claims from the first quarter of 2010 and noticed there were still prescribers without DEA numbers. A small sample of claims filed with no DEA number was further researched, and it turned out that all prescribers had valid DEA numbers. However, the DEA numbers were not listed in the data provided. No other issues arose from our work.

## **Public Necessity Rules**

State agencies can file rules without prior notice or public hearing, but only if the rules (referred to as public necessity/emergency rules) meet certain criteria. TennCare uses public necessity/emergency rules to implement changes more quickly than possible when using the traditional rule-making process. Pursuant to Chapter 566, Public Acts of 2009, public necessity rules will be filed as (and referred to as) emergency rules effective July 1, 2009. Prior to July 1, public necessity rules were effective for a period no longer than 165 days. Effective July 1, such rules are effective for no longer than 180 days. Our audit objective was to review TennCare's process for promulgating public necessity rules and assess its appropriateness. Overall it appears TennCare has used the public necessity rulemaking process appropriately.

Agencies may use the emergency rule process when the rule needs to become effective immediately because of certain specific circumstances. Pursuant to Section 4-5-208, *Tennessee Code Annotated*, agencies may file emergency rules if they find that

- (1) An immediate danger to the public health, safety or welfare exists, and the nature of this danger is such that the use of any other form of rulemaking authorized by this chapter would not adequately protect the public;
- (2) The rule only delays the effective date of another rule that is not yet effective;

- (3) It is required by the Constitution or court order;
- (4) It is required by an agency of the federal government and adoption of the rule through ordinary rulemaking procedures described in this chapter might jeopardize the loss [i.e., might result in the loss] of a federal program or funds;  
or
- (5) The agency is required by an enactment of the general assembly to implement rules within a prescribed period of time that precludes utilization of rulemaking procedures described elsewhere in this chapter for the promulgation of permanent rules.

TennCare has been using emergency rules to make changes to its rules that have been affected by circumstances such as changes in federal and state laws and regulations, TennCare's waiver, and in other waivers that may require TennCare to take immediate action. According to management, when they file the emergency rules TennCare staff have also been filing companion rules that will go through the traditional rulemaking process. The traditional process typically lasts four to five months, and includes a public hearing. Under this time frame, when the emergency rule expires, the final rule would be in place.

We examined TennCare's emergency rules from April 2004 through July 2009 to determine if TennCare has been submitting the rules appropriately and using the process properly. During this period, TennCare filed 61 sets of changes, consisting of 342 emergency rules. We examined the purpose and authority behind the rule, the filing date, expiration date, the subsequent hearing minutes, and the final rule, and also determined whether the emergency rule had been approved by the Attorney General and filed by the Secretary of State. Based on interviews, review of documents, and additional follow-up, it appears that these rules were properly submitted.

The rules TennCare puts in place affect the enrollees and the services TennCare covers. When these rules change, TennCare has to act quickly to ensure that these changes are publicized swiftly and accurately. Some of the changes in the rules are to ensure that TennCare remains in compliance with federal and state mandates and waivers—failure to comply could possibly jeopardize funding. In some instances, the changes are made so quickly that TennCare does not have the time needed to go through the traditional process.

### **The Bureau of TennCare's Division of Long Term Care Took Appropriate Actions in Preparing to Implement the CHOICES Program**

Our audit objectives focused on reviewing the planning for TennCare's Long Term Care program called CHOICES, and assessing TennCare's actions to prepare for CHOICES implementation. Our audit work (which was completed prior to CHOICES implementation) found that Division of Long Term Care staff (as well as other TennCare staff) had developed plans and protocols, held meetings and training sessions, and reviewed MCO policies and procedures to ensure that the CHOICES program implementation would be well-organized. In

addition, staff had taken actions to address concerns expressed by entities involved in CHOICES implementation. The Long-Term Care Community Choices Act of 2008 (codified in *Tennessee Code Annotated*, Section 71) expanded access to more cost-effective home and community-based services for persons who are elderly and/or have physical disabilities. TennCare reported in 2008 that 98% of long-term-care funding in Tennessee was spent on institutional care (nursing facilities). Through the new program CHOICES, TennCare's intent is to "rebalance" the system, providing more home and community-based services for elderly and/or physically disabled persons who would otherwise require nursing facility services, who want to remain in their home and community, and can be served at a cost that does not exceed the cost of a nursing facility.

CHOICES focuses on enabling persons not currently in nursing homes (but who need additional assistance and care) to remain in their homes, using home-based and community care and diverting those persons from nursing facilities, at least for a while. (Moving persons out of nursing homes back into the community is also an available option under this program.) A further goal of CHOICES is, through improved coordination of care and the use of more cost-effective services, to expand access to home and community-based services to persons who do not yet meet a nursing facility level of care but who are "at risk" of needing nursing facility services, thereby delaying or preventing the need for more expensive institutional care. (These persons would be considered part of Target Group 3 described in Table 10 on page 92. According to Division of Long Term Care management, as of January 2011, while the state has approval to establish Target Group 3, Group 3 has not yet been implemented due to CMS interpretations of Maintenance of Effort provisions set forth in the American Recovery and Reinvestment Act and now the Affordable Care Act.)

### Components of CHOICES

Section 71-5-1402, *Tennessee Code Annotated*, states that a long-term-care system should be "based on a model of care delivery that acknowledges that services delivered in home and community-based settings are not primarily medical in nature, but rather support services that will provide needed assistance with activities of daily living and that will allow persons to age in place in their homes and communities." Other components described are:

- less fragmentation;
- one-stop shopping for information, counseling, and assistance;
- services that wrap around the natural support network in order to keep it in place, thereby delaying or preventing the need for more expensive institutional care;
- a continuum of long-term care services (home and community-based options, community-based residential alternatives, nursing facility services); and
- continuous quality improvement with a mechanism for feedback from persons receiving care and their families.

### *Single Point of Entry*

Section 71-5-1405, *Tennessee Code Annotated*, requires a single entry point for the long-term-care system. To reduce fragmentation, CHOICES has a single point of entry that will provide one-stop shopping for information, counseling, and assistance regarding long-term-care programs and services. The designated entities serving as the single point of entry for new applicants are the Area Agencies on Aging and Disability (AAADs). (The Tennessee Commission on Aging and Disability designates an Area Agency on Aging and Disability in each of the state's nine planning and service areas pursuant to the 1973 amendments to the Older Americans Act.) The AAADs also administer Older Americans Act programs. The Division of Long Term Care has established consistent processes and protocols for use by the nine AAADs. Functions to be performed by the single point of entry include

- counseling and assistance in evaluating long-term care options;
- screening and intake for long-term-care programs; and
- facilitated enrollment for Medicaid financial eligibility and assistance with evaluation of level of care in order to determine medical eligibility for Medicaid long-term-care services (all three of these are specifically required in statute).

The Bureau of TennCare contracted with the Tennessee Commission on Aging and Disability to develop a program for conducting statewide marketing activities for CHOICES. In addition, TennCare's contracts with the AAADs require that each AAAD is responsible for conducting outreach and education within its region, including outreach with area hospital discharge planners, nursing facility social workers, long-term-care ombudsmen, physician office staff, senior centers, senior forums and fairs, retirement communities, and other target audiences and locations.

### *Eligibility*

Section 71-5-1406, *Tennessee Code Annotated*, requires that TennCare implement policies and processes that expedite determining financial eligibility and medical eligibility for home and community-based programs and services, and that TennCare use either the Department of Human Services or determine eligibility in house. (TennCare contracts with DHS for eligibility for Medicaid.) The policies and processes can include presumptive or immediate Medicaid eligibility determination, fast-track eligibility determination, development of specialized units or teams for determination of Medicaid eligibility for HCBS, implementation of facilitated enrollment processes and the implementation of an online medical eligibility application process.

TennCare Long Term Care staff provided information about the eligibility processes. The concept paper TennCare submitted to the Centers for Medicare and Medicaid Services (CMS) as part of the waiver approval process lists streamlined eligibility determination processes under the basic design elements of CHOICES. An October 2008 letter to CMS includes a reference to the same. A CHOICES power point presentation (obtained from Long Term Care staff) refers to "prompt determination of Medicaid (financial) eligibility by a centralized unit

based on uniform, streamlined requirements.” CHOICES management uses a web-based eligibility tool that is accessed by DHS. According to management, this has streamlined the process.

*CHOICES Services*

CHOICES offers 13 different types of services, based on the enrollee’s assessment needs and plan of care. See Table 11 for the services available. The long-term-care services provided through the CHOICES program are designed to build upon an enrollee’s existing support system. This support system may include informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term-care insurance. The focus of the services that are provided through CHOICES is to “wrap around” or supplement services already provided by an existing support system. CHOICES services cannot replace any existing support from family and friends.

**Table 11  
CHOICES Services**

<b>Description</b>	<b>Target Group Services Available For *</b>	<b>Limit</b>
Nursing facility care	1	As medically necessary
Community-based residential alternatives	2	Not applicable
Personal care visits	2 and 3	2 visits per day
Attendant care	2 and 3	1080 hours per calendar year
Homemaker services	2 and 3	3 visits per week
Home-delivered meals	2 and 3	1 meal per day
Personal Emergency Response Systems	2 and 3	Not applicable
Adult day care	2 and 3	2080 hours per calendar year
In-home respite care	2 and 3	216 hours per calendar year
In-patient respite care	2 and 3	9 days per calendar year
Assistive technology	2 and 3	\$900 per calendar year
Minor home modification	2 and 3	\$6,000 per project \$10,000 per calendar year \$20,000 per lifetime
Pest control	2 and 3	9 units per calendar year

\*See Table 10 for a description of the three CHOICES target groups.

*Adult Care Homes*

One of the new community-based residential alternatives offered under the CHOICES program will be “adult care homes,” which will provide care for five individuals who need

ventilators or have suffered traumatic brain injuries. Each home must have a licensed professional resident manager who lives on the premises and a licensed professional caregiver on duty 24 hours a day. In the future, CHOICES will offer the same type of home to older adults who need assistance on a daily basis with activities such as getting into and out of bed, preparing meals, or taking their medications, but who do not need the level of services that a nursing facility provides. The idea is to improve the quality of life of people who may otherwise delay needed care (i.e., in order to avoid entering a nursing facility). The Board for Licensing Health Care Facilities promulgated rules on the licensing of adult care homes as emergency rules and, as of November 2, 2010, the rules had been approved by the Attorney General's Office and filed with the Secretary of State. The board held a rulemaking hearing to promulgate permanent rules for adult care homes on November 10, 2010.

### *CHOICES and Managed Care Organizations*

TennCare management says CHOICES is a fundamental change for elderly care in the state, with services delivered through Managed Care Organizations (MCOs). The MCOs (who already contract with TennCare and provide Medicaid medical services) will integrate long-term-care services into their scope of services. The clients receiving home and community-based services under the 1915c waiver (approved by CMS in May 2002) will be transitioned to the CHOICES managed care program.

TennCare requires MCOs to be accredited by the National Committee for Quality Assurance (a nonprofit organization committed to assessing, reporting on, and improving the quality of care provided by organized delivery systems). Under the terms of their contracts with TennCare, the MCOs are responsible for enrollment; health education and outreach; coordination of services; establishing and maintaining a provider network; quality management and quality improvement; customer service; complaint and appeals processing and resolution; claims processing; and maintenance and operation of information systems. MCOs are to cost-effectively implement the care plan, assure coordination and monitoring, and secure availability of a qualified workforce, including backup workers when necessary, so that services are timely. The cost of services is not to exceed the cost of institutional services in a nursing facility.

TennCare's contracts with the MCOs require the MCOs to not only establish and maintain a provider network, but also to credential provider staff, check provider financial qualifications, and perform criminal background checks (or ensure checks are performed) on employees, subcontractors, and providers. Other requirements include education and training for long-term-care providers about CHOICES no later than 30 days prior to implementation and monthly education and training in claims submission, payment processes, and use of information systems for 12 months following the implementation of CHOICES. The MCOs are responsible for providing member education materials; distributing provider directories; operating a toll-free telephone line to respond to member questions, concerns, inquiries, and complaints; issuing a provider handbook to all contract providers; contacting all contract providers semi-annually (one of those contacts is to be face-to-face); conducting an annual survey to assess provider satisfaction; and maintaining a member and provider complaint system.

### *Care Coordination and Electronic Visit Verification*

Each CHOICES enrollee is assigned, by the MCO, to a care coordinator (an MCO employee) who has primary responsibility for overseeing all the services for a CHOICES enrollee. Care coordinators are primarily nurses and social workers; face-to-face interaction by care coordinators is required to ensure the continuum of services and ongoing feedback from the enrollees and their family members. As part of care coordination, providers' staff use the Electronic Visit Verification (EVV) system to check in at the beginning and end of each period of service delivery. This system aids providers, care coordinators, and the MCOs in monitoring an enrollee's service delivery. The EVV software used by the MCOs and network providers has "acceptable" phone numbers for each enrollee (acceptable numbers include the enrollee's number, family members' phone numbers, or neighbors' numbers should the enrollee's phone not work). When a provider enters the homes and starts services, he or she calls the EVV system from the enrollee's phone. The provider calls back upon leaving after providing the service. This function also generates invoices for the services. If the service is not provided according to the plan of care, an immediate missed-visit notification will be generated so that the provider can provide "back-up" care and the care coordinator can be notified. Under the prior Home and Community Based Services waiver, missed visits were not reported until the end of the quarter, which could hinder the state's ability to intervene timely to address gaps in care. According to CHOICES management, a few problems occurred with the EVV during implementation, but the MCOs and the EVV vendor are working together to solve them.

### *Consumer Direction*

CHOICES includes consumer-directed options or self-direction for some services where enrollees can choose who will deliver their services. For example, if an enrollee knows someone who can provide homemaker or personal care services, the enrollee can contract with that person instead of using an MCO provider. This can be a neighbor, friend, or even a family member, although there are certain limitations with respect to family members to ensure that the program does not supplant natural caregiving supports. Appropriate mechanisms are in place to ensure accountability such as having a fiscal employer agent (FEA) responsible for facilitating payment on behalf of the client. Services that can be self-directed include attendant care, personal care, homemaker services, in-home respite, and companion care. As of October 25, 2010, CHOICES management reported that 10% of enrollees have chosen the consumer direction option.

### TennCare's Planning for and Oversight of CHOICES Implementation

As noted above, one of our audit objectives was to assess TennCare's actions to prepare for CHOICES implementation and its plans to monitor the program after implementation. Our audit work (which was completed prior to CHOICES implementation) found that Division of Long Term Care staff (as well as other TennCare staff) had developed plans and protocols, held meetings and training sessions, and reviewed MCO policies and procedures to ensure that the CHOICES program implementation is well-organized. In addition, staff had taken actions to address concerns expressed by entities involved in CHOICES implementation. The information

below describes TennCare's activities, prior to actual implementation of CHOICES and monitoring plans after implementation.

### *Review of MCO Activities*

To determine if the MCO is able to meet all requirements related to the CHOICES program, TennCare's Division of Managed Care Operations and the Division of Provider Networks conducted readiness reviews. The reviews focused on determining the following:

- Can the MCO process claims?
- Does the provider network have adequate capacity?
- Do the providers have adequate training?
- Has the MCO hired an adequate amount of staff?

The reviews included desk and on-site review of documents, a walk-through of the operations, system demonstrations (including systems connectivity testing), and interviews with MCO staff. The divisions held conference calls two times a week with MCO staff, and reviewed and discussed policies and procedures and provider agreements. The Director of Provider Networks determined the adequacy of provider networks by loading provider information into a mapping application. The MCOs, by contract, have levels of care access standards that can result in liquidated damages if TennCare finds noncompliance.

On-site reviews were planned prior to implementation as well as test case enrollees. These test cases determined readiness for assessment, case management, and services recommendation. TennCare and the MCOs have a process in place to track provider complaints. Staff handle CHOICES complaints in the same manner as other TennCare complaints. Complaints are routed to the MCOs and are required to have follow-up action (phone call, memo) within a set amount of time.

### *Plans for Monitoring*

TennCare's contracts with the MCOs have several requirements the MCOs must meet. To determine compliance with those requirements, TennCare performs monitoring on a monthly, quarterly, or annual basis. Monitoring schedules are as follows:

#### Monthly Monitoring

- missed and late visits
- case reviews to determine objectivity of the needs assessment and care planning processes and to ensure consistent and reliable outcomes
- performance when transitioning CHOICES members

### Quarterly Monitoring

- ensure receipt of disease management interventions and the adequacy and appropriateness of the interventions
- determine adherence to time frames for assessments, care planning, and implementation of services
- determine adherence to the timelines regarding intake
- determine adherence to time frames regarding ongoing assessment and care planning and service initiation
- determine adherence to requirements for care coordinator contacts following enrollment
- determine adherence to requirements regarding processes for identifying, assessing, and transitioning members who may have the ability and/or desire to transition from a nursing facility to the community
- ensure provider network requirements are met
- monitor critical incidents
- monitor the complaint process to determine compliance with time frames
- determine adherence to the requirements regarding ongoing assessment and care planning and service initiation time frames

### Annual Monitoring

- survey a representative sample of members and assess program satisfaction
- ensure receipt of disease management interventions and the adequacy and appropriateness of the interventions
- determine whether the long-term-care provider network development plan is making sufficient progress toward network development and expansion goals

### *Improvements Made From the 2002 HCBS Waiver*

When the 2002 Home and Community Based Services (HCBS) waiver was approved, TennCare contracted with the Commission on Aging and Disability (TCAD) for the commission to be the operating agent. TennCare's Quality Assurance Audit (for program year 2005) of the HCBS waiver program identified problems with inadequate performance of quality assessments, inadequate records of service provider credentials, inadequate complaint tracking, unacceptable billing practices, unapproved marketing efforts, and significant delays in admission of enrollees into the program. As of July 1, 2009, TennCare contracted directly with the Area Agencies on Aging and Disability (AAADs), and TCAD was responsible for quality assurance, the ombudsman program, and marketing for the waiver. According to Long Term Care management, significant improvements were made in three areas identified as problems with the Elderly and Disabled waiver:

- quality – Long Term Care standardized the AAADs’ quality reviews of providers;
- enrollment – Long Term Care increased enrollment into the waiver by developing a statewide brochure and establishing an outreach coordinator (a Long Term Care employee) to help increase awareness of the program; and
- missed visit reporting – Long Term Care standardized providers’ and AAADs’ reporting and management of missed visits.

