



STATE OF TENNESSEE COMPTROLLER OF THE TREASURY

Department of Intellectual and Developmental Disabilities

Performance Audit Report

April 2013

Justin P. Wilson
Comptroller of the Treasury



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April 9, 2013

The Honorable Bill Haslam, Governor
State Capitol
Nashville, Tennessee 37243
and

The Honorable James M. Henry, Commissioner
Department of Intellectual and Developmental Disabilities
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Ladies and Gentlemen:

We have conducted a performance audit of selected programs and activities of the Department of Intellectual and Developmental Disabilities for the period January 15, 2011, through July 17, 2012.

Our audit disclosed certain findings which are detailed in the Objectives, Methodologies, and Conclusions section of this report. Management of the Department of Intellectual and Developmental Disabilities has responded to the audit findings; we have included the responses following each finding. We will follow up the audit to examine the application of the procedures instituted because of the audit findings.

We have reported other less significant matters involving internal control and instances of noncompliance to the Department of Intellectual and Developmental Disabilities' management in a separate letter.

Sincerely,

Deborah V. Loveless, CPA
Director

DVL/sah
12/074

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit

Department of Intellectual and Developmental Disabilities

April 2013

AUDIT SCOPE

We have audited the Department of Intellectual and Developmental Disabilities for the period January 15, 2011, through July 17, 2012. Our audit scope included a review of internal control and compliance with laws, regulations, and provisions of contracts or grant agreements in the areas of provider monitoring, the Community Services Tracking system, Clover Bottom Developmental Center and Harold Jordan Center operations, Greene Valley Developmental Center and East Tennessee community homes operations, telephone billing, risk assessment, Medicaid cost reports, the Investigations Unit, and access to computer applications.

We conducted our 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. Management of the Department of Intellectual and Developmental Disabilities is responsible for establishing and maintaining effective internal control and for complying with applicable laws, regulations, and provisions of contracts and grant agreements.

AUDIT FINDINGS

Improvements to the Department's Monitoring Process and Updates to the Provider Manual Are Still Needed and Could Further Reduce Management's Risk of Errors, Fraud, Waste, and Abuse*

Our review of the department's monitoring processes again found areas where improvements are needed in the monitors'

methodologies and in the *Provider Manual* (page 8).

As Noted in the Prior Two Audits, the Department's Controls Over the Community Services Tracking System Are Inadequate, Resulting in \$21,234.50 in Provider Overpayments and

Increasing Opportunities for Fraudulent Transactions**

As noted in the prior two audits, security and internal controls over the Community Services Tracking System were inadequate. We found provider overpayments totaling \$223.25, and the department's internal review disclosed an additional \$21,011.25 in provider overpayments (page 16).

Internal Controls Over Individual Residents' Trust Funds and Personal Inventory Items at Clover Bottom Developmental Center and Harold Jordan Center Were Still Inadequate, Increasing the Risk for Fraud, Waste, or Abuse**

As noted in prior audits that date back to 2003, employees did not always follow established procedures for unspent funds remaining from purchases made on behalf of individuals residing in the centers. Additionally, individuals' personal inventory items were not always accounted for properly (page 23).

Controls Over Individual Residents' Trust Funds at Greene Valley Developmental Center and East Tennessee Community Homes Were Inadequate, Increasing the Risk for Misuse or Loss*

As noted in the prior audit, management and staff did not always adequately safeguard individual residents' money at the developmental center. In addition, Community Home Supervisors did not retain the Safe Logs at the East Tennessee community homes (page 30).

Management Has Not Mitigated the Risks Associated With Inadequate Controls Over the Greene Valley Developmental Center Pharmacy and Supply Inventories, Increasing the Likelihood of Asset Misappropriation or Loss

Pharmacy and supply inventory physical counts differed from inventory listings, and supply inventory duties were inadequately segregated (page 34).

Management Failed to Establish Controls Governing the Preparation of Developmental Center Cost Reports, Increasing the Risk That the Department May Receive Improper Medicaid Reimbursements From the TennCare Program

Management of the department did not implement adequate controls over its process for preparation of the developmental center cost reports, which are used to request Medicaid reimbursement from the Bureau of TennCare. As a result, the department may have received more or less Medicaid reimbursement funds than it was entitled to receive. The central office expenditures portion of the Clover Bottom Developmental Center's and Greene Valley Developmental Center's fiscal year 2010 and 2011 Medicaid cost reports was not adequately supported (page 42).

The Department Did Not Follow Information Systems' Industry Best Practices Regarding Computer Access, Resulting in the Increased Risk of Fraudulent Activity or Loss of Data

Based on our computer access testwork, the department did not follow information systems' industry best practices regarding user access (page 49).

*This finding is repeated from the prior audit.

** This finding is repeated from prior audits.

Performance Audit
Department of Intellectual and Developmental Disabilities

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Performance Audit

Department of Intellectual and Developmental Disabilities

INTRODUCTION

POST-AUDIT AUTHORITY

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

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

BACKGROUND

The Department of Intellectual and Developmental Disabilities (DIDD) is responsible for administering services and support to Tennesseans with intellectual and developmental disabilities. DIDD’s mission is to provide leadership in the development and maintenance of a service delivery system that offers a continuum of services and support so that persons with intellectual and developmental disabilities will be gainfully employed to their maximum ability, live in quality homes, develop meaningful relationships, and be a part of the community in which they live.

On January 15, 2011, the Tennessee General Assembly, through Section 4-3-2701(a), *Tennessee Code Annotated*, established DIDD as a stand-alone department. The department was previously known as the Division of Intellectual Disabilities Services and was part of the Department of Finance and Administration. The division’s transition to an independent department is described in Section 4-3-2705, *Tennessee Code Annotated*, which 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.

DIDD provides services directly or through contracts with community providers in a variety of settings, ranging from institutional care to individual supported living in the community. The department provides long-term care at two developmental centers, Clover Bottom Developmental Center in Nashville and Greene Valley Developmental Center in Greeneville, which are licensed Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID). The Clover Bottom campus also includes the Harold Jordan Center, which houses individuals with intellectual disabilities who have been charged with a crime. A third developmental center in Arlington was closed on October 27, 2010. The most medically fragile individuals were transitioned from that center to state-operated ICF/ID homes in integrated residential settings known as the West Tennessee Community Homes. The department also manages community ICF/ID homes in east Tennessee.

The department operates with a central office based in Nashville that is responsible for providing policy and program administration of the DIDD service delivery system. The central office serves as a liaison with the Bureau of TennCare, which oversees the state's Medicaid program, and works collaboratively with other state agencies involved in the development and implementation of state services. The department also has regional offices in Nashville, Knoxville, and Arlington, which coordinate services to individuals in the community. Each DIDD region operates a resource center, which provides persons with intellectual disabilities, who typically have unique and complex healthcare needs, with access to a variety of medical and health-related services that are sometimes difficult to obtain in the community due to the lack of available and willing providers.