Key learning from the Elderly and Disabled waiver was incorporated into CHOICES:

- in CHOICES, MCOs are responsible for credentialing and monitoring providers, in accordance with NCQA requirements;
- there is a CHOICES brochure and AAADs continue outreach activities within their regions, as participation in home and community-based services continues to grow; and
- with respect to missed visits, CHOICES requires that each MCO implement and maintain an electronic visit verification system that permits immediate identification and resolution of service gaps.

For fiscal year 2011, TennCare did not renew its contract with the Commission on Aging and Disability in anticipation of implementing CHOICES and contracting with the MCOs.

#### *Planning Prior to Implementation*

The Long-Term Care Community Choices Act of 2008 requires TennCare to develop a comprehensive individualized assessment of needs by a qualified entity, and a plan of care based on protocols and in conjunction with active participation of the member and family or other caregivers. To meet the act requirements, TennCare’s Chief of Long Term Care Operations and staff held weekly meetings at the Bureau of TennCare offices beginning in August 2009 and continuing through implementation in March 2010 and after. The meetings were and are attended by representatives of all parties involved in the planning, implementation, and service provision of CHOICES—service providers, MCOs, support brokers, the Electronic Visit Verification software vendor, and the nine Area Agencies on Aging and Disability. Bureau staff (legal, quality assurance, and financial division representatives) also attend. Prior to meetings, documentation (flow charts, protocols, forms, and instructions) is sent electronically to meeting participants. The meetings are an open forum where the director discusses protocol, legal issues, procedures, and documentation.

Nursing facilities were included in weekly conference calls to update them on the program’s progress and permit them to ask questions. The Bureau of TennCare awarded \$2.6 million in grants to 24 nursing facilities in 2009, for diversification projects to help the facilities expand their businesses to include other services offered to CHOICES enrollees such as adult daycare and respite care. In October and November 2009, TennCare staff held nursing facility and home and community-based services provider forums across the three grand divisions of the state. Presentations focused on the CHOICES program, and question and answer sessions were

conducted after the presentations. During implementation, nursing facility representatives were included in CHOICES meetings.

As part of preparations to implement CHOICES, Bureau of TennCare staff (including the Chief of Long Term Care Operations) met twice a week with the bureau's Deputy Commissioner to discuss CHOICES' progress. Staff reported on the MCOs' readiness reviews and information systems testing. To assist with implementation, TennCare contracted with a consulting firm that had previously assisted Hawaii when it implemented a program similar to CHOICES.

### *Concerns Expressed and Actions in Response*

During interviews conducted as part of this CHOICES audit, entities involved in the CHOICES implementation expressed several concerns:

- that the number of potential applicants to be screened by AAADs was unknown,
- that eligibility determination might not be timely,
- that there might not be an adequate number of providers in the network,
- that there might be start-up problems with the EVV system, and
- that enrollees and providers would call regarding every little problem that arises.

According to the Division of Long Term Care, staff addressed these concerns by including all parties in weekly meetings and provider forums. Enrollment forms were reviewed line by line; TennCare staff reviewed network adequacy (see *MCO Activities* above); and the Electronic Visit Verification software vendor was involved in discussions regarding procedures. Staff of the Area Agencies on Aging and Disability, who serve as the Single Point of Entry in CHOICES, were particularly concerned about the timeliness of CHOICES eligibility determination by the Department of Human Services (which contracts with TennCare to determine Medicaid eligibility), because they had experienced delays under the current waiver program. TennCare Long Term Care management and staff have worked toward addressing these concerns by including AAAD staff and DHS staff in meetings about CHOICES implementation. In addition, DHS and TennCare have developed a training manual, presentations focused on eligibility and enrollment, and a checklist of DHS requirements for long-term-care enrollment to help expedite CHOICES eligibility determination.

During implementation, groups of TennCare employees—those who have been advising the MCOs—were on call to answer phones and resolve problems. Now that CHOICES is implemented, the Bureau of TennCare has assimilated the program into the already existing waiver oversight processes, such as quality assurance, ongoing reporting and monitoring activities, calculations of claims promptness and correctness, and provider network adequacy review (see *Plans for Monitoring* section above).

As described above, TennCare staff developed plans and protocols, held meetings and training sessions, and reviewed MCO policies and procedures to ensure that the CHOICES program implementation would be well-organized. In follow-up discussions with TennCare

CHOICES management and AAAD staff, they stated their belief that, because of all of the preparations described above, CHOICES implementation has been successful. Enrollment (for long-term-care facility enrollees and enrollees receiving home and community-based services) in CHOICES, as of October 4, 2010, was

- East – 11,305,
- Middle – 9,743, and
- West – 7,884.

**RESULTS OF OTHER AUDIT WORK**

**Bureau of TennCare Title VI and Other Information**

Title VI

All programs or activities receiving federal financial assistance are prohibited by Title VI of the Civil Rights Act of 1964 from discriminating against participants or clients on the basis of race, color, or national origin. In response to a request from members of the Government Operations Committee, we compiled information concerning federal financial assistance received by the Bureau of TennCare and the bureau’s efforts to comply with Title VI requirements. The results of the information gathered are summarized below.

According to TennCare’s Budget Director, the bureau has received \$867,970,202 in federal assistance for fiscal year 2010 as of October, 26, 2009, broken down as follows:

**Fiscal Year 2010 Federal Assistance by Program/Activity  
As of October 26, 2009**

<b>Program/Activity</b>	<b>Dollar Amount</b>	<b>% of Total</b>
Medical Services	\$572,838,525	66.00%
Waiver and Crossover Services	\$136,731,537	15.75%
Long Term Care	\$135,841,652	15.65%
Administration	\$ 22,108,177	2.55%
Governor’s Office of Children’s Care Coordination	\$ 450,311	0.05%
<b>Total</b>	<b>\$867,970,202</b>	<b>100.00%</b>

The Bureau of TennCare submitted its *Fiscal Year 2009-2010 Title VI Implementation Plan* to the Comptroller of the Treasury’s Division of State Audit, as required by statute. Section 4-21-901, *Tennessee Code Annotated*, requires those state agencies subject to the requirements of Title VI of the Civil Rights Act of 1964 to develop a Title VI implementation plan and submit the plan to the Department of Audit by October 1 each year. Beginning with the 2010-2011 plans, due October 1, 2010, agencies are required to submit the plans to the Tennessee Human Rights Commission, pursuant to Chapter 437, Public Acts of 2009. According to TennCare’s

Title VI Implementation Plan, the Director of Non-Discrimination Compliance and Health Care Disparities is responsible for all nondiscrimination plans and compliance efforts. As to Title VI-specific activities, the plan describes the director as having the following duties:

- developing and implementing TennCare’s Title VI Implementation Plan;
- reviewing all TennCare Managed Care Contractor (MCC) contracts and subcontracts for non-discrimination compliance;
- monitoring MCC and subrecipient compliance with the provisions of Title VI of the Civil Rights Act of 1964;
- receiving, investigating, and resolving discrimination complaints (the Director may be assisted in this task by the bureau’s Office of General Counsel) ;
- providing Title VI training for the MCCs and TennCare itself;
- research in the area of, and the implementation of programs related to, cultural competency, health care literacy and health care disparities;
- reviewing responses to data requests from the U.S. Department of Health and Human Services Office for Civil Rights (DHHS/OCR) prepared by the bureau’s Office of General Counsel;
- reviewing all marketing material prepared by MCCs for use with enrollees; and
- working with contracted divisions of state government, managed care organizations, and advocates on the implementation of non-discrimination programs.

Additionally, TennCare’s Director of Non-Discrimination Compliance monitors federal law and program changes that are likely to have an impact on Title VI. The Director also works interdepartmentally with the Division of Intellectual Disabilities Services, the Department of Health’s Division of Minority Health, the Department of Human Services, and the Department of Children’s Services.

At the federal level, the bureau files its Methods of Administration (MOA) for compliance with Title VI of the Civil Rights Act of 1964 with the Centers for Medicare and Medicaid Services (CMS). TennCare also works with the Office of Civil Rights at CMS’ parent agency, the U.S. Department of Health and Human Services. TennCare does not, however, routinely report to the Office of Civil Rights on Title VI compliance issues.

Title VI compliance efforts are focused primarily on staff training and ensuring proper communication with enrollees. The Director of Non-Discrimination Compliance conducts classes explaining the conduct expectations, rules, and complaint procedures regarding Title VI. Independent training is permitted if an employee is unable to attend a scheduled class and if both the employee and his or her supervisor can attest to the fact that the material was reviewed. A full record of all training activities, including sign-in logs, dating back over the past 14 years has been maintained.

Non-discrimination compliance material must be provided to enrollees. TennCare's website has contact information, explanations about how to obtain foreign language assistance, complaint-filing rights, and other information for enrollees. All vital documents (renewal letters, appeals forms, and so forth) have the following Notice of Fair Treatment language:

*We do not allow unfair treatment in TennCare. No one is treated in a different way because of race, color, birthplace, language, sex, age, or disability. Do you think you've been treated unfairly? Do you have more questions? Do you need more help? You can make a free call to the Family Assistance Service Center at 1-866-311-4287.*

All of these forms are printed in English and Spanish and are sent with a list of the other language services that TennCare has available. Additionally, Limited English Proficiency (LEP) requirements ensure that TennCare offers enrollees language assistance in the form of translation and interpretation services.

All of TennCare's MCCs are also required to have training programs, complaint procedures, Title VI Coordinators, and annual plans. The bureau's Director of Non-Discrimination Compliance sees to it that MCCs' contracts include Title VI language, as well as best practices guidelines for non-discrimination. The contractors are expected to use the Notice of Fair Treatment language and receive template letters from TennCare's Office of Non-Discrimination Compliance and Health Care Disparities. Contractors must also comply with all regulations regarding access and services for TennCare enrollees, including the provision of meaningful services in a non-discriminatory manner. Contractors are required to have a non-discrimination contact who serves as a liaison to TennCare. Finally, non-discrimination training must also be documented by contractors.

Monitoring and tracking activities are focused largely on the MCCs, since they are the entities that interact with the community in providing services. QSource, TennCare's External Quality Review Organization (EQRO), performs external reviews of the bureau's MCCs. QSource's annual reviews include verifying that the MCCs have written Title VI plans; a current, signed Assurance of Non-Discrimination Certification; and posters notifying employees about their rights and obligations under non-discrimination laws. The TennCare Oversight Division of the Tennessee Department of Commerce and Insurance also looks at many of the same items as QSource. Finally, contractors submit quarterly and annual non-discrimination compliance reports to TennCare.

According to the Director of Non-Discrimination Compliance, to promote minority involvement in discussions of program needs, the MCCs are asked to report on the gender and ethnicity of the members of their advisory committees and boards. While there are no diversity requirements, the bureau's request for this information is intended to encourage more minority appointments.

The written description of TennCare's Title VI complaint procedures includes the following:

- Information on how to file complaints must be posted throughout TennCare, its contractors, grantees, sister state agencies, and other organizations that receive funds from the bureau. In addition to basic written forms, accommodations must also be made for the blind, deaf/hard of hearing, and those in need of language assistance.
- Complaints must be filed with TennCare's Non-Discrimination Compliance Coordinator or with the Title VI Coordinator at the MCC within 90 days of the alleged discriminatory act. If the complaint is initially filed with a contractor, its coordinator is expected to investigate and correct any Title VI violation. Once received, the coordinator must notify the complainant that the complaint will be investigated.
- An initial or preliminary investigation must be conducted once a complaint is received. Within 90 days of a complaint being filed, the recipient organization must perform an investigation and provide the complainant with a written determination letter. If an act of discrimination is found to have occurred, action must be taken to prevent the recurrence of such discrimination.
- If a complainant is not satisfied with the outcome, he or she may appeal to the Bureau of TennCare (or DIDS, if appropriate), the Tennessee Human Rights Commission, or HHS/OCR's regional- or national-level offices. Individuals can also initiate complaints at these levels and they must be advised of this right.
- Complaints not submitted directly to TennCare must be reported to the bureau's Non-Discrimination Compliance Coordinator on at least a quarterly basis. They must be reported in writing within 30 days of the end of each calendar year quarter. The reports must document the resolution of complaints and identify those complaints that have not yet been resolved. Records of all discrimination complaints must be maintained by each entity involved for at least 5 years.

From July 1, 2007, to October 30, 2009, TennCare received 48 complaints alleging some type of discrimination. Upon initial review, nearly all of the complaints were recognized as actually relating to eligibility or quality-of-care issues. None of the complaints were determined to be matters of discrimination in violation of Title VI of the Civil Rights Act of 1964.

The bureau prepared several charts showing enrollees by ethnicity, gender, age, and county of residence. These charts, originally compiled for the annual Title VI Implementation Plan for FY 2009-2010, are shown on pages 140-145.

#### Employee Gender and Ethnicity

All programs or activities receiving federal assistance must also comply with Title VII of the Civil Rights Act of 1964 that prohibits employment discrimination based on race, color,

religion, sex, or national origin. A summary of the bureau's employees by title, gender, and ethnicity is included below. As of April 12, 2010, the bureau had 391 staff, of whom 73 percent were female and 27 percent were male. Thirty-two percent of the bureau's staff were minorities—28 percent were Black.

**Bureau of TennCare: Staff by Title, Gender, and Ethnicity  
As of April 12, 2010**

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Accountant 2	3	1	1	0	0	0	3	0
Accountant 3	4	4	0	2	1	0	5	0
Accounting Manager	0	1	0	0	0	0	1	0
Accounting Technician 1	0	2	0	0	0	0	2	0
Accounting Technician 2	0	7	0	5	0	0	2	0
Administrative Assistant 1	1	4	0	1	0	0	4	0
Administrative Secretary	0	3	0	0	0	0	3	0
Administrative Services Assistant 2	1	6	0	3	0	0	4	0
Administrative Services Assistant 3	2	4	0	1	1	0	4	0
Administrative Services Assistant 4	1	11	0	4	0	0	8	0
Administrative Services Assistant 5	1	5	0	1	0	0	5	0
Administrative Services Manager	0	1	0	0	0	0	1	0
Assistant Commissioner 2	1	1	0	0	0	0	2	0
Attorney 2	1	0	0	0	0	0	1	0
Attorney 3	4	6	0	1	0	0	9	0
Attorney 4	3	3	0	0	0	0	6	0
Audit Director 2	0	1	0	0	0	0	1	0
Auditor 2	2	2	0	1	0	0	3	0
Auditor 3	2	2	0	2	0	0	2	0
Auditor 4	1	0	0	0	0	0	1	0
Clerk 2	2	5	1	3	0	0	3	0
Clerk 3	0	3	0	1	0	0	2	0
Data Entry Operator	0	1	0	0	0	0	1	0
Dentist	1	0	0	0	0	0	1	0
Deputy Commissioner 2	1	0	0	0	0	0	1	0
Electronic Data Processing Auditor	2	0	0	0	0	0	2	0
Epidemiologist	0	2	0	0	0	0	2	0
Executive Administrative Assistant 1	0	6	0	0	0	0	6	0
Executive Administrative Assistant 2	2	8	0	1	0	0	9	0
Executive Administrative Assistant 3	0	5	0	0	0	0	5	0
Fiscal Director 1	2	0	0	1	0	0	1	0
Fiscal Director 2	0	1	0	0	0	0	1	0
Fiscal Director 3	1	0	0	0	0	0	1	0
General Counsel 4	1	0	0	0	0	0	1	0
Governor's Office of Children's Care Coordination Director	1	0	0	0	0	0	1	0

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Human Resources Director 2	0	1	0	0	0	0	1	0
Information Resources Support Specialist 2	0	1	0	0	0	0	1	0
Information Resources Support Specialist 3	1	2	0	2	0	1	0	0
Information Systems Support Specialist 4	1	0	0	0	0	0	1	0
Information Officer	0	1	0	0	0	0	1	0
Information Systems Analyst 2	1	0	0	1	0	0	0	0
Information Systems Analyst 3	1	1	0	0	0	0	1	1
Information Systems Analyst 4	1	5	1	2	0	0	3	0
Information Systems Analyst Supervisor	2	1	0	1	0	0	2	0
Information Systems Director 2	2	1	1	0	0	0	2	0
Information Systems Director 3	1	0	0	0	0	0	1	0
Information Systems Manager 1	3	0	0	1	0	0	2	0
Information Systems Manager 2	2	0	0	1	0	0	1	0
Information Systems Manager 3	0	2	0	0	0	0	2	0
Legal Assistant	8	29	0	7	1	0	29	0
Legal Associate	0	1	0	0	0	0	1	0
Legal Services Director	1	0	0	0	0	0	1	0
Long Term Care Program Director	0	2	0	0	0	0	2	0
Managed Care Analytics Director	1	0	0	0	0	0	1	0
Managed Care Director Quality Oversight	0	1	0	0	0	0	1	0
Managed Care Division Director	3	7	0	4	0	0	6	0
Managed Care Operator	0	6	0	6	0	0	0	0
Managed Care Program Manager 1	1	4	0	2	0	0	3	0
Managed Care Program Manager 2	0	11	0	2	0	0	9	0
Managed Care Specialist 1	3	13	0	9	0	0	7	0
Managed Care Specialist 2	0	13	0	5	0	0	8	0
Managed Care Specialist 3	6	18	0	15	0	0	9	0
Managed Care Tag Consultant	0	3	0	1	0	0	2	0
Managed Care Technician	1	16	0	11	1	0	5	0
Mental Health Program Specialist 3	0	1	0	1	0	0	0	0
Mental Health/Mental Retardation Planner	0	1	0	1	0	0	0	0
Mental Retardation Program Specialist 3	1	0	0	0	0	0	1	0
Pharmacist 2	1	1	0	0	0	0	2	0
Physician	2	2	0	0	0	0	4	0