The Bureau of TennCare contracts with DIDD to operate three Medicaid home and community based services (HCBS) waiver programs for Tennessee citizens with intellectual disabilities: the statewide waiver, the Arlington waiver, and the self-determination waiver. Waiver programs allow individuals to receive long-term care in their homes and the community as an alternative to institutionalized settings. The statewide waiver offers individuals a broad range of residential, day, therapy, respite, personal assistance, and other services. The Arlington waiver is for class members certified in *United States v. State of Tennessee et al.* (Arlington Developmental Center). The self-determination waiver serves persons who have an established non-institutional place of residence where they live with their family, a non-related caregiver, or in their own home and whose needs can be met effectively by the combination of waiver services and other supports available to them. The self-determination waiver affords participants the opportunity to lead the person-centered planning process and directly manage selected services, including the recruitment and management of service providers.

DIDD assists with several different types of programs for persons with intellectual and developmental disabilities not enrolled in an HCBS waiver, such as family support and case management services. The Family Support program is a community-based, state-funded program that provides assistance to families with a family member who has a severe disability. Because of limited state resources, services available through DIDD may not be available

immediately even though an individual is eligible, in which case the individual is placed on a waiting list for services and assigned a case manager. The purpose of case management services is to provide individuals on the waiting list with information about DIDD programs and services and to direct individuals to other community resources, advocacy organizations, and support programs.

Another DIDD 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.

DIDD has two related councils. The Tennessee Council on Developmental Disabilities has an administrative agreement with the department for fiscal and administrative transaction services. This council promotes public policies to increase and support the inclusion of individuals with developmental disabilities in their communities. It also 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, health care, and all other aspects of community life. The Statewide Planning and Policy Council for DIDD was established by the Tennessee General Assembly in 2011, and assists in planning a comprehensive array of high quality prevention, early intervention, treatment, and habilitation services; advising the department on policy and budget requests; and developing and evaluating services and supports.

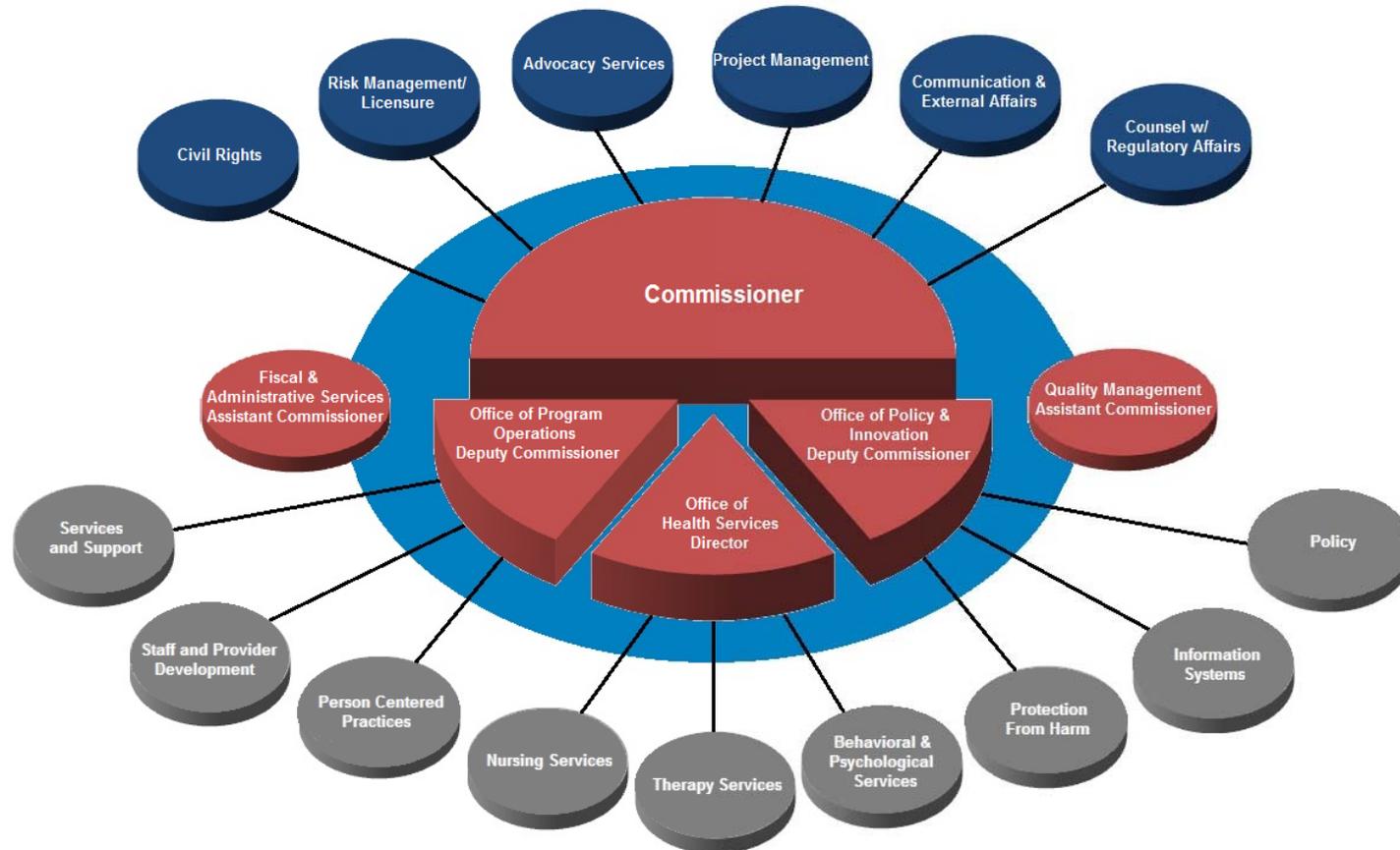
As of June 30, 2012, DIDD was serving 8,107 individuals—193 in the developmental centers, 97 in the community homes, and 7,817 in the community. Of the total number in the community, 7,677 are served through the Medicaid HCBS waiver programs—6,213 through the statewide waiver, 321 through the Arlington waiver, and 1,143 through the self-determination waiver—and 140 individuals are served by the state. There were 7,179 people on the department's waiting list for the waiver services as of June 30, 2012. This number encompasses individuals who are not currently receiving any services as well as those waiting for specifically requested services that are not yet available. The department operates under three court orders/agreements: *United States v. State of Tennessee* (Arlington Remedial Order), *People First v. Clover Bottom et al.* (Settlement Agreement), and the Revised Consent Decree Governing TennCare Appeals (Grier Lawsuit).

An organization chart of the Department of Intellectual and Developmental Disabilities is on the following page.

DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

May 2012

Organizational Framework



AUDIT SCOPE

We have audited the Department of Intellectual and Developmental Disabilities for the period January 15, 2011, through July 17, 2012. Our audit scope included a review of internal control and compliance with laws, regulations, and provisions of contracts or grant agreements in the areas of provider monitoring, the Community Services Tracking system, Clover Bottom Developmental Center and Harold Jordan Center operations, Greene Valley Developmental Center and East Tennessee community homes operations, telephone billing, risk assessment, Medicaid cost reports, the Investigations Unit, and access to computer applications.

We conducted our 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. Management of the Department of Intellectual and Developmental Disabilities is responsible for establishing and maintaining effective internal control and for complying with applicable laws, regulations, and provisions of contracts and grant agreements.

PRIOR AUDIT FINDINGS

The prior financial and compliance audit report of the Department of Finance and Administration, which was released in May 2008 and covered the period April 1, 2005, through May 31, 2007, contained ten findings involving the Division of Mental Retardation Services (now the Department of Intellectual and Developmental Disabilities). Section 8-4-109, *Tennessee Code Annotated*, requires that each state department, agency, or institution report to the Comptroller of the Treasury the action taken to implement the recommendations in the prior audit report. The Department of Finance and Administration filed its report with the Department of Audit on October 23, 2008. We conducted a follow-up of all prior audit findings as part of a review covering the period June 1, 2007, through May 31, 2010. In the follow-up review, we determined that management had corrected four of the ten prior findings. We conducted a follow-up of the remaining six unresolved prior audit findings as part of the current audit.

RESOLVED AUDIT FINDINGS

Follow-up Review

The follow-up review disclosed that the department had corrected the previous audit findings concerning inadequate controls over the contract with the Community Services Network of West Tennessee, failure to collect available federal reimbursement for waiver services, arbitrary payments of housing subsidies without rules for eligibility, and improper employer-employee relationships.

Current Audit

The current audit disclosed that the department has corrected the previous audit findings concerning failure to promptly terminate the service for unused telephone lines and the unfulfilled responsibility to formally assess the risks of errors, fraud, waste, and abuse.

REPEATED AUDIT FINDINGS

The prior audit report also contained findings concerning the need for improvements to the provider monitoring process, inadequate controls over the Community Services Tracking System, control weaknesses over the Clover Bottom Developmental Center resident trust funds, and insufficient controls over the Greene Valley Developmental Center resident trust funds. These findings have not been resolved and are repeated in the applicable sections of this report.

OBJECTIVES, METHODOLOGIES, AND CONCLUSIONS

PROVIDER MONITORING

The Department of Intellectual and Developmental Disabilities oversees a network of participating agencies responsible for providing services to individuals with intellectual disabilities. The department conducts two types of provider monitoring, Fiscal Accountability Review monitoring and Quality Assurance monitoring. The purpose of the Fiscal Accountability Review monitoring is to assess providers' compliance with certain financial requirements, while the objective of the Quality Assurance monitoring is to determine providers' compliance with designated staff qualifications and training requirements. To increase providers' awareness of the basic principles and requirements for delivery of quality services to individuals with intellectual disabilities, the department issues the *Provider Manual*. Each provider participating in a state or federally funded service delivery program must have an executed provider agreement requiring compliance with this manual.

The objectives of our review were to follow up on the prior audit finding and to

- determine whether sufficient monitoring of service contracts was performed;
- assess whether the monitoring of service providers was properly conducted;
- assess the department's follow-up actions on monitoring reviews;
- determine whether the *Provider Manual* was clear and updated; and
- evaluate whether the *Provider Manual* website was well organized.

We interviewed key personnel involved with provider monitoring, the *Provider Manual*, and the *Provider Manual* website. We obtained and reviewed relevant monitoring policies and procedures, as well as the *Provider Manual*. We also accessed the *Provider Manual* website.

We obtained a list of Fiscal Accountability Review reports issued for the entire 2011 monitoring cycle and for the 2012 monitoring cycle through May 14, 2012, and we obtained a summary of provider payments made during the 2010 and 2011 fiscal years. For the top 10 providers in terms of funding over these fiscal years and 15 randomly selected providers from the remaining population of 130 providers who received \$300,000 or more in departmental funding, we obtained and inspected the providers' Fiscal Accountability Review monitoring files to determine whether the required monitoring review was performed, monitoring procedures were properly designed and executed, the department recouped any questioned cost amounts identified by the monitors, and sanctions were issued for those providers with repeat findings. From the 25 providers, we selected one review performed by each of the five Fiscal Accountability Review monitors and reperformed their work to ascertain if our findings agreed with the monitors' findings. From these five reviews, we selected a sample of clients who received services from the provider and some individual charges that were billed for each of the sample clients for those services; we tested a nonstatistical sample of 80 charges in total. We analyzed our results and identified explanations for any differences between our findings and the monitors' findings to determine whether the department's monitoring reviews were properly conducted. We also obtained and reviewed all Quality Assurance warning letters issued by the department from January 15, 2011, through April 25, 2012.

We obtained and inspected a list of proposed changes to the *Provider Manual* structure, in addition to preliminary versions of chapters to be included in the updated *Provider Manual*. We compared the *Provider Manual* website as of May 22, 2012, with the *Provider Manual* website as of February 25, 2010, which was documented in the follow-up review, to determine if any changes had been made.

Based on the procedures performed, we determined that

- sufficient monitoring of service contracts was performed;

- monitoring of service providers was not always properly conducted (see finding 1);
- the department's follow-up actions on monitoring reviews could be strengthened, as discussed in the Observations and Comments section;
- the *Provider Manual* was unclear and out-of-date, as discussed in finding 1; and
- the *Provider Manual* website was well organized.

1. Improvements to the department's monitoring process and updates to the *Provider Manual* are still needed and could further reduce management's risk of errors, fraud, waste, and abuse

Finding

The Department of Intellectual and Developmental Disabilities (DIDD) performs Fiscal Accountability Review (FAR) monitoring of its service providers. The objectives of the FAR monitoring reviews of the service providers are to a) obtain reasonable assurance that the service provider is a going concern, meaning it should be able to continue operations for the foreseeable future; b) assess the reliability of the service provider's internal controls; c) verify that the service provider has met civil rights requirements; d) test the service provider's costs to determine if they are allowable and services are eligible for reimbursement; and e) verify the service provider's contractual compliance. Additionally, when applicable, these reviews satisfy the requirements of the Department of Finance and Administration's (F&A's) Policy 22, "Subrecipient Contract Monitoring."

In our review of DIDD's monitoring processes, we found that some of the issues noted in the prior finding from the 2007 audit had been resolved, specifically, those involving the number of subrecipients reviewed, incorporation of adjustments into the FAR samples, review of best available evidence, review of Day Services totals, and the provider website; however, we also found that improvements are still needed in the FAR monitors' methodologies and in the *Provider Manual*.