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Procurement Officer 2	0	1	0	0	0	0	1	0
Programmer/Analyst 3	4	3	0	0	0	0	6	1
Programmer/Analyst 4	0	1	0	0	0	0	1	0
Programmer/Analyst Supervisor	2	0	0	1	0	0	1	0
Psychologist	1	0	0	0	0	0	1	0
Public Health Nursing Consultant 1	0	9	0	2	0	1	6	0
Public Health Nursing Consultant 2	3	18	1	5	0	0	15	0
Public Health Nursing Consultant Manager	0	3	0	1	0	0	2	0
Statistical Programmer Specialist 2	1	1	0	1	0	0	1	0
Statistical Research Specialist	7	3	3	1	0	0	6	0
TennCare Budget Director	0	1	0	0	0	0	1	0
TennCare Director-Operations	1	0	0	0	0	0	1	0
TennCare Director-Managed Care Operations	1	0	0	0	0	0	1	0
TennCare Long-Term Care Director	0	1	0	0	0	0	1	0
TennCare Project Director	1	3	1	0	0	0	3	0
TennCare Project Manager	1	2	0	0	0	0	3	0
Website Developer	1	0	0	0	0	0	1	0
<b>Total</b>	<b>106</b>	<b>285</b>	<b>9</b>	<b>110</b>	<b>4</b>	<b>2</b>	<b>264</b>	<b>2</b>
<b>Percent</b>	<b>27%</b>	<b>73%</b>	<b>2%</b>	<b>28%</b>	<b>1%</b>	<b>.5%</b>	<b>68%</b>	<b>.5%</b>

### Contracts

As of October 23, 2009, the bureau had 78 active contracts, many of which were with institutions of higher education, medical centers, government agencies, and for-profit organizations and corporations. According to the contracts, TennCare has one contractor owned by a minority or disadvantaged group. The following chart lists summary information about the ownership of TennCare's contractors:

#### **Bureau of TennCare: Active Contracts As of October 23, 2009**

Government	Female	Not Minority/ Disadvantaged	Not Applicable/ Not Specified
19	1	36	22

**Bureau of TennCare: Enrollment by County and Race  
As of March 31, 2009**

County	Race						
	All Races	White	Black	American Indian or Alaskan Native	Asian	Hispanic	Other
<b>All Counties</b>	<b>1,210,148</b>	<b>713,848</b>	<b>371,565</b>	<b>1,802</b>	<b>12,429</b>	<b>55,234</b>	<b>55,270</b>
Anderson	14,238	12,014	1,085	32	85	281	741
Bedford	10,130	7,036	1,281	13	55	1,431	314
Benton	3,746	3,380	128	16	12	40	170
Bledsoe	3,069	2,847	51		9	32	130
Blount	18,191	15,618	1,024	43	112	515	879
Bradley	18,071	15,043	1,295	34	128	816	755
Campbell	13,164	12,334	65	10	24	26	705
Cannon	2,836	2,618	45	1	15	41	116
Carroll	6,661	5,243	1,023	13	27	84	271
Carter	11,873	10,985	174	20	39	93	562
Cheatham	5,577	5,091	127	19	26	98	216
Chester	3,449	2,584	676	1	9	48	131
Claiborne	9,067	8,340	100	11	16	24	576
Clay	2,138	1,958	45	2	7	30	96
Cocke	10,466	9,526	295	26	39	96	484
Coffee	10,860	9,302	571	15	78	428	466
Crockett	3,443	2,267	632	2	5	396	141
Cumberland	10,328	9,511	36	19	51	225	486
Davidson	110,945	33,966	54,648	274	3,566	13,583	4,908
Decatur	2,741	2,444	122	3	6	54	112
Dekalb	4,313	3,835	66	2	14	215	181
Dickson	8,874	7,414	693	28	49	289	401
Dyer	9,778	6,547	2,636	8	50	121	416
Fayette	5,759	1,950	3,365	5	22	140	277
Fentress	6,119	5,741	7	4	18	10	339
Franklin	6,722	5,743	521	5	22	131	300
Gibson	11,749	7,004	4,034	13	48	160	490
Giles	5,730	4,407	1,014	4	30	46	229
Grainger	5,126	4,644	37	5	13	136	291
Greene	13,575	12,084	449	13	51	275	703
Grundy	5,216	4,944	25	3	15	6	223
Hamblen	12,693	9,608	816	15	70	1,575	609
Hamilton	55,103	24,984	24,224	49	535	2,945	2,366
Hancock	2,325	2,169	8		4	3	141
Hardeman	7,036	2,614	3,828	4	67	52	471

County	Race						
	All Races	White	Black	American Indian or Alaskan Native	Asian	Hispanic	Other
Hardin	6,662	5,861	372	16	29	61	323
Hawkins	12,765	11,822	225	12	34	105	567
Haywood	5,519	1,352	3,739	3	11	150	264
Henderson	6,190	5,109	724	4	17	83	253
Henry	7,105	5,623	1,081	8	24	62	307
Hickman	5,398	5,005	138	11	21	35	188
Houston	2,012	1,772	112	7	7	22	92
Humphreys	3,817	3,382	191	5	26	40	173
Jackson	2,689	2,534	6	1	4	9	135
Jefferson	10,533	9,417	252	12	31	325	496
Johnson	4,370	4,054	22	11	14	27	242
Knox	62,549	42,176	13,767	116	751	2,389	3,350
Lake	2,049	1,345	598		3	14	89
Lauderdale	7,425	3,391	3,500	43	21	109	361
Lawrence	8,576	7,723	292	10	42	116	393
Lewis	2,975	2,777	68	5	20	22	83
Lincoln	6,356	5,058	823	11	33	166	265
Loudon	6,926	5,916	170	19	34	476	311
Macon	5,394	4,933	26	16	22	210	187
Madison	21,245	6,180	13,283	17	165	614	986
Marion	6,585	5,814	403	2	29	50	287
Marshall	5,400	4,246	643	13	25	289	184
Maury	14,786	9,596	3,711	28	129	771	551
McMinn	10,857	9,392	732	16	35	232	450
McNairy	7,374	6,195	741	4	26	46	362
Meigs	3,010	2,842	23	6	6	12	121
Monroe	10,171	9,155	272	36	42	213	453
Montgomery	22,164	11,438	7,911	80	389	1,124	1,222
Moore	825	773	31	1	2	2	16
Morgan	4,684	4,423	14	6	16	14	211
Obion	6,783	4,782	1,401	4	18	230	348
Overton	4,909	4,588	27	6	11	17	260
Perry	1,659	1,501	62	4	7	16	69
Pickett	1,125	1,053	1		3	16	52
Polk	3,847	3,596	15		11	31	194

County	Race						
	All Races	White	Black	American Indian or Alaskan Native	Asian	Hispanic	Other
Putnam	13,979	11,719	360	25	95	1,061	719
Rhea	7,902	6,978	202	18	30	322	352
Roane	10,261	9,179	404	9	32	49	588
Robertson	10,880	7,535	1,740	18	52	1,129	406
Rutherford	32,619	19,472	7,409	56	982	3,370	1,330
Scott	7,801	7,428	13	7	26	6	321
Sequatchie	3,241	3,023	7	3	9	80	119
Sevier	14,951	13,300	187	45	77	720	622
Shelby	228,995	22,458	183,681	138	2,762	10,988	8,968
Smith	3,881	3,509	137	13	10	51	161
Stewart	2,476	2,216	95	2	22	23	118
Sullivan	28,023	25,017	1,029	29	133	274	1,541
Sumner	21,299	16,203	2,920	29	243	1,025	879
Tipton	11,770	6,540	4,655	18	44	78	435
Trousdale	1,741	1,393	238	1	5	30	74
Unicoi	3,868	3,414	10	5	10	223	206
Union	4,643	4,377	14	4	7	34	207
Van Buren	1,344	1,280	18		2	1	43
Warren	9,627	7,967	410	9	33	770	438
Washington	19,200	15,952	1,471	16	90	541	1,130
Wayne	3,094	2,911	31	10	14	19	109
Weakley	6,322	5,170	786	5	24	81	256
White	5,725	5,210	131	15	27	53	289
Williamson	8,322	5,381	1,463	23	151	958	346
Wilson	13,227	10,051	1,919	28	87	669	473
Other*	9,112	5,546	1,713	31	87	136	1,599

\* Persons in the "Other" category represent race categories not listed or race categories not reported. Counts are subject to change due to retroactivities.

Source: Bureau of TennCare.

**Bureau of TennCare: Enrollment by Age and Race  
As of March 31, 2009**

Age and Gender	RACE						
	All Races	White	Black	American Indian or Alaskan Native	Asian	Hispanic	Other
<b>Total</b>							
<b>All Ages</b>	<b>1,210,148</b>	<b>713,848</b>	<b>371,565</b>	<b>1,802</b>	<b>12,429</b>	<b>55,234</b>	<b>55,270</b>
Age 0 - 1	99,304	54,039	29,308	97	1,123	13,016	1,721
Age 2 - 5	159,672	85,257	48,916	198	1,947	18,406	4,948
Age 6 - 12	224,462	123,020	74,081	394	2,618	14,095	10,254
Age 13 - 18	169,579	96,631	58,874	296	1,592	4,504	7,682
Age 19 - 20	46,257	27,073	17,450	72	298	641	723
Age 21 - 40	237,179	148,249	80,205	365	1,528	2,773	4,059
Age 41 - 64	189,377	123,484	45,770	318	1,911	1,153	16,741
Age 65 +	84,318	56,095	16,961	62	1,412	646	9,142
<b>MALE</b>							
<b>All Ages</b>	<b>518,503</b>	<b>308,367</b>	<b>151,482</b>	<b>762</b>	<b>5,629</b>	<b>26,924</b>	<b>25,339</b>
Age 0 - 1	50,431	27,438	14,874	52	558	6,615	894
Age 2 - 5	81,538	43,441	24,799	98	1,010	9,373	2,817
Age 6 - 12	115,547	63,049	37,132	192	1,334	7,294	6,546
Age 13 - 18	85,454	48,156	29,121	135	829	2,219	4,994
Age 19 - 20	17,709	10,248	6,662	24	112	221	442
Age 21 - 40	61,965	42,743	16,016	105	370	536	2,195
Age 41 - 64	80,710	55,854	18,249	133	856	418	5,200
Age 65 +	25,149	17,438	4,629	23	560	248	2,251
<b>FEMALE</b>							
<b>All Ages</b>	<b>691,644</b>	<b>405,480</b>	<b>220,083</b>	<b>1,040</b>	<b>6,800</b>	<b>28,310</b>	<b>29,931</b>
Age 0 - 1	48,873	26,601	14,434	45	565	6,401	827
Age 2 - 5	78,134	41,816	24,117	100	937	9,033	2,131
Age 6 - 12	108,914	59,970	36,949	202	1,284	6,801	3,708
Age 13 - 18	84,125	48,475	29,753	161	763	2,285	2,688
Age 19 - 20	28,548	16,825	10,788	48	186	420	281
Age 21 - 40	175,214	105,506	64,189	260	1,158	2,237	1,864
Age 41 - 64	108,667	67,630	27,521	185	1,055	735	11,541
Age 65 +	59,169	38,657	12,332	39	852	398	6,891

Notes: Counts may change due to retroactivities. Persons in the "Other" category represent race categories not listed or race categories not reported.

Source: Bureau of TennCare.

**Bureau of TennCare: Enrollment by MCC and Race  
As Reported in MCCs' 2008 Title VI Compliance Plans**

Managed Care Organizations	Race							Total Enrollment Per MCC
	White (Non-Hispanic)	Black (Non-Hispanic)	Hispanic/Latino	American Indian/Alaskan Native	Asian or Pacific Islander	Other Race/Ethnicity	Race Unknown	
Amerigroup	119,246	41,892	12,985	373	3,101	-----	6,573	184,170
Percent	64.75%	22.75%	7.05%	0.20%	1.68%	-----	3.57%	100%
AmeriChoice East	129,675	18,488	7,256	265	1,210	-----	5,889	162,783
Percent	79.66%	11.36%	4.46%	0.16%	0.74%	-----	3.62%	100%
AmeriChoice West	47,367	95,287	7,600	179	1,630	-----	3,922	155,985
Percent	30.37%	61.09%	4.87%	0.11%	1.04%	-----	2.52%	100%
AmeriChoice Middle	117,822	41,869	14,468	402	3,116	-----	5,173	182,850
Percent	64.44%	22.90%	7.91%	0.22%	1.70%	-----	2.83%	100%
BlueCare	225,849	145,956	10,034	407	2,855	11,928	4,184	401,213
Percent	56.29%	36.38%	2.50%	0.10%	0.71%	2.98%	1.04%	100%
TennCare Select	41,800	21,308	997	125	363	23,512	497	88,602
Percent	47.18%	24.05%	1.12%	0.14%	0.41%	26.54%	.56%	100%
Total Per Race All MCCs	681,759	364,800	53,340	1,751	12,275	35,440	26,238	1,175,603
Percent	57.99%	31.03%	4.54%	0.15%	1.04%	3.02%	2.23%	100%

Source: Bureau of TennCare.

**Bureau of TennCare: Long-Term Care Population  
by Waiver, Gender, and Race  
as of May 11, 2009**

Gender	Race	MR Arlington Waiver	MR Main HCBS Waiver	MR Self Determination Waiver	Statewide Elderly and Disabled Waiver	Grand Total
Female	White	74	2,082	427	2,554	5,137
	Black	57	477	159	886	1,579
	Hispani c	0	3	2	11	16
	Other	8	182	38	170	398
Total Female		139	2,744	626	3,621	7,130
Male	White	113	2,636	534	1,068	4,351
	Black	73	746	186	339	1,344
	Hispani c	0	8	1	6	15
	Other	10	252	56	45	363
Total Male		196	3,642	777	1,458	6,073
Grand Total		335	6,386	1,403	5,079	13,203

Source: Bureau of TennCare.

**Bureau of TennCare Performance Measures Information**

As stated in the Tennessee Governmental Accountability Act of 2002, “accountability in program performance is vital to effective and efficient delivery of governmental services, and to maintain public confidence and trust in government.” In accordance with this act, all executive branch agencies are required to submit annually to the Department of Finance and Administration a strategic plan and program performance measures. The department publishes the resulting information in two volumes of *Agency Strategic Plans: Volume 1 - Five-Year Strategic Plans* and *Volume 2 - Program Performance Measures*. Agencies were required to begin submitting performance-based budget requests according to a schedule developed by the department, beginning with three agencies in fiscal year 2005, with all executive-branch agencies included no later than fiscal year 2012. At the time of our audit field work, TennCare was not yet included in the agencies that submit the performance-based budget requests.

Detailed below are the Bureau of TennCare’s performance standards and performance measures, as reported in the September 2009 *Volume 2 - Program Performance Measures*. Also reported below is a description of the agency’s processes for (1) identifying/developing the standards and measures; (2) collecting the data used in the measures; and (3) ensuring that the standards and measures reported are appropriate and that the data are accurate.

## Performance Standards and Measures

### Performance Standard–TennCare Administration

Performance Standard 1 – Avoid repeat audit findings.

Performance Measure 1 – Number of repeat audit findings:

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
0	0	0

Audit findings show an obvious area that needs improvement. The audit findings come from the audit report that is released each year. Auditors from the Comptroller’s Office perform the audit. Employees from Internal Audit and the Fiscal/Budget staff help to analyze the data. Management reviews the findings in a preliminary report, and they comment on the accuracy of any findings made by the Comptroller’s Office. TennCare’s goal is to keep the repeat audit findings at zero. TennCare appears to be keeping this goal. While audit findings do not represent the only area that needs to be monitored for efficiency or improvement, audit findings are an appropriate way to measure performance.

### Performance Standard–TennCare Services

Performance Standard 1 – Maintain the number of Managed Care Organizations that demonstrate significant improvement in one or more of the quality measures identified in the contractor risk agreement.

Performance Measure 1 – The number of Managed Care Organizations demonstrating significant improvement in one or more quality indicators identified in the contractor risk agreement:

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
2	4	4

Performance Standard 2 – Maintain the number of Managed Care Organizations that report well child screening scores on the Health Plan Employer Data and Information Set (HEDIS) at or above the national average in all three age categories.

Performance Measure 2 – The number of Managed Care Organizations that report HEDIS well child screening scores at or above the national average in all three age categories:

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
0	4	4

TennCare monitors the Managed Care Organizations (MCOs) to help ensure quality, as well as to keep costs reasonable. These measures are based on national standards, using the Healthcare Effectiveness Data and Information Set (HEDIS) scores. The National Committee on

Quality Assurance (NCQA) publishes national averages, percentiles, and ratios that help to determine where the MCOs are compared nationally. Each MCO reports the information for the performance measures to TennCare, and TennCare staff verifies the information on a regular basis. TennCare management reviews the accomplishments and reports from the MCOs to determine their compliance levels. To date, in looking at the quality indicators and HEDIS scores, TennCare is meeting the performance measures. Showing significant improvement and having well child screening scores above the national average are both appropriate measures of performance.

**Performance Standard–TennCare Waiver and Crossover Services**

Performance Standard 1 – Work with the Commission on Aging and Disability and other community providers to improve enrollment in the Home and Community Based Services waiver for the elderly.

Performance Measure 1 – The number of unduplicated participants in Home and Community Based Services programs for elderly and/or physically disabled:

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
5,100	6,500	6,500

Performance Standard 2 – Rebalance the long term care system, by implementing the Community Choices Act and tracking expenditure balances.

Performance Measure 2 – The percent of long-term care funding spent on Home and Community Based Services programs:

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
40%	45%	46%

TennCare looks at the enrollment and expenditures of the Home and Community Based Services (HCBS) for an indication of the level of participation in HCBS. Enrollment is generated through the eligibility determination process. Each enrollee is re-verified annually. The expenditures information is generated through the state financial system and reviewed by TennCare management regularly. To date, in looking at enrollment information, budgets, and spending for fiscal year 2009, TennCare appears to be meeting its goals. Enrollment and expenditure information together are appropriate to verify the participation in the HCBS program.

## Performance Standard–TennCare Long Term Care

Performance Standard 1 – Complete all reviews of Pre-Admission Evaluations within eight days.

Performance Measure 1 – The percent of Pre-Admission Evaluations completed within eight days:

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
100%	100%	100%

Performance Standard 2 – Retain, and be able to retrieve as necessary, copies of all approved and denied Pre-Admission Evaluations.

Performance Measure 2 – The percent of copies of all approved and denied Pre-Admission Evaluations, retained and retrieved as necessary:

Actual (FY 2008-2009)	Estimate (FY 2009-2010)	Target (FY 2010-2011)
100%	100%	100%

Pre-Admission Evaluations help to determine the eligibility of enrollees for certain benefits. Without timely processing, the enrollee may have a delay in receiving the services. TennCare management, with the help of the Project Management Office, track the completion of the Pre-Admission Evaluations. Pre-Admission Evaluations can now be done electronically, although some are still being submitted on paper applications. Copies are maintained onsite for two years, and then moved offsite. The copies maintained offsite are still accessible, but they do require slightly longer to access. TennCare Long-Term Care staff monitors the Pre-Evaluation completion rate on a regular basis through the use of time stamps on the electronic forms and time cards for the paper applications, which are attached to the applications. TennCare seems to be meeting these performance measures.

**Bureau of TennCare Appendix**  
**Processing Times That Could Be Calculated for Providers in the Sample**

<b>File Review of TennCare Providers Not in the MCC Network</b>	<b>TennCare Processing Time</b>
Average Enrollment Processing Days*	28.7 days
Processed <= 30 days	28/38 (73.7%)
Processed <= 15 days	21/38 (55.3%)

\* TennCare operates under internal guideline of 15 days for enrollment processing.

AmeriChoice, Amerigroup, and BlueCross/BlueShield do their own credentialing. Providers wanting to work with MCOs must first go through TennCare to fill out an application and provide disclosures (W-9s, license, etc.), depending on the type of practice setting. This information is loaded into interChange, TennCare’s management information system, into the provider file electronic database; and provider applicants are assigned a provider number, which they must have before they can work with an MCO. Once the number is assigned, the provider then works with an MCO to become enrolled in the network.

<b>Managed Care Contractors Provider File Review</b>	<b>AmeriChoice</b>	<b>Amerigroup</b>	<b>BlueCross\ BlueShield</b>
Average Processing Time*	10.0 days	16.3 days	17.2 days
Processed <= 30 days	5/6 (83.3%)	7/8 (88%)	16/18 (88.8%)
Files Not Credentialed	15/21 (71.4%)	3/11 (27.2%)	71/89 (79.7%)

\* MCOs’ goal is processing within 30 days.

Dentists must contact the dental benefits manager, DentaQuest, in order to become a TennCare provider. All dentists must obtain a Medicaid ID before becoming an active provider. They can obtain the ID on their own, which takes about 3-5 days, or they can have DentaQuest obtain it. All credentialing for DentaQuest is performed in-house. Staff can check medical licenses for applicants on-line. DentaQuest sends a confirmation letter to the dentists once they are approved, and at that point the dentists can start billing TennCare.

<b>Dental Benefits Manager File Review</b>	<b>DentaQuest</b>
Average Processing Time (No processing goals set)	90.2 days

Pharmacy providers electing to work with TennCare must contract with SXC Health Solutions, the pharmacy benefit manager. SXC contracts with pharmacy groups or stores, not individual pharmacists. Applicants can download an on-line document, complete it, and return it to SXC. All practicing and licensed pharmacists are on file with the NCPDP (National Council for Prescription Drug Programs). When a pharmacist group or pharmacy store applies with TennCare, SXC verifies the applicant’s credentials and backgrounds through the NCPDP database. As soon as SXC receives and validates the information, SXC staff load the information into their system and the discounted rates go into effect immediately.

<b>Pharmacy Benefits Manager File Review</b>	<b>SXC Pharmacy</b>
Average Processing Time (No processing goals set)	1.6 days

Division of Intellectual Disabilities Services’ provider files are located in a separate database. An on-site file review was conducted at DIDS that included an examination of physical provider files spanning from 2005 to 2009.

<b>DIDS Provider File Review</b>	<b>DIDS</b>
Average Processing Time (No processing goals set. DIDS provider manual says process typically takes 60 to 90 days.)	238 days
Processed <= 30 days	13/30 (43.3%)
Processed <= 90 days	22/30 (73.3%)

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## DIVISION OF INTELLECTUAL DISABILITIES SERVICES

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### BACKGROUND

The Division of Intellectual Disabilities Services was responsible for providing services and supports to Tennesseans with intellectual disabilities and their families. Effective January 15, 2011, the division became part of the newly created Department of Intellectual and Developmental Disabilities.

#### Objectives

The objectives covered in this chapter were to

1. assess the division's ability to address the needs of the people on its waiting list for community services;
2. determine the status of the Settlement Agreement for Arlington Developmental Center;
3. determine the adequacy of services available in the community for those residents who are transitioned out of the developmental centers; and
4. determine the impact on the division of proposed budget reductions and funding received through the American Recovery and Reinvestment Act.

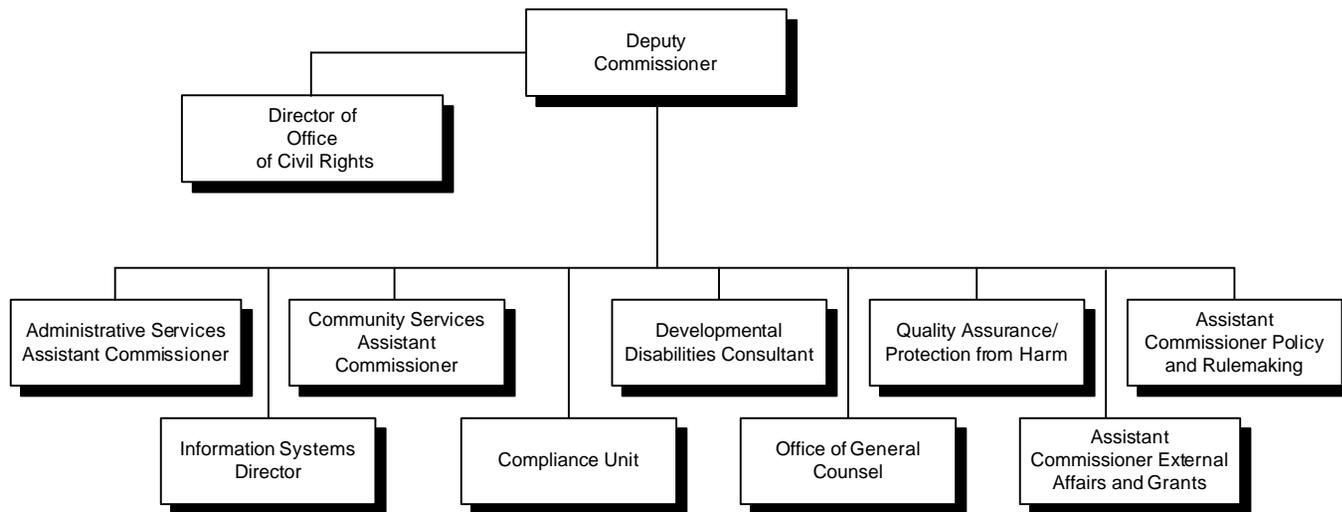
#### Organization and Statutory Responsibilities

The state law granting the Division of Intellectual Disabilities Services the authority and responsibility to provide services and supports for individuals with intellectual disabilities is Title 33 of *Tennessee Code Annotated*. The division was transferred by Executive Order in 1996 from the Department of Mental Health and Developmental Disabilities to the Department of Finance and Administration. Services are either provided directly or through contracts with community providers. Per Section 33-1-201, *Tennessee Code Annotated*, the division recognizes the importance of involving individuals and members of their families in planning, developing, and monitoring the service system. The division also provides administrative support to the Tennessee Council on Developmental Disabilities. Title 33 of the *Tennessee Code Annotated* specifies that there is no entitlement to services and supports from the state. Services are always subject to the availability of funds appropriated by the General Assembly. See organization chart on the following page.

#### *Tennessee Council on Developmental Disabilities*

The Tennessee Council on Developmental Disabilities works to promote public policies and service systems that advance the inclusion of individuals with developmental disabilities in their communities. The council works with public and private groups across the state to find necessary supports for individuals with disabilities and their families, so that they may have equal access to public education, employment, housing, healthcare, and all other aspects of community life. The council encourages individuals with developmental disabilities and their families to play decision-making roles in policies and programs that affect them. The council consists of 21 members

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Division of Intellectual Disabilities Services  
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appointed by the Governor and is administratively attached to the Division of Intellectual Disabilities Services.

### *The Developmental Centers*

The division provides facility-based long-term care at two developmental centers—Greene Valley in Greeneville and Clover Bottom in Nashville. Until June 30, 2010, services were also provided at Arlington Developmental Center in Arlington. Information about the downsizing and/or closure of the developmental centers is on page 162. The division contracts with community agencies across the state to provide a comprehensive system of support services. Services provided include residential services, daycare services, respite care, transportation, therapy-related services, and behavior health services.

### *Regional Offices*

The division operates regional offices in Nashville, Knoxville, and Arlington and operates four additional satellite offices located in Jackson, Chattanooga, Greeneville, and Johnson City. These regional offices are the local point of entry to the community services system. The regional offices are responsible for enrolling individuals with intellectual disabilities into a service delivery system that best meets their individual needs for support. It is the mission of these offices to develop and support opportunities for persons with intellectual disabilities to live as contributing members of their community. The regional offices exist to ensure that the division has local presence and can respond quickly to local needs for community intellectual disabilities services on an individual basis.

### *Case Management Services*

Case Management Services provides support for individuals who are on the Self-Determination Waiver or who are on the waiting list for services. Case Management Services provide ongoing assessment, development, evaluation, and revision of a “plan of care” as well as assistance with the selection of service providers. The plan of care includes an intellectually disabled individual’s short- and long-term goals for treatment and support, the roles and responsibilities of team members, identifying goals and developing measurable steps to achieve those goals, monthly monitoring to ensure progress, and identification of formal and informal resources.

### *Quality Assurance Program*

The Quality Assurance Program provides direction and oversight for regional surveys of contracted day, residential, and independent support coordination and clinical service providers to determine levels of performance. The program serves as a safeguard for the service recipient and focuses on investigation, complaint resolution, and incident management.

The survey instruments that are used have been developed by DIDS in conjunction with TennCare, the Centers for Medicare and Medicaid Services, and other stakeholders and are based on a set of quality outcomes and indicators that measure performance. Generally, providers are surveyed annually with the exception of independent clinical services providers, who are surveyed every three years. Regional Quality Assurance surveyors conduct the surveys. Data are collected from the survey results and used to determine the level of quality across the service system. Data are also incorporated into DIDS' quality management reports for distribution to interested persons.

### *Family Support Program*

In 1992, the Tennessee legislature established the Family Support Program. Funded by state dollars, the program was created to assist individuals with severe disabilities and their families to remain in their homes and communities. The division administers the program through contracts with community agencies across the state. Family Support benefits are flexible, with a maximum benefit of \$4,000 per individual per year. The division estimates that the average amount given to a family is \$1,500 per year.

Families are eligible to receive Family Support if they have a family member with a severe disability living in the home. Individuals with a severe disability who live alone are also eligible. Family Support services can include, but are not limited to the following: respite care, daycare, home modifications, equipment, supplies, personal assistance, transportation, homemaker services, housing costs, health-related needs, nursing/nurses aides, counseling, camp, and training. An essential element of the Family Support Program is family and individual involvement. See Appendix 3 for a breakdown by county of the number of families who received Family Support funds in 2009.

State funding for this program was eliminated after fiscal year 2009. The American Recovery and Reinvestment Act of 2009 (ARRA) provided funds to continue the program through fiscal year 2010. For fiscal year 2011, the program is being funded through an allocation from Tennessee's rainy day fund.

### *The Medicaid Home and Community-Based Waiver Services Programs*

The Medicaid Home and Community-Based Waiver Services (HCBS) Programs were developed to provide individuals with an alternative to long-term-care services that were being provided to intellectually disabled persons in institutional settings. The Bureau of TennCare contracts with DIDS to serve as the Operational Administrative Agency for the Home and Community-Based Services Waiver and for the Self-Determination Waiver. Through this contract, DIDS serves as the administrative agency for the waiver programs and is responsible for the day-to-day operations, including helping individuals who want to apply for services.

In order to receive waiver services, an individual must live in Tennessee, meet Medicaid income eligibility requirements, need the level of care that would be provided in an institution (developmental center or Intermediate Care Facility for the Mentally Retarded [ICF/MR]), and be able to obtain services to keep them safe in their community. An ICF/MR is a licensed facility approved for Medicaid vendor reimbursement that provides specialized services for individuals with intellectual disabilities or related conditions and that complies with current federal standards and certification requirements.

Home and Community-Based Services Waiver. The Home and Community-Based Services Waiver, also known as the Medicaid Waiver, provides an alternative to services provided in an institutional setting and is the primary source of supports and services for people with intellectual disabilities who live in the community. Examples of services which persons may be eligible to receive through the Home and Community-Based Services Waiver include

- Support Coordination, Residential Services (Residential Habilitation, Supported Living, Family Model Residential Support)
- Day Services, Behavior Services
- Physical and Occupational, Speech Therapy Services
- Nursing and Nutrition Services
- Respite Services and Behavioral Respite Services
- Personal Assistance
- Transportation

Tennessee Self-Determination Waiver. Entry into the Self-Determination Waiver Program is limited to individuals who are on the DIDS waiting list for services. As the name implies, this program allows an intellectually disabled individual to self-direct the services they receive, including services such as personal assistance. In addition to Case Management services provided by the division, persons may be eligible to receive the following services through this waiver:

- Adult Dental Services
- Behavioral Respite Services
- Behavior Services
- Day Services Respite
- Environmental Accessibility Modifications
- Financial Administration
- Individual Transportation Services
- Nutrition Services
- Nursing Services

- Occupational Therapy Services
- Orientation and Mobility Training
- Personal Assistance
- Personal Emergency Response Systems
- Physical Therapy Services
- Respite
- Specialized Medical Equipment (Supplies and Assistive Technology)
- Speech, Language, and Hearing Services
- Vehicle Accessibility Modifications

### Revenues and Expenditures

According to the fiscal year 2010-2011 budget, for the year ended June 30, 2010, the Division of Intellectual Disabilities Services had budgeted revenues and expenditures of \$835,619,700. The division revenues were derived from state appropriations of \$69,791,300, interdepartmental revenues and TennCare funds of \$763,769,800, and federal revenues of \$2,058,600. A chart illustrating the relationship of the Centers for Medicare and Medicaid Services, the Bureau of TennCare and the division is in Appendix 1 and a chart illustrating the flow of federal funds from the Centers for Medicare and Medicaid Services through the Bureau of TennCare to the Division of Intellectual Disabilities Services can be found in Appendix 2.

### Impact of the American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009 (ARRA) restored a 14.76% budget reduction to the division's fiscal year 2010 budget. The State of Tennessee made the cuts to this division because revenue collections fell short of budgeted projections. Budget restorations for fiscal year 2009-2010 totaled \$59.3 million, and for fiscal year 2011, totaled \$19.3 million. The following list contains some of the budget items that were restored to the division's fiscal year 2010 budget with the passage of ARRA:

- the Tennessee Family Support Program, which serves approximately 4,000 families who have a family member with a severe developmental disability;
- a 6.7% reduction in funding for Home and Community-Based Services for individuals with mental retardation;
- operational funding for the Harold Jordan Center, a forensic services program located on the campus of the Clover Bottom Developmental Center;
- state funding for services not provided in the Medicaid program such as hospital attendants, transportation, housing subsidies, some dental services, household establishment, etc.; and

- respite services provided by the state’s developmental centers.

The ARRA funds allowed the division to delay implementing these reductions until fiscal year 2011 at the earliest. In February 2010, Governor Phil Bredesen announced his plan to use reserves to fund the continuation of the Family Support Services programs for a two-year period once the ARRA funding was exhausted. The reason for funding for two years instead of one was to give additional time for the economy to recover.