Continuing Weaknesses With the Provider Monitoring Process

Although the department performed an adequate number of FAR monitoring reviews, program monitors failed to properly question unallowable costs for multiple transactions. For our program monitoring testwork, we tested one provider that had been monitored by each of the department's five FAR monitors. From each of those five providers, we tested three service recipients who had been monitored by the FAR monitors, including at least one where the monitor had identified unallowable costs for which the department had reimbursed the provider. For each service recipient, we reviewed three or more expenditure transactions that the FAR monitor had tested. We tested 80 separate expenditure transactions totaling \$197,054.71. As part of our review, we used the provider's Daily Notes to determine whether the expenditures were allowable charges according to DIDD's regulations. We also reviewed each service

recipient's Individual Support Plan (ISP), as well as the provider's employee timesheets, visitor logs, and transportation logs for the related cost centers billed. In evaluating the charges, we based our billing parameters on information from the *Provider Manual*, Commissioner's Correspondence, and the *Fiscal Accountability Review Procedure Manual*. Based on the testwork performed, for 17 of 80 expenditures that we reviewed (21%), our results differed from the program monitors' results. We identified questioned costs of \$4,675.81, while the program monitors only reported questioned costs of \$1,048.11, a difference of \$3,627.70. We questioned 2.5% of the costs we tested; the program monitors questioned .5%, a difference of 2%. The issues we found are detailed below.

Community-based Day Services

Community-based (CB) day services accounted for \$3,449.20 of the questioned cost difference between our review and the program monitors' review. Section 10.4.b. of the *Provider Manual* states, "Community-based day services enable the service recipient to participate in meaningful and productive activities in integrated settings with other community members who may or may not have disabilities."

- For three service recipients, the ISP specified personal outcomes and action steps for CB day services; however, the services provided for 26 days did not align with the listed outcomes or action steps, as required by the *Provider Manual*. For example, one service recipient's ISP documented CB day services as the recipient's choice to participate in various activities weekly, such as going shopping, eating out, exploring settings to inspire her to write poetry, and getting her nails done. However, instead of participating in these activities, the provider's Daily Notes only documented that she ate and watched television. In addition to not aligning with ISP provisions, three days of CB day services for one service recipient were provided in the home instead of in the community without a documented reason for the venue change, in violation of *Provider Manual* provisions. Section 10.4.b. of the *Provider Manual* specifies that CB day services "may be provided in a service recipient's home if there is a health, behavioral or other medical reason or if the enrollee has chosen retirement." This section of the *Provider Manual* further states, "Requirements for community-based day services include: 1) The services must be individualized and aligned with the outcomes and action steps specified in the ISP . . ." Therefore, we questioned costs of \$1,544.40 because services billed by the provider and subsequently reimbursed by DIDD did not meet the criteria for CB day services. The Office of Risk Management Director noted that the department's *Fiscal Accountability Review Procedure Manual* does include instructions for the monitors to question costs whenever CB day services are provided in the home without proper justification. The Guidelines for Questioned Costs section of the manual states, "The expectation is for CB day services to be delivered in the community; however, CB may be provided in the individual's residence if there is a health, behavioral, or other medical reason, or if the enrollee has chosen retirement."
- Four service recipients did not receive the required six hours of day services for 20 days; the provider did not document the reason for the fewer hours. The department's

regulations require that providers bill for day services in increments of days, not hours. If the provider performs less than six hours of day services without appropriate documentation, the provider is not eligible to bill for that day. Specifically, DIDD's service guidelines stipulate, "The per diem may be billed if at least 2 hours of services were provided WHEN there is documentation that the person was unable to complete the full 6 hours for reasons beyond the control of the provider. Examples would be: sickness of person, behavioral issues, refusal by the person to continue, weather-related or environmental issues, medical appointments, family/conservator picked up the person, individual or family/conservator requested 5 or fewer hours per day on an ongoing basis." We questioned costs of \$1,234.00.

- One service recipient received at least some allowable CB day services for 11 days; however, the provider's supporting documentation did not show that the full six hours of services required for reimbursement were provided. Therefore, we questioned costs of \$653.40.
- For another service recipient, the provider billed for CB day services but should have billed for facility-based (FB) day services instead since the individual spent the majority of her day at a facility. DIDD reimburses providers at a rate of \$82.40 per day for the level of CB services provided to the service recipient but only reimburses providers at a rate of \$65.00 per day for the corresponding level of FB services. The *Fiscal Accountability Review Procedure Manual* states, "If CB and FB are combined, the service with the majority of the time is to be billed." Therefore, we questioned the difference between the CB and FB rates, \$17.40.

Behavioral Analyst Services

Behavioral Analyst (BA) services accounted for \$37.38 of the questioned cost difference between our review and the program monitors' review. Section 12.2 of the *Provider Manual* defines behavior services as

(1) assessment and amelioration of service recipient behavior that presents a health or safety risk to the service recipient or others or that significantly interferes with home or community activities; (2) determination of the settings in which such behaviors occur and the events which precipitate the behaviors; (3) development, monitoring, and revision of crisis prevention and behavior intervention strategies; and (4) training of caregivers who are responsible for direct care of the service recipient in the prevention and intervention strategies.

For one service recipient, the provider billed for two units of BA services but did not maintain documentation showing that the services were performed.

Personal Assistance Services

Personal Assistance (PA) services accounted for \$77.49 of the questioned cost difference between our review and the program monitors' review. The *Provider Manual*, section 16.3.a,

describes PA services as “the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments and interpersonal and social skills building to enable the enrollee to live in a home in the community.” As stated in the manual, PA services also “may include medication administration as permitted under Tennessee’s Nurse Practice Act.” For one service recipient, PA and CB services were provided on the same day, but the total services for which the provider billed for the day exceeded 24 hours. As a result, 21 units and \$77.49 were questioned.

Transportation Services

Transportation services accounted for \$63.63 of the questioned cost difference between our review and the program monitors’ review. Section 16.5.a of the *Provider Manual* defines transportation services as “non-emergency transport of an enrollee to and from approved activities specified in the plan of care.” The provider billed nine units for one service recipient to travel to her day services location, which the *Provider Manual* states is an ineligible transportation charge. According to the *Provider Manual*, section 16.5.a, “Individual Transportation Services shall not be used for: 1) Transportation to and from Day Services . . .”

Ineffective program monitoring jeopardizes the proper execution of DIDD’s mission of maintaining a system that offers a continuum of support for individuals with intellectual disabilities.

Provider Manual Still Not Updated

The purpose of the department’s *Provider Manual* is to outline the basic principles and requirements for delivery of quality services to people with intellectual disabilities. All providers who participate in state and federally funded service delivery programs must have an executed provider agreement with DIDD, which requires compliance with this manual.

In 2010, the Division of State Audit follow-up review team found that the “Day Services” chapter in the *Provider Manual* was not updated with the most current information; the last update was in March 2005. The team interviewed key staff and providers in order to determine their understanding of billing rules and with what manner of consistency that information was understood. The results of their interviews concluded that the manual was redundant, contained misrepresentations, and was open to multiple interpretations. Furthermore, most providers surveyed stated that they chose to call the regional offices to find answers to their questions rather than attempt to find them in the manual.