Impact of State Budget Reductions

Although the overall total of funding from all sources only declined 2% between fiscal year 2006 and fiscal year 2011, the amount received from state appropriations has declined by 68%, down from \$743.6 million in fiscal year 2006 to \$30.9 million in fiscal year 2011. The chart below illustrates the funding dollars in millions received in the last five years.

Fiscal Year	2006	2007	2008	2009	2010	2011	5-Yr. Change
<b>Total</b>	\$ 743.6	\$ 841.7	\$ 829.9	\$ 839.0	\$ 835.6	\$ 728.1	-2%
<b>Appropriations</b>	97.2	82.9	75.8	72.5	69.8	30.9	-68%
<b>Federal</b>	2.6	2.6	2.2	2.2	2.1	1.9	-28%
<b>*Other</b>	\$ 646.5	\$ 756.2	\$ 751.9	\$ 764.3	\$ 763.8	\$ 695.3	8%

\*The majority of “Other” funds are from TennCare.

The reduction in total funds also resulted in the loss of 599 positions from fiscal year 2010 to fiscal year 2011. From fiscal year 2006 to fiscal year 2011, the division reduced its workforce by 36%, down from a total of 4,028 full-time positions to 2,578 full-time positions.

**Table 12**  
**Division of Intellectual Disabilities Services**  
**Decline in Full-Time Positions**

	<b>Full-Time FY 2010</b>	<b>Full-Time FY 2011</b>	<b>Gain/Loss</b>
Services Administration	136	136	0
Developmental Disabilities Council	9	9	0
Quality Assurance Program	118	119	1
West TN Regional Office	197	206	9
Middle TN Regional Office	140	142	2
East TN Regional Office	150	153	3
West TN Resource Center	45	45	0
West TN Community Homes	282	205	(77)
East TN Community Homes	148	243	95
Arlington Developmental Center	103	0	(103)
Clover Bottom Developmental Center	706	552	(154)
Greene Valley Developmental Center	1,143	768	(375)
	3,177	2,578	(599)

Source: 2010-2011 State Budget.

## **OBSERVATIONS AND COMMENTS**

The topics discussed below did not warrant a finding but are included in this report because of their effect on the operations of the Division of Intellectual Disabilities Services and on the citizens of Tennessee.

### **Transfer of the Division of Intellectual Disabilities Services to the Department of Intellectual and Developmental Disabilities**

The Division of Intellectual Disabilities Services became part of the newly created Department of Intellectual and Developmental Disabilities on January 15, 2011. Section 4-3-2705, *Tennessee Code Annotated*, states,

Notwithstanding any law to the contrary, January 15, 2011, all duties of the department of mental health and developmental disabilities and the department of finance and administration, whose duties fall within those duties required to be performed by the department of intellectual and developmental disabilities pursuant to Acts 2010, ch. 1100, shall be transferred to the Department of Intellectual and Developmental Disabilities. Also, all employees of the department of mental health and developmental disabilities and the department of finance and administration, whose duties fall within those duties transferred to the department of intellectual and developmental disabilities pursuant to Acts 2010, ch. 1100, shall be transferred to the department of intellectual and developmental disabilities.

In accordance with Acts 2010, Chapter 1100, the deputy commissioner of the division created a transition team to facilitate the transition of the division into the Department of Intellectual and Developmental Disabilities. The new department's termination date is June 30, 2012.

### **The Number of Intellectually Disabled Persons on the Division's Monthly Waiting List for Services Has Remained High**

According to the division's Monthly Waiting List Report, as of December 2010, there were 6,584 people on the waiting list for services. The number of people on the waiting list has almost doubled in recent years, up from 3,163 in December 2003 (reported in the December 2004 performance audit). That audit found that the inability to receive needed services can negatively affect the ability of a person with an intellectual disability to meet his or her full potential, detract from the person's quality of life, negatively impact the health and safety of that individual and others, and place an increased burden on family members and other caregivers.

The 6,584 people on the December 2010 Waiting List Report were classified as follows:

- **In crisis: 79.** A person in crisis needs services immediately due to being on the verge of becoming homeless, the death or incapacitation of all available caregivers, and/or being an immediate danger to themselves or others.
- **Urgent: 763.** The person is at risk of meeting the criteria for “urgent” if one or more of the following criteria are met: aging or failing health of caregiver and no alternative available to provide supports, living situation presents a significant risk of abuse or neglect, increasing risk to self or others, stability of current living situation is severely threatened because of extensive needs or family catastrophe, and discharge from other service system (e.g., Children’s Services or a mental health institute) is imminent.
- **Active: 4,494.** The person and/or family or guardian is requesting access to services but does not yet have the intensive needs to meet the criteria for “in crisis” or “urgent.”
- **Deferred: 1,248.** The person and/or family or guardian does not have intensive needs at the current time but is requesting access to services at some point in the future (after 12 months or more).

A comparison of the waiting list numbers presented in the December 2004 performance audit report and those presented in this current audit report reveals that the number of individuals classified as “in crisis” and “urgent” has remained more constant than in the area of “active” and “deferred,” where the greatest increase can be seen. Division personnel attribute the significant jump in the numbers of people classified as “active” to the outreach programs that were a requirement of the Brown lawsuit. The outreach programs have successfully identified intellectually disabled persons who may be in need of services, and case managers are able to put those intellectually disabled individuals in contact with appropriate service providers as well as monitor individuals who do not currently need services but may in the future because of a change in their life situation (death of a primary caregiver, for example).

<b>Classification</b>	<b>December 2003</b>	<b>December 2010</b>
In Crisis	79	79
Urgent	413	763
Active	1,961	4,494
Deferred	710	1,248
Total	3,163	6,584

As was reported in the prior audit, division personnel voiced concerns that the division has not been able to move individuals off the waiting list as rapidly as they would like because of insufficient funding.

## The Waiting List

Services available through DIDS may not be available immediately even though someone is eligible. Each person who is assigned to the waiting list is assigned a DIDS case manager. The case manager is responsible for maintaining regular contact with the intellectually disabled individuals and their families while they are on the waiting list. The frequency of contact depends on whether they meet the Crisis, Urgent, Active, or Deferred criteria as described above. Contacts are more frequent for people in the Crisis category and less frequent for those on the Deferred list. If individuals' status changes while they are waiting for services and they meet the criteria for a different category of need, they can be reassessed when changes occur.

Case managers provide information to individuals on the waiting list about community services that may be available to meet some of their needs while they are waiting for DIDS services. When individuals receive money through state-funded programs like Family Supports, the case manager can assist in determining options for use of the funds and in locating service providers. Case managers can also assist in accessing benefits available through insurance programs or TennCare, including helping to file appeals as needed. The statewide demographics for individuals on the Waiting List from July 2009 to December 2009 are listed below.

**Table 13**  
**Statewide Waiting List Demographics**  
**July 2009 – December 2009**

	<b>July</b>	<b>Aug</b>	<b>Sep</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>
<b>In Crisis</b>	51	64	70	66	81	75
<b>Urgent</b>	713	707	725	724	732	736
<b>Active</b>	4,257	4,260	4,297	4,329	4,357	4,374
<b>Deferred</b>	995	1,006	999	1,007	1,017	1,033
<b>Total</b>	6,016	6,037	6,091	6,126	6,187	6,218
<b>Number Added to Waiting List</b>	<b>91</b>	<b>75</b>	<b>91</b>	<b>65</b>	<b>82</b>	<b>59</b>
<b>Number Removed to SD Waiver</b>	1	6	3	2	1	3
<b>Number Removed to HCBS Waiver</b>	6	12	10	13	7	11
<b>Number Removed to Arlington Waiver</b>	0	0	0	0	0	0
<b>Number Removed for Other Reasons</b>	46	36	24	15	13	15
<b>Total Number Removed</b>	53	54	37	30	21	29
<b>Total Number on Statewide Waiting List</b>	6,016	6,037	6,091	6,126	6,187	6,218

## **Lawsuits and the Division of Intellectual Disabilities Services**

Several federal lawsuits have influenced the Division of Intellectual Disabilities Services' service system in recent years. Following is background on the litigation.

### Arlington Developmental Center Remedial Order

In January 1992, the U.S. Department of Justice sued the State of Tennessee for violations of the Civil Rights of Institutionalized Persons Act (CRIPA) at the Arlington Developmental Center located in Arlington, Tennessee. The case is known as *United States v. State of Tennessee (Arlington)*. Since November 1993, the facility has been under a U.S. District Court order to correct conditions at the facility. After the district court entered an order requiring the state to improve conditions at Arlington, the court allowed a class of former residents, current residents, and individuals at risk of placement at Arlington to intervene and become party to the suit. After years of litigation, the district court approved a settlement agreement in 2007 defining the "at risk" class and providing for the closure of the Arlington Developmental Center. A court-appointed monitor ensures that Arlington Developmental Center complies with the terms of the remedial order. The remedial monitor's staff review treatment programs at Arlington twice a year and also perform quarterly reviews of community services in West Tennessee.

### Clover Bottom/Greene Valley Developmental Center Settlement Agreement

In December 1995, *People First of Tennessee v. Clover Bottom Developmental Center* challenged the conditions at Clover Bottom Developmental Center in Nashville, Nat T. Winston Developmental Center in Bolivar, Greene Valley Developmental Center in Greeneville, and the Harold Jordan Center in Nashville. A settlement agreement was reached in 1996. Since that time, the Nat T. Winston Development Center was closed by the State of Tennessee and the Greene Valley Developmental Center was released from the litigation (March 2006) based on substantial compliance with the agreed order. In 2008, the district court entered an order releasing the Harold Jordan Center based on substantial compliance with the terms of the settlement agreement. According to division officials, the state is continuing work at Clover Bottom Developmental Center to improve conditions and services being provided to class members in the community.

### Brown Waiting List Settlement

In 2000, a lawsuit was filed by "Tennessee Protection and Advocacy" on behalf of Medicaid-eligible citizens of Tennessee who were either on the waiting list for services provided through the division or had been denied the opportunity to apply for services. In a settlement agreement signed on June 15, 2004, the division had to seek approval for a new Self-Determination Waiver from the federal Centers for Medicare and Medicaid Services (CMS). The waiver was approved in January 2005. Under the terms of the settlement agreement, the division was required to provide targeted case management to each individual on the waiting list in order to assist them with accessing services within their communities. In addition, the division

executed a public relations campaign to inform people about how to apply for services, as well as what types of services are available.

The division complied with the requirements of the settlement agreement. By its terms, the settlement agreement ended on December 31, 2009. In February 2010, the United States District Court issued a final order on the Brown case declaring the case closed.

### **The Transition of Developmental Center Residents to Community Housing**

The 2004 audit found that “placements of developmental center residents into the community had declined in recent years.” The division created the “Master Workplan for Community Residential Placements” as a guideline for the transition to communities of approximately 750 persons living in the Arlington, Greene Valley, and Clover Bottom Development Centers. The audit recommended that the division continue its efforts to place developmental center residents into community settings.

In November 2009, the division reported that Arlington Developmental Center was slated to close by June 30, 2010. With the closure of Arlington Developmental Center, all remaining residents were transitioned to one of the ICF/MR (Intermediate Care Facilities for Persons with Mental Retardation) that have been constructed on the grounds of the Arlington facility or will be transitioned to housing provided through the Home and Community-Based Services Waiver Program. Forty-eight of the most “medically fragile” persons at Arlington will reside in 12 state-of-the-art ICF/MR community homes. These homes, referred to as the DIDS West Tennessee Community Homes, will recognize the need for specific attention to life-safety issues; the persons living in them will be supported by caregivers, who will seek to ensure their living comforts. Plans are also underway to downsize the Clover Bottom Developmental Center during fiscal year 2010-2011.

The division is making efforts to place residents in appropriate community settings. As part of this, an assessment process has been used to identify individual support needs. Division staff have worked closely with residents’ families and guardians to help ensure appropriate placements. As the chart below indicates, at the time of the prior audit (2003-2004) the average daily census for Tennessee’s three developmental centers was 718 residents. The average daily census for 2009-2010 was only 364 residents, a drop of 354 residents (49%).

### Average Daily Census of Intellectual Disabilities Developmental Centers

<b>Fiscal Year</b>	<b>Arlington</b>	<b>Clover Bottom</b>	<b>Greene Valley</b>	<b>Total</b>
2003-2004	211	199	308	718
2004-2005	194	188	302	684
2005-2006	176	184	285	645
2006-2007	145	164	278	587
2007-2008	73	150	273	496
2008-2009	39	141	258	438
2009-2010	13	125	226	364

## **RESULTS OF OTHER AUDIT WORK**

### **Title VI and Other Information**

#### Title VI

All programs or activities receiving federal financial assistance are prohibited by Title VI of the Civil Rights Act of 1964 from discriminating against participants or clients on the basis of race, color, or national origin. In response to a request from members of the Government Operations Committee, we compiled information concerning federal financial assistance received by the Division of Intellectual Disabilities Services (DIDS) and the division's efforts to comply with Title VI requirements. The results of the information gathered are summarized below.

The Division of Intellectual Disabilities Services submitted its Title VI Implementation Plan for July 1, 2009 – June 30, 2010, as required by statute. Chapter 97 of the Public Acts of 2007 (Section 4-21-901, *Tennessee Code Annotated*) requires those state agencies subject to the requirements of Title VI of the Civil Rights Act of 1964 to develop a Title VI Implementation Plan. Prior to 2010, the plans were to be submitted to the Department of Audit by October 1 each year. Effective in 2010, agencies are to submit plans to the Tennessee Human Rights Commission. According to the division's 2009 Title VI Implementation Plan, the Deputy Commissioner "has overall responsibility for DIDS' compliance with the provisions of Title VI," but has designated the Office of Civil Rights Director as the division's Title VI Coordinator. The plan lists the Title VI Coordinator's responsibilities as the following:

- Develop and monitor implementation of DIDS Title VI nondiscrimination compliance plan.
- Coordinate periodic evaluations of all aspects of DIDS activities to ensure programs and services are being conducted without discrimination on the basis of race, color, or national origin.
- Develop divisional policy relating to nondiscrimination.
- Conduct and coordinate Title VI training for DIDS staff and service providers.
- Disseminate to all DIDS staff, applicants for services, and beneficiaries of services Title VI related information.
- Conduct pre- and post-award compliance reviews to ensure that all funds are disbursed and services are provided on an equal opportunity basis.
- Investigate Title VI complaints.
- Submit data and reports that the responsible state and federal agency determines necessary to ascertain whether DIDS has complied or is complying with Title VI requirements.
- Monitor service provider records and review reports necessary to ascertain whether service providers' records have complied or are complying with Title VI.
- Track and review racial and ethnic makeup of staff administering federal assisted services and activities including management, board of directors or other administrative staff.
- Provide technical assistance.

The division's efforts to ensure an understanding of Title VI are aimed at three different groups: employees, contracted service providers, and service recipients.

For DIDS employees, the New Employee Orientation Training Session covers Title VI. Additionally, notices are posted in DIDS' workspaces explaining Title VI requirements and complaint procedures.

For service providers, the division's main effort at ensuring an understanding comes in the form of the manual and training received during new provider orientation. Providers are, from this point onward, largely responsible for ensuring their own awareness of Title VI. Each service provider must submit a documented Title VI plan and record of any complaints (also referred to as a "self-assessment survey") to the division on an annual basis. Subrecipient providers must also appoint their own Title VI coordinators. Contracted service providers must also see to it that their staff receives the necessary training regarding Title VI compliance. This may be accomplished either through internally developed training or through use of the division's material, available online through the Tennessee College of Direct Support.

Service recipients are informed about Title VI through service providers and through the division itself. Initially, service recipients are given a notification of their rights under Title VI. This form must be signed by the recipient and is kept on file with division. The division includes a blank copy of this form, along with other Title VI information, on its website. Recipients are also informed about Title VI through notices that must be posted in conspicuous locations in service provider and agency offices. Finally, the division publishes pamphlets explaining Title VI rights, policies, and complaint procedures. The brochures are made available to recipients through service providers and, in order to make this information available to individuals with limited English proficiency, are printed in both English and Spanish.

The division's Office of Internal Audit performs Title VI monitoring activities as a part of its agency review process. Specifically, the Fiscal Accountability Review (FAR) Unit of this office checks the following while reviewing subrecipient contractors: that Title VI posters are displayed; that self-assessment surveys are completed; that each agency has a Title VI coordinator; and whether any complaints have been filed. A report (which includes specific mention of Title VI, regardless of whether there were any findings) is prepared for each agency reviewed. The Office of the Comptroller is copied on these reports. The division's Title VI Coordinator reviews the FAR Unit's reports and includes the Title VI-related content of them in the annual Title VI Implementation Plan. (According to the 2009 plan, 178 agencies were reviewed in the preceding year. Five agencies had not submitted self surveys—and two of these also did not have posters displayed. Based on a review of the FAR Unit's records and review reports, the plan does include all of the Title VI findings.) The Title VI Coordinator also reviews and summarizes the contents of the self-assessment surveys submitted by providers.