For our audit period, the Director of Research and Strategic Planning stated that while the department has released updates to five *Provider Manual* chapters, no update to the “Day Services” chapter has been issued. The Office of Risk Management Director explained that the Commissioner has chosen to stop updating the manual one chapter at a time because of the lengthy approval process. Instead, the department now plans to release an update of the entire manual at once. The Commissioner initially wanted a complete updated manual to be available by May 1, 2012. Although we observed that all *Provider Manual* chapters, including the “Day

Services” chapter, have been edited to some extent, a draft of the *Provider Manual* had not been released for stakeholder comment as of July 25, 2012. The Office of Risk Management Director stated that the Deputy Commissioner of Policy and Innovation has notified providers that the revised deadline for issuance of the updated *Provider Manual* is March 2013. Based on the monitoring testwork we performed, the outdated *Provider Manual* continues to cause misunderstandings among providers and the department’s own staff, which in turn heightens the risk of inaccurate billings and fraud, waste, and abuse.

Given the problems we identified in our testwork, we also reviewed the department’s risk assessment. Although management identified risks of payment to providers for services not performed and unauthorized billings caused by superseded *Provider Manual* requirements, management just listed updated monitoring procedures as the corresponding control, which was insufficient to adequately compensate for the issues noted.

Recommendation

In order to properly execute its mission of maintaining a service delivery system that offers a continuum of support for individuals with intellectual disabilities, DIDD should continue to make improvements to its monitoring process and the *Provider Manual*. Specifically, the department should perform the actions delineated below.

Continuing Weaknesses With the Provider Monitoring Process

The Assistant Commissioner for Quality Management should ensure that the additional questioned costs that we noted are immediately recouped from the applicable provider agency. Furthermore, the Assistant Commissioner for Quality Management should ensure that the FAR program monitors receive the training necessary to thoroughly perform their job duties. For the individuals who received CB day services in the home, the support coordinators should reassess the individual’s needs and, if necessary, identify a service that better correlates with the level of care required by that individual. If no such service exists, the department should consider seeking federal approval for developing and implementing a new service for those individuals.

Provider Manual Still Not Updated

The Commissioner should push for the release of the new *Provider Manual* as early as possible. The Director of Research and Strategic Planning should ensure that the updated manual is completed and released promptly. Once the updated *Provider Manual* is issued, the Commissioner should institute a new mandatory training program to increase provider awareness of applicable service guidelines and regulations, to enhance provider understanding of implementing those services that are listed in the service recipient’s ISP, and to demonstrate methods for adequately documenting the provision of services.

While the risks associated with this finding were partially identified in the department’s risk assessment, the Commissioner should ensure that the additional risks identified are properly

documented in management's risk assessment, and mitigating controls are developed and documented.

Management's Comment

We concur.

The Assistant Commissioner for Quality Management, in coordination with the Director of Risk Management and Licensure, has overseen the recoupment of funds identified as additional questioned costs by the Comptroller's staff during the review of the Fiscal Accountability Review (FAR) process.

The vast majority of the additional questioned costs (95%) were associated with a specific waiver service - Community Based Day. Per the audit recommendation,

. . . support coordinators should reassess the individual's needs and, if necessary, identify a service that better correlates with the level of care required by that individual. If no such service exists, the department should consider seeking federal approval for developing and implementing a new service for those individuals.

This approach, which was discussed at length with the auditors, has been successfully initiated. Effective January 2013, federal approval for a new service, "In-Home Day Services," was obtained. The necessary steps to begin implementing this service are underway. The rate methodology has been submitted to TennCare for review and once that is obtained, the required public meeting will be scheduled.

The Assistant Commissioner for Quality Management has initiated training for the FAR reviewers in the service areas that were cited by the audit. This training has focused on discussion of the actual findings of the audit and procedures for reviewing each service. The goal of this activity is for there to be increased effectiveness in future FAR reviews. Training occurred at two FAR staff meetings in August and November 2012, and will continue at future staff meetings.

DIDD management has initiated the task of making substantive revisions to the *Provider Manual*. The goal is to streamline the manual by eliminating content that is obsolete, duplicative, and/or published elsewhere, such as the DIDD website. In addition, wherever needed in the *Provider Manual*, requirements are being strengthened with clarifying language which should help reduce risk (errors, fraud, waste, and abuse) as noted in the above recommendation. The department will solicit feedback from providers and other key stakeholders as appropriate throughout the process. The department intends to finalize the manual and publish it before the end of the year.

The Office of Risk Management and Licensure will revise the 2013 Risk Assessment to address the areas noted.

COMMUNITY SERVICES TRACKING SYSTEM

The Department of Intellectual and Developmental Disabilities uses the Community Services Tracking (CS Tracking) system to keep track of persons with intellectual disabilities who receive services from the department's providers. The system maintains provider, rate, cost plan, and service information. CS Tracking works in conjunction with other applications to produce an electronic bill that the department submits to the Bureau of TennCare so that providers can receive reimbursement for both Medicaid-funded and state-funded services.

The objectives of our review were to follow up on the prior audit finding and to

- ascertain the status of the department's plan to replace CS Tracking with a new computer system;
- evaluate the CS Tracking access controls;
- evaluate the CS Tracking password controls;
- ascertain whether the system edits to prevent provider payments in excess of the day services yearly maximum had been implemented and were operating as described;
- evaluate the department's controls over adjustments to previously billed invoices;
- determine whether the department maintained adequate and updated CS Tracking system documentation for users and programmers to follow; and
- determine whether the housing subsidy records that appeared to be duplicates actually represented provider overpayments.

We conducted interviews and performed walkthroughs with key personnel. In addition, we reviewed documentation related to the department's implementation of a computer system to replace CS Tracking. We also obtained and reviewed the access and password policies and procedures the department follows.

We obtained a list of all 1,070 active and inactive CS Tracking users as of May 7, 2012, showing users' access levels and passwords. Using this list, we created a schedule of all users with full (add/edit/delete) access to one or more of the following CS Tracking functions: cost plan, actuals, payments, authorize, and adjustments. We conducted management inquiries to determine if each user's access was appropriate for his or her job duties. We identified the users who had full access to both the cost plan and authorize functions and conducted inquiries and walkthroughs to evaluate whether the department had designed and implemented controls that would prevent a user from adding/editing/deleting a cost plan and authorizing the same plan. We also identified the users who had full access to the cost plan, actuals, payments, authorize,

and adjustments functions and conducted interviews and performed reviews to assess whether the department had designed and implemented controls that would prevent a user from both entering key payment information and making adjustments without independent verification or approval. From the CS Tracking user list, we determined which accounts were listed as inactive as of May 7, 2012, and which accounts were listed as active as of that date. We reviewed access for all 722 accounts listed as inactive to ascertain if users' access was properly revoked. For the 348 CS Tracking users listed as active, we calculated the number of days since the user's last login to determine whether the user list was reviewed with the frequency described by management. We identified the department's active test user accounts, performed management inquiries to determine the use of those accounts, and assessed whether the department's use of the test user accounts was proper.