The division's Title VI Implementation Plan states that, in order for a discrimination complaint to be filed with the U.S. Commission on Civil Rights, it must be filed within 180 days of the act of alleged discrimination. Title VI complaints can also be submitted to service providers, local Title VI Coordinators, the DIDS Title VI Coordinator, the Deputy

Commissioner of DIDS, the Commissioner of Finance and Administration, or the Department of Health and Human Services Office for Civil Rights. According to the plan, “[a]ttempts will be made to resolve the complaint at the lowest level possible.” In order to allow for appeal to the U.S. Commission on Civil Rights while still allowing for complaints to be submitted to lower levels, the following deadlines must be met:

1. no later than 30 calendar days after the alleged discrimination occurred—a complainant must file a written complaint within DIDS;
2. no later than 30 calendar days after the written complaint is filed within DIDS—the Title VI Coordinator shall review and investigate the complaint and issue a written determination of findings and, if there is a finding of *Title VI* violation, proposed remedial action (information regarding appeal rights shall also be provided at that time);
3. no later than 20 calendar days after the Title VI Coordinator’s written determination—the complainant may file a written appeal, with the Commissioner, of the Title VI Coordinator’s finding or proposed remedial action;
4. no later than 30 calendar days after the appeal is filed with the Commissioner—the Commissioner shall review and investigate the complaint and issue a written determination in the matter.

Complaints submitted to DIDS are reviewed to determine whether they meet the criteria for Title VI complaints (i.e., alleging discrimination on the basis of race, color, or national origin by a program receiving financial assistance from DIDS within 180 days of the incident of alleged discrimination). If a complaint is not deemed a Title VI issue, the complainant is notified; the complaint may also be referred to an advocacy group, another section of DIDS, or another state or federal agency. Once a complaint is accepted, the division’s Title VI Coordinator opens an investigative case file and begins the complaint investigation by contacting the complainant by telephone within three days of receiving the complaint. (During this initial interview, the complainant is given the opportunity to provide any documents that might be relevant to his/her complaint.) Within 15 days of receiving the complaint, the Title VI Coordinator must send the complainant a written notice of receipt of the complaint. The allegedly discriminatory service or program official is given the opportunity to respond to the complaint before a decision is made. If the Title VI Coordinator determines that there is no discrimination, the case is dismissed. If there is a finding of disparate impact, the discriminatory program or subrecipient is asked to either rebut the findings, develop a plan to mitigate the disparate impact, or justify its actions. If the program or subrecipient asserts that it had a “substantial, legitimate interest” for its actions, the Title VI Coordinator will consider whether this interest can be satisfied while also addressing the disparate impact concern.

From July 1, 2007, to July 31, 2009, DIDS received seven complaints alleging discrimination on the basis of race, color, or national origin. However, all of these complaints were found to be unrelated to Title VI upon initial review.

The division provides services to individuals in the community and in the state's developmental centers. Through its Family Support Program, it also "provides financial assistance to fund the purchase of services and equipment needed by qualified families who have children with disabilities and adults with disabilities who live with their families or by themselves." The plan provides the following breakdown of these service recipients by program, ethnicity, and region:

**Family Support Program FY 2009 – 2010**

**Family Support program (July 1 Through May 31)**

Total Number of Service Recipients receiving funding during the reporting period	4,055
Total Number of Service Recipients receiving waiver services	127
Total Number of Service Recipients not receiving waiver services	3,928

**Total Number of Non-waiver\* Service Recipients by Ethnicity:**

Caucasian	African-American	Hispanic	Other	Total
2,982	863	36	47	3,928

(\*This number does not include persons receiving waiver services through the division.)

**Home and Community-Based and Developmental Centers FY 2009**

**Title VI Report for FY 2009**

**East Region Race and Ethnicity Breakdown**

	<b>Developmental Centers</b>		<b>Community</b>	
	#	% of Total	#	% of Total
White	237	93.3%	2614	88.8%
Black	16	6.3%	292	9.9%
Other	1	0.4%	30	1.0%
Not Known	0	0.0%	8	0.3%
<b>TOTAL</b>	<b>254</b>	<b>100.0%</b>	<b>2944</b>	<b>100.0%</b>

Hispanic	0	0.0%	8	0.3%
Non Hispanic	254	100.0%	2928	99.4%
Not Known	0	0.0%	8	0.3%
TOTAL	254	100.0%	2944	100.0%

**Middle Region Race and Ethnicity Breakdown**

	<b>Developmental Centers</b>		<b>Community</b>	
	#	% of Total	#	% of Total
White	103	75.2%	2276	79.0%
Black	29	21.2%	553	19.2%
Other	0	0.0%	37	1.3%
Not Known	5	3.6%	14	0.5%
TOTAL	137	100.0%	2880	100.0%

Hispanic	0	0.0%	13	0.4%
Non Hispanic	132	96.4%	2853	99.1%
Not Known	5	3.6%	14	0.5%
TOTAL	137	100.0%	2880	100.0%

**West Region Race and Ethnicity Breakdown**

	<b>Developmental Centers</b>		<b>Community</b>	
	#	% of Total	#	% of Total
White	39	60.9%	1172	55.9%
Black	25	39.1%	893	42.6%
Other	0	0.0%	16	0.8%
Not Known	0	0.0%	15	0.7%
TOTAL	64	100.0%	2096	100.0%

Hispanic	0	0.0%	5	0.2%
Non Hispanic	64	100.0%	2076	99.1%
Not Known	0	0.0%	15	0.7%
TOTAL	64	100.0%	2096	100.0%

**Statewide Race and Ethnicity Breakdown**

	<b>Developmental Centers</b>		<b>Community</b>	
	#	% of Total	#	% of Total
White	379	83.3%	6062	76.6%
Black	70	15.4%	1738	21.9%
Other	1	0.2%	83	1.0%
Not Known	5	1.1%	37	0.5%
<b>TOTAL</b>	<b>455</b>	<b>100.0%</b>	<b>7920</b>	<b>100.0%</b>
Hispanic	0	0.0%	26	0.3%
Non Hispanic	450	98.9%	7857	99.2%
Not Known	5	1.1%	37	0.5%
<b>TOTAL</b>	<b>455</b>	<b>100.0%</b>	<b>7920</b>	<b>100.0%</b>

Employee Gender and Ethnicity

A summary of the division’s employees by title, gender, and ethnicity is included below. As of April 12, 2010, the division had 2,978 staff, of whom 27% were female and 73% were male. Minorities comprised 33% of the division’s staff—30% were Black and the remaining 3% were Asian, Hispanic, Indian, and other ethnicity.

**Division of Intellectual Disabilities Services Staff by Title, Gender, and Ethnicity  
As of April 12, 2010**

<b>TITLE</b>	<b>Gender</b>		<b>Ethnicity</b>					
	<b>Male</b>	<b>Female</b>	<b>Asian</b>	<b>Black</b>	<b>Hispanic</b>	<b>Indian</b>	<b>White</b>	<b>Other</b>
Account Clerk	1	7	0	2	0	0	6	0
Accountant 2	3	4	0	0	0	0	5	2
Accountant 3	3	2	0	1	0	0	4	0
Accountant/Auditor 1	1	0	0	0	0	0	1	0
Accounting Manager	2	2	0	1	0	0	3	0
Accounting Technician 1	1	4	0	0	0	0	5	0
Accounting Technician 2	0	3	0	0	0	0	3	0
Adjunctive Therapy Director	1	0	0	0	0	0	1	0
Administrative Assistant 1	0	6	0	3	0	0	3	0
Administrative Assistant 3	0	1	0	0	0	0	1	0
Administrative Secretary	1	41	1	12	0	0	29	0
Administrative Services Assistant 1	0	1	0	1	0	0	0	0

TITLE	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Administrative Services Assistant 2	5	23	0	6	0	0	22	0
Administrative Services Assistant 3	0	13	0	3	0	0	10	0
Administrative Services Assistant 4	0	6	0	2	0	0	4	0
Administrative Services Assistant 5	1	3	0	1	1	0	2	0
Administrative Services Assistant Superintendent	1	0	0	0	0	0	1	0
Administrative Services Manager	2	4	0	0	0	0	6	0
Assistant Commissioner	1	0	0	0	0	0	1	0
Attorney 3	1	0	0	0	0	0	1	0
Attorney 4	0	1	0	0	0	0	1	0
Audiologist 1	0	2	0	0	0	0	2	0
Auditor 2	1	2	0	0	0	0	3	0
Auditor 3	2	1	0	0	0	0	3	0
Auditor 4	0	1	0	0	0	0	1	0
Beautician	0	1	0	0	0	0	1	0
Behavior Management Specialist	0	2	1	0	0	0	1	0
Boiler Operator 1	7	1	0	0	0	0	8	0
Boiler Operator Supervisor	2	0	0	0	0	0	2	0
Budget Analysis Director 2	0	1	0	0	0	0	1	0
Budget Analyst 2	0	1	0	1	0	0	0	0
Building Maintenance Worker 1	3	0	0	0	0	0	3	0
Building Maintenance Worker 2	8	0	0	1	1	0	6	0
Building Maintenance Worker 3	5	0	0	0	0	0	5	0
Clerk 1	0	2	0	2	0	0	0	0
Clerk 2	3	11	0	3	0	0	10	1
Clerk 3	4	7	0	0	0	0	11	0
Cook 1	1	8	0	1	0	0	8	0
Cook 2	1	1	0	0	0	0	2	0
Counseling Associate 2	11	40	0	11	1	0	39	0
Custodial Worker 1	20	36	1	27	0	0	27	1
Custodial Worker 2	8	4	0	3	0	0	9	0

TITLE	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Custodial Worker Supervisor 1	1	3	0	1	0	0	3	0
Custodial Worker Supervisor 2	1	1	0	2	0	0	0	0
Data Processing Operator 2	0	1	0	0	0	0	1	0
Dental Assistant 1	0	1	0	0	0	0	1	0
Dental Assistant 2	0	4	0	1	0	0	3	0
Dental Hygienist	0	3	0	0	0	0	3	0
Dentist	1	1	0	0	0	0	2	0
Deputy Commissioner 2	1	0	0	0	0	0	1	0
Developmental Center Assistant Superintendent	3	7	0	4	0	0	6	0
Developmental Disabilities Council Executive Director	0	1	0	0	0	0	1	0
Developmental Disabilities Program Director	2	1	0	0	0	0	3	0
Developmental Services Regional Director	1	2	0	0	0	0	3	0
Developmental Services Regional Monitor	3	20	0	6	1	0	16	0
Developmental Services Regional Program Administrator	0	3	0	1	0	0	2	0
Developmental Services Regional Program Coordinator 1	2	3	0	1	0	0	4	0
Developmental Services Regional Program Director	4	13	0	3	0	0	14	0
Developmental Technician	237	690	6	307	1	1	608	4
Developmental Technician Supervisor 1	22	54	0	31	1	0	44	0
Developmental Technician Supervisor 2	25	31	1	12	0	1	42	0
Developmental Center Superintendent	2	1	0	2	0	0	1	0
Developmental Services Regional Program Coordinator 2	6	33	0	12	0	1	26	0
Dietitian	0	7	1	0	0	1	5	0
Dietitian 1	0	1	0	0	0	0	1	0

TITLE	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Dietitian Supervisor	0	2	0	0	0	0	1	1
Distributed Computer Operator 2	0	1	0	0	0	0	1	0
Electronics Technician 1	1	0	0	1	0	0	0	0
Equipment Mechanic 1	1	0	0	0	0	0	1	0
Equipment Mechanic 2	2	0	0	0	0	0	2	0
Executive Administrative Assistant 1	0	1	0	1	0	0	0	0
Executive Administrative Assistant 2	2	0	0	0	0	0	2	0
Executive Administrative Assistant 3	1	3	0	1	0	0	3	0
Executive Housekeeper 2	2	0	0	1	0	0	1	0
Executive Secretary 1	0	5	0	0	0	0	5	0
Facilities Manager 3	3	0	0	0	0	0	3	0
Facilities Safety Officer 3	1	0	0	0	0	0	1	0
Facilities Supervisor	6	0	0	0	0	0	6	0
Facility Administrator 3	1	0	0	0	0	0	1	0
Fiscal Director 1	4	1	0	0	0	0	5	0
Fiscal Director 2	1	0	0	0	0	0	1	0
Fiscal Director 3	1	0	0	0	0	0	1	0
Food Service Director 3	0	1	0	0	0	0	1	0
Food Service Manager 2	0	1	0	0	0	0	1	0
Food Service Supervisor 2	0	4	0	0	0	0	4	0
Food Service Supervisor 3	2	1	0	0	0	0	3	0
Food Service Worker	8	28	0	9	0	0	27	0
General Counsel 2	1	0	0	0	0	0	1	0
Grounds Worker 1	4	0	0	0	0	0	4	0
Grounds Worker 2	2	0	0	0	0	0	2	0
Habilitation Therapist	14	42	1	36	0	0	19	0
Habilitation Therapist Supervisor	0	3	0	2	0	0	1	0
Habilitation Therapist Director	1	0	0	1	0	0	0	0
Habilitation Therapist Technician	22	163	0	136	0	0	48	1
Health Information Manager	0	2	0	0	0	0	2	0
Heating & Refrigeration Mechanic 1	2	0	0	1	0	0	1	0

TITLE	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Heating & Refrigeration Mechanic 3	3	0	0	0	0	0	3	0
Human Resources Analyst 1	0	2	0	1	0	0	1	0
Human Resources Analyst 2	0	6	0	1	0	1	4	0
Human Resources Analyst 3	0	1	0	0	0	0	1	0
Human Resources Director 1	2	1	0	1	0	0	2	0
Human Resources Director 3	0	1	0	0	0	0	1	0
Human Resources Manager 2	0	1	0	0	0	0	1	0
Human Resources Technician 1	0	1	0	0	0	0	1	0
Human Resources Technician 2	0	5	0	1	0	0	4	0
Human Resources Technician 3	1	0	0	1	0	0	0	0
Human Resources Transactions Supervisor	0	2	0	0	0	0	2	0
Information Resource Support Specialist 2	1	2	0	0	0	0	3	0
Information Resource Support Specialist 3	4	1	0	2	0	0	3	0
Information Resource Support Specialist 4	2	3	0	1	0	0	4	0
Information Resource Support Specialist 5	0	3	0	1	0	0	2	0
Information Systems Analyst 2	0	1	0	0	0	0	0	1
Information Systems Analyst 3	0	1	0	0	0	0	1	0
Information Systems Analyst 4	3	1	1	0	0	0	2	1
Information Systems Analyst Supervisor	2	0	0	0	0	0	2	0
Information Systems Consultant	2	1	0	0	0	0	2	1
Information Systems Director 3	0	1	0	0	0	0	1	0
Information Systems Manager 3	4	0	0	2	0	0	2	0
Laboratory Technician 2	0	1	0	1	0	0	0	0
Laundry Manager 1	0	1	0	0	0	0	1	0
Laundry Worker 1	2	3	0	0	0	0	5	0

TITLE	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Legal Assistant	0	1	0	0	0	0	1	0
Licensed Practical Nurse 1	1	6	0	0	0	0	7	0
Licensed Practical Nurse 2	3	60	0	12	0	0	51	0
Licensed Practical Nurse 3	2	34	0	8	0	0	28	0
Locksmith	1	0	0	0	0	0	1	0
Maintenance Carpenter 1	3	0	0	0	0	0	3	0
Maintenance Carpenter 2	3	0	0	0	0	0	3	0
Maintenance Electrician 1	1	0	0	0	0	0	1	0
Maintenance Electrician 2	2	0	0	0	0	0	2	0
Maintenance Mechanic 2	2	0	0	0	0	0	2	0
Maintenance Mechanic 3	2	0	0	1	0	0	1	0
Maintenance Painter 1	2	0	0	0	0	0	2	0
Maintenance Painter 2	2	0	0	1	0	0	1	0
Maintenance Plumber 1	2	0	0	0	0	0	2	0
Maintenance Plumber 2	3	0	0	1	0	0	2	0
Medical Records Assistant	0	1	0	0	0	0	1	0
Medical Technologist 1	0	1	0	0	0	0	1	0
Medical Technologist 2	0	3	0	0	0	0	3	0
Medical Transcriber 1	0	1	0	0	0	0	1	0
Medical Transcriber 2	0	1	0	0	0	0	1	0
Mental Health/Mental Retardation Institutional Program Coordinator	1	2	1	1	0	0	1	0
Mental Health/Mental Retardation Institutional Program Director	8	20	0	11	0	0	17	0
Mental Health/Mental Retardation Investigator	25	26	0	13	0	0	37	1
Mental Health/Mental Retardation Nursing Consultant	0	1	0	0	0	0	1	0
Mental Health/Mental Retardation Planner	0	1	0	0	0	0	1	0
Mental Health/Mental Retardation Program Director	8	15	0	3	0	0	20	0
Mental Health/Mental Retardation Standards Coordinator	0	2	0	1	0	0	1	0
Mental Retardation Administrator	1	2	0	0	0	0	3	0

TITLE	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Mental Retardation Program Specialist 2	11	50	0	29	0	0	31	1
Mental Retardation Program Specialist 3	30	63	0	25	0	0	67	1
Mental Retardation Quality Assurance & Improvement Administrator	0	2	0	0	0	0	2	0
Mental Retardation Teacher Supervisor	0	1	0	0	0	0	1	0
Music Therapist 1	2	0	0	0	0	0	1	1
Nurse Practitioner	0	4	0	1	0	0	3	0
Occupational Therapist	0	15	1	1	1	1	10	1
Occupational Therapy Assistant (Certified)	2	16	0	3	0	1	14	0
Occupational Therapy Director	0	4	0	0	0	0	4	0
Occupational Therapy Technician	1	6	0	2	0	0	5	0
Patient Accounts Specialist 2	0	1	0	0	0	0	1	0
Patient Accounts Specialist 3	0	1	0	0	0	0	1	0
Pharmacist 1	0	3	0	0	0	0	3	0
Pharmacist 2	2	1	0	0	0	0	3	0
Pharmacy Technician	1	6	0	1	0	0	6	0
Physical Therapist	5	9	4	1	0	0	9	0
Physical Therapy Assistant-Certified	5	14	0	1	0	0	18	0
Physical Therapy Director	2	1	0	0	0	0	3	0
Physical Therapy Technician	2	11	0	0	0	0	13	0
Physician	3	2	3	0	0	0	2	0
Physician- Developmental Center Medical Director	3	0	1	0	0	0	2	0
Physician- Internal Medicine	1	0	1	0	0	0	0	0
Physician- Psychiatrist	1	1	1	0	0	0	1	0
Physician- Specialty	4	2	1	1	0	0	3	1
Procurement Officer 1	1	3	0	2	0	0	2	0
Procurement Officer 2	1	1	0	0	0	0	2	0
Program Monitor 2	0	1	0	0	0	0	1	0
Program Monitor 3	0	1	0	0	0	0	1	0