We conducted interviews and performed walkthroughs to determine controls over passwords.

We obtained a list of all providers who billed the department for more than the 243-unit day services yearly maximum during calendar year 2011, and we selected a random sample of 60 items and reviewed TennCare's interChange system to determine whether TennCare's edits were reliable in preventing overpayments. We also obtained and analyzed the results of the department's review of calendar year 2011 self-determination waiver day services payments.

We obtained a file of all CS Tracking adjustments to previously billed invoices for the period January 15, 2011, through June 10, 2012, and we selected a nonstatistical sample of 60 adjustments from a population of 8,906 adjustments and reviewed the associated documentation and entries in interChange to see if the CS Tracking adjustments were also properly entered into interChange. To ensure that the amount billed by providers agreed to the amount paid, we inspected reconciliations the department performed as well as exception reports that CS Tracking generated and the department reviewed.

We analyzed the department's CS Tracking system documentation. We obtained a CS Tracking payment file for the period January 15, 2011, through June 19, 2012, and performed a computer-assisted audit technique to identify potentially duplicate housing subsidy records.

Based on the procedures performed, we determined that

- the department has not replaced CS Tracking with a new computer system but is working toward that goal, as discussed in finding 2;
- CS Tracking access controls were inadequate (see finding 2);
- CS Tracking password controls were lacking (see finding 2);
- system edits to prevent provider payments in excess of the day services yearly maximum had not been implemented in CS Tracking for any of the department's

three waiver programs and TennCare's edits were not operating effectively for the self-determination waiver, as noted in finding 2;

- the department's controls over adjustments to previously billed invoices were operating as designed, with immaterial differences;
- the department failed to maintain adequate and updated CS Tracking system documentation for users and programmers to follow (see finding 2); and
- there were no potentially duplicate housing subsidy records.

2. As noted in the prior two audits, the department's controls over the Community Services Tracking system are inadequate, resulting in \$21,234.50 in provider overpayments and increasing opportunities for fraudulent transactions

Finding

As noted in the prior two audits, security and internal controls over the Community Services Tracking (CS Tracking) system in the Department of Intellectual and Developmental Disabilities (DIDD) were inadequate. Issues disclosed in the prior findings related to adjustments, segregation of duties, and duplicate payments have been corrected. In response to the prior findings, management concurred and stated that CS Tracking would be replaced with a new system. Although management has worked to replace CS Tracking for more than 10 years, this project has not yet come to fruition. As of the end of July 2012, management planned to replace CS Tracking as well as certain other computer applications with a single integrated database solution by the end of fiscal year 2014.

Inadequate Day Services Edits Again Led to Provider Overpayments

Based on our inquiries with the Chief Information Officer, Administrative Services Manager for the Denied Claims Unit, Director of Special Services, and the Accounting Manager, the DIDD computer systems still do not contain an edit that would prevent providers from being paid more than the 243-unit yearly maximum for day services. Instead, DIDD relied on TennCare's edits to prevent provider overpayments. Therefore, we performed testwork on 60 individuals whose providers billed more than 243 day services units in calendar year (CY) 2011 to determine whether TennCare's edits were operating effectively. We found that in three instances (5%), all involving the self-determination waiver, TennCare's edits allowed the provider to be paid more than the maximum allowable units, resulting in overpayments totaling \$223.25.

The Administrative Services Manager for the Denied Claims Unit said that DIDD has known since 2008 that TennCare did not have an edit for the self-determination waiver day services yearly maximum. Since the self-determination waiver also contains an annual expenditures cap of \$36,000, TennCare just implemented an edit for the cap and not for the

service limits. In order to compensate for the weakness in computer system edits, staff in the Denied Claims Unit had been performing reviews beginning two months after the end of the calendar year. However, the Denied Claims Unit postponed the reviews after one staff member left in July 2011. In addition, the Special Services staff had previously performed analyses of a report showing providers who billed more than 243 day services units in a calendar year, but department staff suspended the review because they believed that the report was obsolete and that the personnel resources expended exceeded the benefits derived.

After being made aware of the problems we found in our sample, the Administrative Services Manager for the Denied Claims Unit instructed her staff to review all CY 2011 self-determination waiver day services payments. DIDD's internal review disclosed an additional \$21,011.25 in provider overpayments, for total overpayments of \$21,234.50. The Denied Claims Unit then worked with Special Services to correct billing records and recoup overpayments from providers. Furthermore, DIDD met with TennCare to discuss the day services edits for the self-determination waiver. During the meeting, TennCare agreed to implement a day services yearly maximum edit for the self-determination waiver. Failure to implement the appropriate computer system edits or controls to compensate for system weaknesses increases the risk that providers will be paid unallowable amounts.

Continuing Information Security Control Deficiencies

Security control deficiencies were still present within CS Tracking in the areas of password and access controls. The Director of Special Services for the central office and the Regional Administrative Directors (or their designees) for each of the three regional offices set up the CS Tracking user accounts, including each user's initial password and access levels. We noted the following deficiencies.

Password Controls

Our testwork on CS Tracking users revealed serious issues regarding passwords. We are refrained from identifying specific vulnerabilities that could allow someone to exploit the department's systems. Disclosing those vulnerabilities could present a potential security risk by providing readers with information that might be confidential pursuant to Section 10-7-504(i), *Tennessee Code Annotated*. We provided department management with detailed information regarding the specific vulnerabilities we identified as well as our recommendations for improvement.

Access Levels Inconsistent With Users' Job Duties

We performed testwork on the entire population of CS Tracking users as of May 7, 2012, who had full access to one or more of the following functions: cost plan, actuals, payments, authorize, and/or adjustments. Based on management inquiries, we found that 12 of 66 users (18%) had higher access levels than their job duties required, in violation of OIR's security policies. Of these 12 users, 8 were from the east region, 2 were from the central office, one was from the west region, and one was from the middle region. Four of the accounts with inappropriate access were also listed in the "inactive" group. According to the Director of

Special Services, in order for users to be rendered unable to perform their former functions, their access must be manually removed. In these four instances, user access was not properly removed. Therefore, the users would have still been able to log into their accounts and utilize the access they had been assigned. OIR's *Enterprise Information Security Policies*, Section 9 (Access Control Policy), states, "Access to the State of Tennessee's information resources shall be granted consistent with the concept of least privilege." The concept of "least privilege" entails that users are only granted access to those functions necessary for their work. After we brought these instances of inappropriate access to management's attention, they immediately changed the users' level of access. Users with inappropriate CS Tracking access represent a security threat to the department.