TITLE	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Program Monitor 4	0	1	0	0	0	0	1	0
Programmer/Analyst 3	1	0	0	1	0	0	0	0
Programmer/Analyst 4	2	1	0	1	0	0	2	0
Programmer/Analyst Supervisor	1	0	0	0	0	0	1	0
Property Officer 1	1	1	0	1	0	0	1	0
Psychiatric Chaplain 2	0	1	0	0	0	0	1	0
Psychiatric Social Worker 2	0	1	0	0	0	0	1	0
Psychological Examiner 1	1	1	0	0	0	0	2	0
Psychological Examiner 2	6	9	0	0	0	0	15	0
Psychologist	1	1	0	0	0	0	2	0
Psychology Director	1	4	0	0	0	0	5	0
Recreation Therapist 1	3	5	0	5	0	0	3	0
Recreation Therapist 2	2	1	0	1	0	0	2	0
Recreation Therapy Technician	2	12	0	1	0	0	13	0
Registered Nurse 1	0	2	0	1	0	0	1	0
Registered Nurse 2	0	12	1	0	0	0	11	0
Registered Nurse 3	4	53	18	10	0	0	29	0
Registered Nurse 4	2	46	1	8	1	1	37	0
Registered Nurse 5	2	3	1	1	0	0	3	0
Rehabilitation Technology Specialist	1	0	0	0	0	0	1	0
Residential Program Specialist	19	72	0	35	0	0	55	1
Respiratory Care Technician-Certified	7	10	0	6	1	0	10	0
Respiratory Care Therapist	3	4	0	1	0	0	6	0
Respiratory Care Therapy Director	1	1	0	0	0	0	2	0
Secretary	1	69	0	8	1	0	61	0
Security Chief	2	0	0	0	0	0	2	0
Security Guard 1	13	3	1	4	1	0	10	0
Security Guard 2	3	0	0	3	0	0	0	0
Social Counselor 2	2	1	0	0	0	0	3	0
Social Services Specialist 2	0	3	0	3	0	0	0	0
Speech and Language Pathologist	2	21	0	2	0	0	21	0
Speech and Language Pathology Director	0	2	0	0	0	0	2	0

TITLE	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Storekeeper 1	4	1	0	1	0	0	4	0
Storekeeper 2	2	2	0	2	0	0	2	0
Stores Clerk	2	0	0	0	0	0	2	0
Telephone Operator 1	0	8	0	3	0	0	5	0
Telephone Operator 2	0	2	0	0	0	0	2	0
Telephone Operations Supervisor	0	1	0	0	0	0	1	0
Therapeutic Equipment Worker	17	1	0	1	0	0	17	0
Training Officer 1	0	1	0	1	0	0	0	0
Training Officer 2	0	4	0	1	0	0	3	0
Training Specialist 2	0	1	0	0	0	0	1	0
Vehicle Operator	16	6	0	7	0	0	15	0
Website Developer 2	1	0	0	0	0	0	1	0
X-Ray Technician 2	0	1	0	0	0	0	1	0
X-Ray Technician 3	0	1	0	0	0	0	1	0
<b>Total</b>	793	2,185	48	892	11	8	1,999	20

### Contract Information

The division does not collect data on the ethnicities of contractors. According to the Title VI Coordinator, the number of subrecipient service providers makes it difficult to maintain and track demographic information for contractors. (The plan states that, as of June 30, 2009, the division had “490 DIDS contract agencies providing home and community-based services.”) Moreover, contracts are, according to division staff, awarded to the entities that are qualified to act as service providers and willing to go through the provider agreement process.

The division also provides support to the Council on Developmental Disabilities, which is an independent office established through federal legislation. The council works for public policies and service systems that promote the inclusion of Tennesseans with disabilities in their communities. The council is only administratively attached to the division; it is monitored by the federal Administration on Developmental Disabilities. According to the council’s Executive Director, as of April 8, 2010, the council had 20 members appointed by the Governor—4 African Americans and 16 Caucasians. There are also 13 *ex officio* members of the council from advocacy groups and state government—one African American, one Hispanic, and 11 Caucasians.

**Performance Measures Information**

As stated in the Tennessee Governmental Accountability Act of 2002, “accountability in program performance is vital to effective and efficient delivery of governmental services, and to maintain public confidence and trust in government.” In accordance with this act, all executive branch agencies are required to submit annually to the Department of Finance and Administration a strategic plan and program performance measures. The department publishes the resulting information in two volumes of *Agency Strategic Plans: Volume 1 – Five Year Strategic Plans* and *Volume 2 – Program Performance Measures*. Agencies were required to begin submitting performance-based budget requests according to a schedule developed by the department, beginning with three agencies in fiscal year 2005, with all executive-branch agencies included no later than fiscal year 2012. The Department of Finance and Administration began submitting performance-based budget requests effective for fiscal year 2009.

Detailed below are the Department of Finance and Administration’s performance standards and performance measures for the Division of Intellectual Disabilities Services, as reported in the September 2010 *Volume 2 – Program Performance Measures*. We gathered information from the department about how it collects and verifies the data in the measures, and its methods appear appropriate.

**Performance Standards and Measures**

**Performance Standard-Intellectual Disabilities Services Administration**

Performance Standard 1 – Administrative costs to total services costs will not exceed 2.00%

Performance Measures 1 – Percent of administrative costs to total service costs.

Actual (FY 2009-2010)	Estimate (FY 2010-2011)	Target (FY 2011-2012)
1.50%	2.00%	2.00%

**Performance Standard-Developmental Disabilities Council**

Performance Standard 1 – Utilize council federal funding to support priority areas: education, housing, employment, childcare, community supports, quality assurance, health, and transportation.

Performance Measure 1 – Percent of actual federal expenditures spent to support federal priority areas.

Actual (FY 2009-2010)	Estimate (FY 2010-2011)	Target (FY 2011-2012)
75%	80%	72%

Performance Standard 2 – Develop and enhance leadership and self advocacy skills of Tennesseans with disabilities and their families to direct the supports they receive.

Performance Measure 2 – Number of individuals trained, educated, and informed through the council’s Leadership Institute, educational publications and information/referral service.

Actual (FY 2009-2010)	Estimate (FY 2010-2011)	Target (FY 2011-2012)
12,775	29,000	13,461

**Performance Standard-Community Intellectual Disabilities Services**

Performance Standard 1 – Provide medically necessary services to individuals in the Home and Community Based Services waivers.

Performance Measure 1 – Number of individuals served in the community.

Actual (FY 2009-2010)	Estimate (FY 2010-2011)	Target (FY 2011-2012)
7,580	7,838	7,821

**Performance Standard-Quality Assurance Program**

Performance Standard 1 – Resolve and close complaint cases within 30 days of receipt.

Performance Measure 1 – Percent of complaints cases resolved and closed within 30 days of receipt.

Actual (FY 2009-2010)	Estimate (FY 2010-2011)	Target (FY 2011-2012)
100%	99%	99%

Performance Standard 2 – Increase the number of investigations closed within 30 days.

Performance Measure 2 – Percent of investigations closed within 30 days.

Actual (FY 2009-2010)	Estimate (FY 2010-2011)	Target (FY 2011-2012)
94%	98%	98%

**Performance Standard-West, Middle, and East Tennessee Regional Offices**

Performance Standard 1 – Maximize percentage of waiver participants surveyed who have had an annual re-evaluation completed within 12 months of their initial evaluation or last annual re-evaluation.

Performance Measure 1 – Percent of waiver participants surveyed who had an annual re-evaluation completed within 12 months of their initial evaluation or last annual re-evaluation.

	Actual (FY 2009-2010)	Estimate (FY 2010-2011)	Target (FY 2011-2012)
West Tennessee Regional Office	100%	100%	100%
Middle Tennessee Regional Office	100%	100%	100%
East Tennessee Regional Office	100%	100%	100%

**Performance Standard-West Tennessee Resource Center**

Performance Standard 1 – Provide clinical and medical services through the West Tennessee Resource Center.

Performance Measure 1 – Number of individuals receiving services at the West Tennessee Resource Center.

Actual (FY 2009-2010)	Estimate (FY 2010-2011)	Target (FY 2011-2012)
173	225	225

Performance Standard 1 – Reduce serious injuries to consumers each year.

Performance Measure 1 – The number of serious injuries to consumers.

	Actual (FY 2009-2010)	Estimate (FY 2010-2011)	Target (FY 2011-2012)
West Tennessee Community Homes	0	5	5
East Tennessee Community Homes	Not Applicable	8	8

**Performance Standard-Developmental Centers**

Performance Standard 1 – Reduce serious injuries to consumers each year.

Performance Measure 1 – The number of serious injuries to consumers.

	Actual (FY 2009-2010)	Estimate (FY 2010-2011)	Target (FY 2011-2012)
Arlington Developmental Center	4	0	Not Applicable
Clover Bottom Developmental Center	37	14	25
Greene Valley Developmental Center	48	41	46
Harold Jordon Center	738	730	720

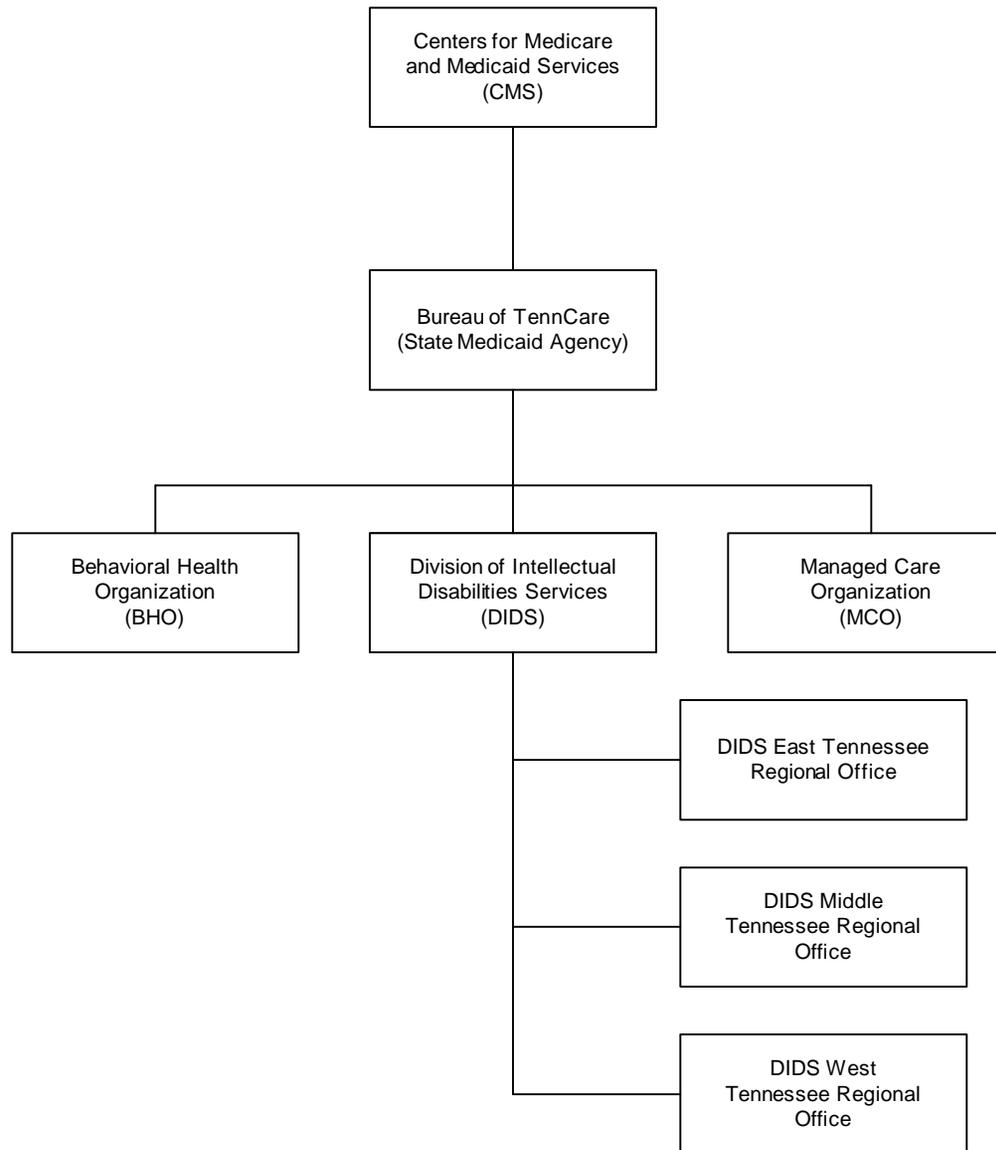
**Performance Standard-Major Maintenance**

Performance Standard 1 – Reduce percentage of major maintenance funds disbursed for emergency maintenance of the facilities each year.

Performance Measure 1 – Percent of funds disbursed for emergency maintenance.

Actual (FY 2009-2010)	Estimate (FY 2010-2011)	Target (FY 2011-2012)
80%	70%	75%

Division of Intellectual Disabilities Services Appendix 1  
Relationship of CMS,  
TennCare, and DIDS



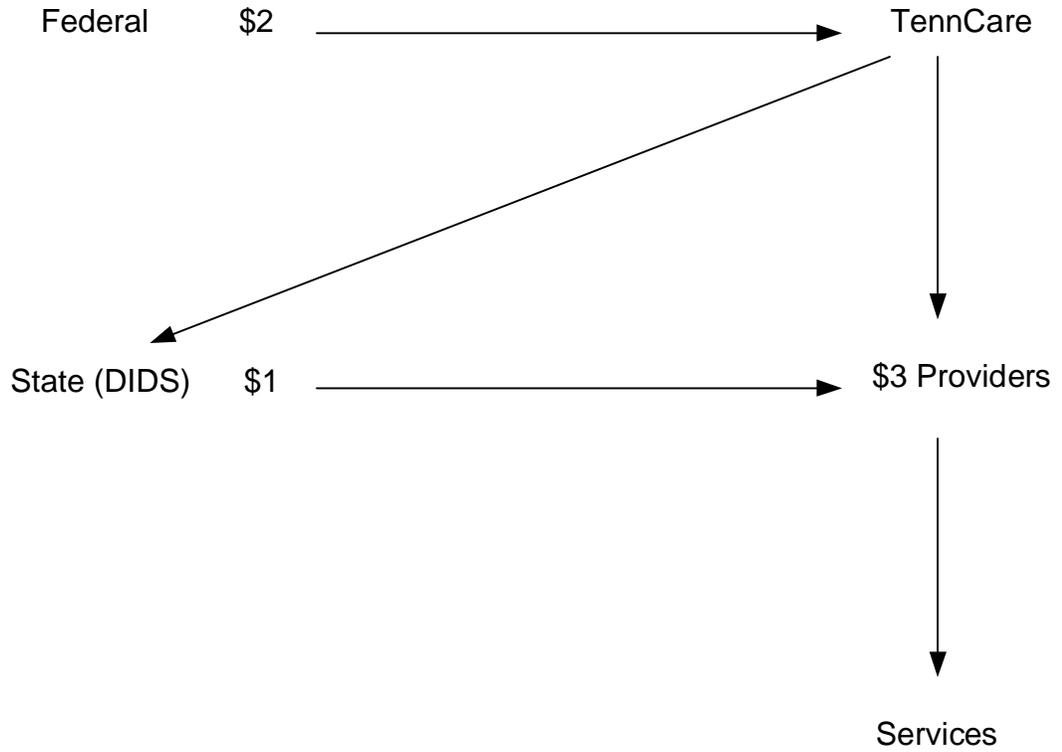
**Division of Intellectual Disabilities Services Appendix 2**  
**Flow of Federal Funds to the Division of Intellectual Disabilities Services (DIDS)**

Medicaid funds Home and Community-Based Services (HCBS) Waivers in Tennessee. These are long-term care programs that serve or support individuals at home and in their communities. An HCBS waiver program is called a waiver because it sets aside certain requirements of the Intermediate Care Facility for the Mentally Retarded (ICF/MR) program so that individuals can live in community settings rather than in developmental centers or other ICFs/MR. The Division of Intellectual Disabilities Services administers HCBS waivers for TennCare. The state has to apply to the federal government for permission to have HCBS waivers.

There are two primary funding sources for services administered by the Division of Intellectual Disabilities Services. The State of Tennessee and the federal Medicaid Program. Some services are funded on an annual basis by the state legislature. The primary source of funding for DIDS services, however, comes from Medicaid. State dollars allotted to Medicaid are matched approximately 2:1 by federal Medicaid dollars. The state matching money is appropriated by the Tennessee General Assembly. See the following chart on the flow of federal funds.