Since the department had intended to completely revoke access to 4 accounts listed as inactive but failed to do so, we expanded our testwork to encompass all 722 CS Tracking users listed as inactive as of May 7, 2012, to determine if they still had access to CS Tracking. We found that an additional 45 users had access to at least one CS Tracking function. Of the 45 users, 21 were from the central office, 9 were from the east region, 8 were from the middle region, and 7 were from the west region. The Director of Special Services speculated that access for the user accounts may not have been completely removed because she and/or the Regional Administrative Directors expected the users to need access again in the near future. The Director of Special Services also said that if access to the "Agency" function was completely removed, then access to the other functions might automatically be revoked. However, based on discussion with the Director of IS Business Solutions, this was not the case. The Director of Special Services added that since the users' passwords were reset, the users would not be able to access the accounts anyway unless they knew the new password. Failure to properly remove access to all CS Tracking functions when deactivating user accounts could result in data manipulation by unauthorized users.

System Documentation for Users and Programmers Still Lacking

While performing internal control testwork, we found that although improvements had been made, the department still did not maintain adequate and updated CS Tracking system documentation for users and programmers to follow. The application lacked the following documentation: (1) comprehensive instructions for application users, (2) flow charts and/or data flow diagrams, and (3) software security information. If the department does not maintain proper system documentation, users may unknowingly be performing functions improperly.

The Director of IS Business Solutions agreed that the documentation should have been created at the time of CS Tracking's implementation in 1993 and kept current as changes were made to the system. However, the department believes that it would be impractical to create the documentation at this point due to the time and personnel resources required to complete the task, as well as the planned implementation of a new computer system by the end of FY 2014.

System Does Not Provide Adequate Audit Trail

In addition to the weaknesses identified in prior audits, we found that CS Tracking does not provide an adequate audit trail for either ongoing user activity or password changes.

According to the Director of IS Business Solutions, since CS Tracking was built using older technology, the system only records who originally added the data (such as a cost plan), the date they were added, who changed the data last, and the date they were changed. CS Tracking does not maintain a record of changes between the time the data were originally added and the time the data were last changed. Without this change history, department management is not able to properly monitor CS Tracking user activity to ensure that information integrity is preserved.

In addition, the Director of IS Business Solutions stated that CS Tracking does not keep track of the last date users changed their passwords. Without this data, we were unable to determine users' compliance with the OIR's *Enterprise Information Security Policies*, Section 9.2.5 (User Password Management), which stipulates the frequency with which users should update their passwords. As of the end of May 2012, management did not monitor users' passwords for compliance with the password change frequency requirement. Although management would in the future be able to monitor password change frequency by running a report of user passwords at designated intervals and manually comparing the users' previous passwords with their current passwords, this process would be inefficient. The Director of IS Business Solutions noted that management was aware of the problems with CS Tracking's audit trail; however, management did not plan to correct these issues due to the upcoming system conversion.

Given the problems identified in our testwork, we also reviewed the department's risk assessment. We found that management's risk assessment did not fully address the issues noted in this finding. The risk assessment does reference the problems noted in the prior finding in general but only specifically includes the following risk: "Information systems programming not adequate to stop payments for services not approved and duplicate payments to multiple vendors." The mitigating controls listed for this risk event merely state that DIDD is upgrading its computer software to better track payments and that TennCare is adjusting its payment methodology.

Recommendation

As the department transitions to a new computer system, the Chief Information Officer should ensure that adequate security and internal controls are designed and implemented. Specifically, the Chief Information Officer should ensure that

- the self-determination waiver day services edit is implemented as planned or alternative methods are developed to ensure that providers are not paid beyond the 243-unit day services yearly maximum;
- password controls are strengthened;
- the Director of Special Services and the Regional Administrative Directors develop uniform procedures for assigning users an initial password;

- the Director of Special Services and the Regional Administrative Directors perform a comprehensive review of access levels for each user in their area;
- after the initial review is performed, access is reviewed at least annually, in addition to whenever employees change job duties or separate from the department;
- since establishing and monitoring passwords and user access levels are decentralized functions, he enhances oversight by designating an employee uninvolved in setting up user accounts to perform reviews to ensure that proper policies and procedures are followed; and
- the Director of Special Services and the Regional Administrative Directors remove access to all CS Tracking functions when deactivating user accounts.

Although the risks associated with inadequate CS Tracking controls were partially identified in the department's risk assessment, the Commissioner should ensure that the additional risks noted in this finding are properly identified and assessed in management's documented risk assessment.

Management's Comment

We concur.

DIDD and TennCare have been in communication regarding this finding and agree that the edit to restrict DIDD's Self Determination (SD) Waiver providers from exceeding the 243 unit annual maximum should be enforced in TennCare's system. TennCare has reviewed the requirements and is currently testing the new edit. It is expected that this new edit will be put in place by April 2013.

In February 2013, DIDD implemented edits within its Provider Claims Processing portal to strengthen its controls on Day Services Billing. These new edits restrict multiple providers from submitting billing for Day Services on the same date of service.

The Department's CS Tracking system was written in an outdated programming language, which does not support adequate password controls. DIDD is currently engaged in a project effort to replace CS Tracking by the end of fiscal year 2014. The new system (Project Titan) will be integrated with the state's Active Directory system, which will apply the appropriate password controls according to State Standards.

Role-based security is a critical component of the new system that is currently being developed. The requirements for users' level of access to information will be identified and documented as part of the implementation process. The new system will provide reporting capabilities that will allow system administrators to easily monitor and audit users' level of access on a recurring basis.

Currently, no user or technical documentation exists for the CS Tracking application. DIDD has included as a requirement in the implementation services contract for Project Titan a complete technical design specification. The implementation vendor is also required to provide DIDD with detailed end user and technical training documentation for the new system, which will be updated and maintained by DIDD's Information Systems Training staff.

The technology solution used to develop the CS Tracking application does not support adequate audit capabilities. The new system will include full audit functionality for all user activities within the system. This audit function will be able to capture all changes made, including the date and time of the change, the user who made the change, what data elements were changed, and what those data elements were changed to.

The Office of Risk Management and Licensure will revise the 2013 Risk Assessment to address the areas noted.

CLOVER BOTTOM DEVELOPMENTAL CENTER AND HAROLD JORDAN CENTER OPERATIONS

Individual residents of the Clover Bottom Developmental Center (CBDC) and the Harold Jordan Center have trust funds; the trust funds for the Harold Jordan Center are managed by the Clover Bottom Developmental Center's accounting staff. The money individuals receive from various sources, such as the Social Security Administration, relatives, and jobs, is deposited into their trust fund accounts, and individuals with sufficient account balances may purchase or have items purchased on their behalf for their personal use. The Clover Bottom Developmental Center has a fiduciary duty to ensure proper protection of and reasonable access to the trust funds and has established policies and procedures to provide for the safeguarding of these funds and accountability for the use of these funds. The centers are also responsible for safeguarding individuals' personal property and have established policies and procedures governing the recording of purchases of personal property and maintaining an inventory of each individual's property.