Division of Intellectual Disabilities Services Appendix 2  
Flow of Federal Funds to the  
Division of Intellectual Disabilities  
Services (DIDS)

Waiver Services



State Funded  
Services



**Division of Intellectual Disabilities Services Appendix 3**  
**Family Support 2009**  
**Number of Families Served by County and the Average Amount Received**

<b>County</b>	<b>Families Served in 2009</b>	<b>Average Cost of Direct Aid</b>	<b>Families on the Waiting List</b>	<b>Total Funding</b>
Anderson	34	\$1,967.57	72	\$66,897.38
Bedford	28	\$1,297.72	47	\$36,336.16
Benton	16	\$1,264.38	20	\$20,230.08
Bledsoe	18	\$1,123.89	22	\$20,230.02
Blount	66	\$1,504.30	122	\$99,283.80
Bradley	51	\$1,639.22	85	\$83,600.22
Campbell	19	\$1,946.09	27	\$36,975.71
Cannon	19	\$1,058.16	23	\$20,105.04
Carroll	30	\$933.73	28	\$28,011.90
Carter	30	\$1,739.80	64	\$52,194.00
Cheatham	40	\$873.69	0	\$34,947.60
Chester	19	\$1,064.74	14	\$20,230.06
Claiborne	12	\$2,365.00	36	\$28,380.00
Clay	27	\$725.96	49	\$19,600.92
Cocke	22	\$1,399.82	16	\$30,796.04
Coffee	35	\$1,303.74	7	\$45,630.90
Crockett	16	\$1,264.38	24	\$20,230.08
Cumberland	51	\$868.92	76	\$44,314.92
Davidson	362	\$1,496.17	1,810	\$541,613.54
Decatur	16	\$1,264.38	11	\$20,230.08
DeKalb	21	\$1,060.32	13	\$22,266.72
Dickson	73	\$607.07	0	\$44,316.11
Dyer	26	\$1,363.04	14	\$35,439.04
Fayette	11	\$2,488.80	50	\$27,376.80
Fentress	29	\$695.38	33	\$20,166.02
Franklin	20	\$1,437.30	3	\$28,746.00
Gibson	36	\$1,271.19	40	\$45,762.84
Giles	13	\$2,395.25	27	\$31,138.25
Grainger	9	\$2,247.78	19	\$20,230.02
Greene	23	\$2,599.43	37	\$59,786.89
Grundy	15	\$1,348.67	24	\$20,230.05
Hamblen	23	\$2,401.91	38	\$55,243.93
Hamilton	194	\$1,508.34	194	\$292,617.96
Hancock	8	\$2,216.25	13	\$17,730.00
Hardeman	26	\$1,027.31	9	\$26,710.06
Hardin	26	\$934.96	13	\$24,308.96
Hawkins	27	\$1,872.67	39	\$50,562.09
Haywood	27	\$749.26	17	\$20,230.02
Henderson	27	\$898.37	19	\$24,255.99
Henry	15	\$1,971.40	6	\$29,571.00
Hickman	11	\$2,234.00	14	\$24,574.00
Houston	26	\$639.63	0	\$16,630.38
Humphreys	29	\$688.91	0	\$19,978.39
Jackson	27	\$747.63	65	\$20,186.01

<b>County</b>	<b>Families Served in 2009</b>	<b>Average Cost of Direct Aid</b>	<b>Families on the Waiting List</b>	<b>Total Funding</b>
Jefferson	24	\$1,631.35	19	\$39,152.40
Johnson	9	\$2,344.31	23	\$21,098.79
Knox	174	\$2,086.64	212	\$363,075.36
Lake	16	\$1,264.38	2	\$20,230.08
Lauderdale	31	\$830.84	10	\$25,756.04
Lawrence	20	\$1,689.16	66	\$33,783.20
Lewis	8	\$2,153.55	10	\$17,228.40
Lincoln	32	\$1,152.75	29	\$36,888.00
Loudon	17	\$1,972.36	21	\$33,530.12
Macon	22	\$898.14	33	\$19,759.08
Madison	115	\$758.96	43	\$87,280.40
Marion	19	\$1,389.35	45	\$26,397.65
Marshall	21	\$1,211.36	3	\$25,438.56
Maury	18	\$3,779.45	42	\$68,030.10
McMinn	27	\$1,725.28	45	\$46,582.56
McNairy	21	\$1,115.71	11	\$23,429.91
Meigs	16	\$1,264.38	31	\$20,230.08
Monroe	21	\$1,763.22	42	\$37,027.62
Montgomery	79	\$1,632.99	124	\$129,006.21
Moore	14	\$1,506.24	1	\$21,087.36
Morgan	12	\$1,526.25	11	\$18,315.00
Obion	24	\$1,285.00	8	\$30,840.00
Overton	38	\$531.76	69	\$20,206.88
Perry	6	\$3,369.12	13	\$20,214.72
Pickett	22	\$923.50	21	\$20,317.00
Polk	15	\$1,348.67	26	\$20,230.05
Putnam	96	\$607.27	130	\$58,297.92
Rhea	15	\$1,799.39	39	\$26,990.85
Roane	21	\$2,298.82	23	\$48,275.22
Robertson	62	\$834.38	3	\$51,731.56
Rutherford	168	\$1,029.70	42	\$172,989.60
Scott	12	\$1,652.50	56	\$19,830.00
Sequatchie	13	\$1,556.15	20	\$20,229.95
Sevier	23	\$2,912.53	37	\$66,988.19
Shelby	362	\$2,356.18	997	\$852,937.16
Smith	20	\$1,000.75	10	\$20,015.00
Stewart	13	\$1,556.15	14	\$20,229.95
Sullivan	63	\$2,371.00	87	\$149,373.00
Sumner	151	\$821.03	24	\$123,975.53
Tipton	34	\$1,433.15	8	\$48,727.10
Trousdale	22	\$919.55	0	\$20,230.10
Unicoi	10	\$1,915.30	16	\$19,153.00
Union	7	\$2,890.00	13	\$20,230.00
Van Buren	18	\$1,116.56	28	\$20,098.08
Warren	58	\$673.34	124	\$39,053.72
Washington	58	\$1,772.25	109	\$102,790.50
Wayne	10	\$1,889.03	21	\$18,890.30
Weakley	26	\$1,275.50	4	\$33,163.00

<b>County</b>	<b>Families Served in 2009</b>	<b>Average Cost of Direct Aid</b>	<b>Families on the Waiting List</b>	<b>Total Funding</b>
White	36	\$605.50	71	\$21,798.00
Williamson	125	\$996.03	240	\$124,503.75
Wilson	94	\$877.40	47	\$82,475.60
Total	3,991		6,363	\$5,656,008.63

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## RECOMMENDATIONS

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### ADMINISTRATIVE

The Department of Finance and Administration should address the following areas to improve the efficiency and effectiveness of its operations.

#### Divisions of Finance and Administration

1. The commissioner should promptly initiate steps to develop formal policies and procedures that clearly state which division(s) are responsible for preparing the disaster recovery plan and business continuity plan for each division within the department.
2. In the future, the department should adhere to all contractual responsibilities with health insurance carriers. If contract requirements are deemed to be unnecessary, the department should amend the contract to address this change.

#### Office for Information Resources

3. The Chief Information Officer (CIO) over the Office for Information Resources should ensure that these conditions are remedied by the prompt development and implementation of effective controls (standards and procedures) to ensure compliance with stated policy. The CIO should ensure that risks associated with this finding are adequately identified and assessed in OIR's documented risk assessment. The CIO should implement effective controls to ensure compliance with applicable requirements, assign staff to be responsible for ongoing monitoring of the risks and mitigating controls, and take action if deficiencies occur. The CIO should also take all other steps available to establish or improve any compensating controls until these conditions are remedied.
4. The Chief Information Officer should ensure that OIR properly designates all projects under the appropriate procurement rules. The Chief Information Officer should review and evaluate OIR's procurement policies and practices to ensure that project purchasing decisions incorporate the expertise of OIR procurement officials working in conjunction with officials from the Department of General Services' Purchasing Division and Finance and Administration's Office of Contracts Review.
5. The General Assembly passed legislation in 2010 to combine the procurement regulatory authority between the Department of Finance and Administration and the Department of General Services into a new Procurement Commission. We recommend that any new or existing entity charged with procurement regulatory

- authority for the state consider the risks associated with the procurement of personal, professional, and consulting services under the current rules of the Department of General Services, in the development and promulgation of any new rules, particularly those risks noted in this report.
6. OIR's Chief Information Security Officer (CISO) should ensure that state agency IT officials adequately and promptly correct information system security risks. The CISO should ensure that these conditions are remedied by the prompt development and implementation of effective controls (standards and procedures) to ensure compliance with stated policy. The CISO should ensure that risks associated with this finding are adequately identified and assessed in OIR's documented risk assessment. The CISO should implement effective controls to ensure compliance with applicable requirements, assign staff to be responsible for ongoing monitoring of the risks and mitigating controls, and take action if deficiencies occur. The CISO should also take all other steps available to establish or improve any compensating controls until these conditions are remedied.
  7. OIR's Chief Information Officer should also provide the Information Systems Council with periodic updates regarding information security risks and the status of OIR and agency remediation efforts.
  8. Upper management of the Office for Information Resources, in consultation with the financial manager, should continue their efforts to formalize the rate setting process by adequately documenting its cost model and rate reviews, rate analysis, and review and approval of rates by upper management.
  9. As staff to the Information Systems Council, OIR management in consultation with ISC members should establish written guidelines for the review of ISC policies. These guidelines should both address the timeliness of review and establish a process for assessing compliance with the policy, policy objectives, and implementation requirements.
  10. OIR management should also draft written guidelines (in consultation with the ISC) for defining major information systems projects for the purpose of reporting to the ISC, taking into account factors such as the complexity of each project, total funding, project size, and risks to the state.

#### Bureau of TennCare

11. The Director of Managed Care Operations and the Chief Financial Officer should work together to develop policies and procedures to adequately monitor the Managed Care Contractors' compliance with contract requirements as they relate to properly assessing, collecting, and recording liquidated damages. In addition, the Chief Financial Officer should evaluate the newly implemented internal controls within Fiscal Services to ensure all liquidated damages are being received and processed

from the Office of Contract Compliance and Performance. He should continually evaluate these controls to ensure they are working effectively and efficiently. Finally, TennCare management and its Office of General Counsel should improve the process for ensuring that contract terms are consistent with requirements set forth by external entities such as the federal courts.

12. The Deputy Commissioner should ensure the provider database in interChange is purged of all non-active provider files. This would include reconciling files with missing or fragmented documentation; eliminating system-generated reporting; replacing documentation for missing files; and developing a uniform and reliable numbering and filing system. For any provider contained in interChange who does not have a file on site, the Deputy Commissioner should insist these providers reenroll. TennCare should also develop policies and procedures detailing processing times and instituting a periodic reenrollment process similar to what the MCCs have in place.
13. TennCare should consider adopting a web-based application and enrollment system, one that could better track the application process, monitor processing lengths, keep track of required documentation, and ensure consistency for all providers during the enrollment and application process.

## **LEGISLATIVE**

This performance audit identified areas in which the General Assembly may wish to consider statutory changes to improve the efficiency and effectiveness of the Department of Finance and Administration's operations.

### Divisions of Finance and Administration

1. The General Assembly may wish to consider adding language to each direct appropriation regarding the intended purpose of that appropriation, including clearly expected outcomes that are measurable. The General Assembly may also wish to add language to each appropriations act outlining when a state pass-through agency should perform on-site monitoring of grantees to ensure the grantees make efficient and effective use of direct appropriations and to avoid the appearance of open-ended grants of funds with little oversight or accountability. Criteria on whether such monitoring should be performed should take into consideration such factors as the amount of the direct appropriation and whether the direct appropriation has been granted to the same grantee for multiple years.
2. The General Assembly may wish to consider directing the Department of Finance and Administration, in consultation with state pass-through agencies, to develop and implement requirements (e.g., audited financial statements or other types of accounting measures) for on-site monitoring by these agencies of direct

appropriations grantees to ensure the grantees are make efficient and effective use of direct appropriations. Monitoring should take into consideration whether each direct appropriation was used by the grantee in a manner that met the General Assembly's intent for this appropriation.

3. The General Assembly may wish to consider requiring the state pass-through agencies report to the General Assembly and the general public the results of their monitoring of direct appropriations recipients. The General Assembly may wish to use these results in making decisions about future direct appropriations, including making improvements in monitoring requirements for the state pass-through agencies.

#### Office for Information Resources

4. The General Assembly may wish to consider revising Section 12-4-109(a)(1)(G), *Tennessee Code Annotated*, [Transferred to §4-56-106 effective October 1, 2011.] to ensure that the Fiscal Review Committee receives notification of procurement of all non-competitive personal, professional, and consulting services regardless of whether the services were purchased through a personal, professional, and consulting services contract or an existing General Services contract. If the General Assembly's intent is to house all procurement regulatory authority for the state within the new Procurement Commission, we recommend that Section 4-3-5504, *Tennessee Code Annotated*, pertaining to the legislative intent of ISC policymaking authority over telecommunications, computer, or computer-related equipment or services, be reviewed to determine its relevance. At a minimum, OIR management, as staff to the ISC, should assist the ISC in drafting procurement policy to comply with the legislative intent of Section 4-3-5504.

## Appendix

### Objectives of the Audit of the Department of Finance and Administration

#### The objectives for the audit of the Divisions of Finance and Administration were to

1. determine whether the Division of Benefits Administration has an adequate system for screening individuals and their dependents for eligibility for insurance benefit programs and whether it has adequate systems for measuring client satisfaction and handling complaints;
2. determine whether the department has developed an efficient and effective capital budget process;
3. determine the status of implementing performance-based budgeting;
4. determine whether the department's efforts to reduce the amount of deferred maintenance are efficient and effective;
5. determine whether the department adequately manages the disposal/sale of state real estate declared surplus to maximize revenue;
6. determine whether the department takes adequate measures to ensure that leases are renewed on time and holdovers (especially costly holdovers) are kept to a minimum, and whether the division ensures the proper allocation of leasing costs when billing agencies;
7. determine whether there are adequate controls over direct appropriations from the General Assembly and the department's role (and that of any other agency) in monitoring the controls;
8. review the use of a contractor for determining eligibility for Cover Kids, determine the adequacy of client satisfaction procedures for CoverTN, and determine the long-term financial stability of AccessTN;
9. determine the responsibilities of the Office of Inspector General for investigating fraud in the TennCare and Cover Tennessee programs and any barriers to meeting those responsibilities;
10. determine the division's compliance with state law requiring a State Health Plan which shall guide the state in the development of health care programs and policies and in the allocation of health care resources in the state;
11. determine the current status of the e-Health Initiative, including the development and implementation of any plans, acceptance of electronic prescriptions and patient records by providers, concerns providers have about relevant training, technology issues (including privacy concerns), and other possible obstacles to implementation;
12. determine the role of the Office of Shared Technology Services in assisting with the department's disaster recovery plan; and

13. determine the Office of Shared Service Solutions' services, utilization, and client satisfaction measures.

**The objectives for the audit of the Office for Information Resources (OIR) were to**

1. determine the adequacy of the disaster recovery guidance provided by OIR, whether adequate resources have been assigned by OIR to assist agencies in disaster recovery planning, and whether state agencies with applications hosted at the State Data Center sufficiently understand what is necessary for successful restoration of agency applications;
2. determine whether OIR billing rates for services and equipment supplied to state agencies are reasonable and justifiable and whether it has adequate systems to prevent and correct billing errors;
3. review the information technology (IT) contract and project management process and identify any weaknesses and improvements needed in the process, particularly with time and cost management;
4. assess OIR's efforts to maintain security for the state's information resources;
5. determine the responsibilities of OIR and the Information Systems Council for project planning and development and assess whether these responsibilities are being fulfilled;
6. determine OIR's compliance with the Information Systems Council policy on open access to electronic information; and
7. determine the status of the new state data center and the continued use of the existing data center.

**The objectives for the audit of the Bureau of TennCare were to**

1. review and assess TennCare's processes for monitoring compliance of Managed Care Organizations (MCOs) with contract requirements;
2. review and assess TennCare's effort to ensure its MCOs are offering quality healthcare to enrollees;
3. review and assess the efficiency of the credentialing process for TennCare providers;
4. assess the pharmacy program's systems for measuring effectiveness of services and the controls in place to maintain acceptable levels of care while also preventing fraud and abuse of medications;

5. assess the adequacy of TennCare resources to monitor the Pharmacy Benefits Manager (PBM) contract and the adequacy of the PBM's system to process claims timely and efficiently;
6. review TennCare's disease management program and assess TennCare's efforts to monitor the MCOs' provision of disease management services;
7. review the process for denying services and tracking MCOs' denial of services;
8. assess compliance with provider network requirements and completeness and accuracy of provider and enrollee files, and to examine pharmacy claims to identify any trends that may indicate problems;
9. review the process for promulgating public necessity rules and determine whether TennCare has used the process appropriately.
10. review Long Term Care staff's monitoring plans for the CHOICES program, both prior to and after implementation;
11. summarize the CHOICES program's "single point of entry" system, focusing on how it will assist applicants and their families and efforts to ensure a continuum of care; and
12. review Long Term Care staff's actions to assess the adequacy of services available under the CHOICES program, in order to reduce the need for more expensive services;

**The objectives for the audit of the Division of Intellectual Disabilities Services were to**

1. assess the division's ability to address the needs of the people on its waiting list for community services;
2. determine the status of the Settlement Agreement for Arlington Developmental Center;
3. determine the adequacy of services available in the community for those residents who are transitioned out of the developmental centers; and
4. determine the impact on the division of proposed budget reductions and funding received through the American Recovery and Reinvestment Act.