In March 2012, the CBDC implemented a petty cash system, which allotted \$20 to each individual. Petty cash can be used for small purchases such as snacks and personal hygiene supplies. In accordance with the central office's "Personal Fund and Special Fund Accounts" policy, the petty cash funds are secured in a locked, zippered money bag for each individual and further secured in a locked money box, which is kept in a locked filing cabinet. An Individual Accounting Form is used to record petty cash fund activity.

The objectives of our review were to follow up on the prior audit finding and to determine whether staff at the Clover Bottom Developmental Center and the Harold Jordan Center

- followed the policies and procedures regarding the trust fund accounts;

- followed the policies and procedures regarding individuals' personal property; and
- followed the policies and procedures over individuals' petty cash funds.

To gain an understanding of the controls over the trust funds, individuals' personal property, and individuals' petty cash funds, we obtained and reviewed the policies and procedures, interviewed key personnel, and performed walkthroughs of the procedures with staff. In addition, we reviewed the department's most recent Clover Bottom Developmental Center internal monitoring reports.

To determine whether staff followed the trust fund policies and procedures, we obtained a list of the 1,038 trust fund Request for Funds forms for the period January 15, 2011, through March 23, 2012, and selected a random sample of 75 disbursements from the individual trust funds. For the sample items, we reviewed the original and completed copies of the Request for Funds forms, purchase receipts, drop box and cottage logs, and deposit receipts to test compliance with the policies and procedures. To ensure the trust fund accounts were being properly maintained, we reviewed bank statements and the related reconciliations for the period January 2011 through March 2012 to evaluate whether bank reconciliations were performed promptly.

To determine whether staff followed the personal property policies and procedures, we obtained all 1,038 Request for Funds forms for the period January 15, 2011, through March 23, 2012, and haphazardly selected a sample of 75 Request for Funds forms, which included property purchases. The 75 forms included 15 for each of the Clover Bottom Developmental Center's four cottages and 15 for the Harold Jordan Center. To test compliance with the personal property policies and procedures, we attempted to physically locate the inventory items purchased and reviewed the facilities' inventory log book to determine whether the inventory items were logged in promptly and correctly. We also inspected working papers to determine if the accounting staff completed monthly audits of the individuals' personal inventory for the period January 2011 through March 2012, as required by policy.

We obtained a list of individuals residing at the four Clover Bottom Developmental Center cottages and at the Harold Jordan Center and performed unannounced counts of each individual's petty cash funds.

Based on the procedures performed, we determined that staff at the Clover Bottom Developmental Center and the Harold Jordan Center

- did not always follow the policies and procedures regarding the trust fund accounts, as noted in finding 3;
- failed to comply with policies and procedures regarding individuals' personal property (see finding 3); and
- followed policies and procedures over individuals' petty cash funds.

3. **Internal controls over individual residents' trust funds and personal inventory items at Clover Bottom Developmental Center and Harold Jordan Center were still inadequate, increasing the risk for fraud, waste, or abuse**

Finding

As noted in prior audits that date back to 2003, the Clover Bottom Developmental Center (CBDC) continued to have multiple internal control deficiencies related to individual residents' trust fund accounts and their personal inventory. Management concurred with the prior findings and has taken steps, which include policy revisions and additional staff training, to correct the deficiencies. We reviewed both CBDC and Harold Jordan Center trust funds and found that the following areas have improved: Request for Funds forms and receipts were maintained, the forms listed items to be purchased or the trips to be taken and alternatives if an item could not be found or a trip could not be taken, the forms were approved (signed and dated), the forms were stamped "Completed" (signed and dated) by Accounting, receipts detailed the amount spent per individual, and the receipts and the amount of money returned equaled the amount originally requested. In spite of these improvements, we still found issues that need to be addressed.

Continuing Issues Over the Handling of Unspent Funds

At Clover Bottom Developmental Center and Harold Jordan Center (HJC), we tested 75 Request for Funds forms for individuals and found that the Trust Fund Policy was not always followed. For the purchase of items or a field trip for an individual, staff at CBDC or HJC fill out a Request for Funds form. The form includes the name of the staff member filling out the request (originator), the amount of money needed and for which individual and what items are to be purchased, the date the money is needed, and which staff member is picking up the money from the Accounting office. Unspent funds are to be returned to the Accounting office.

- For 18 of 22 Request for Funds forms tested (82%), the CBDC or HJC staff person responsible for purchasing items for an individual did not properly document the return of unspent funds when the transaction occurred after normal office hours. According to the center's *ADMINISTRATIVE POLICIES AND PROCEDURES*, Trust Fund Policy, Part D.7.3.4, "**During times when the Accounting Office is not open**, the purchaser will call the switchboard and request that Security accompany him or her to the after hours drop box in Fir." Part D.7.3.4.1 states, "Security will accompany the purchaser to the drop box and observe the locked money bag [with unspent funds] being placed in the drop box." Part D.7.3.4.2 states, "Both Security and the Purchaser will sign the drop box control log to record the time and date of this transaction. (The drop box control log will be maintained in the Fir Building at the drop box)."

In addition, since our follow-up review performed in May 2010 found that the Drop Box Control Log did not include the date accounting staff retrieved the money from the drop box, who picked up the money, or the specific request to which funds were related, we looked for evidence of this information in our testwork. Our current review found that the Fiscal Director 1 revised the Drop Box Control Log in February

2011 to document the accounting staff who picked up the money from the drop box; however, management still did not add columns to document the date the accounting staff member retrieved the money or the specific request number to which the drop-off was related. Therefore, the information presented on the Drop Box Control Log again provided an inadequate audit trail for the unspent money from filled requests, and neither we nor staff could trace returned funds from a specific request to a particular drop-off. In addition, we were unable to determine compliance with the requirement that accounting staff retrieve the money on the next business day.

- For 4 of 30 Request for Funds forms tested (13%), the CBDC or HJC staff responsible for purchasing items for an individual did not return unspent funds to the accounting office within the required time frame. According to the Trust Fund Policy, Part D.7.2.1, “Upon returning to campus, the purchaser must present the receipt and all items purchased immediately to a supervisory staff member for verification that items match the receipt.” Part D.7.3.1 states, “Immediately after having the purchase verified, the purchaser shall place the receipts, two copies of the Request for Funds, and any unspent funds in the money bag and lock the bag.” If the accounting office is open, Part D.7.3.3 states, “. . . the purchaser will take the locked money bag to Accounting.” If the accounting office is closed, the purchaser should follow the procedures discussed in the previous bulleted item. We found that the unspent funds were outstanding for two to three days.

Failure to maintain the chain of custody of an individual’s unspent funds and return unspent funds to the accounting office within the required time frame increases the risk that funds may be stolen or lost.

The department developed Policy #209, Personal Fund and Special Fund Accounts, which became effective September 30, 2011, to streamline its business functions across the three different regions of the state. That policy requires employees to submit receipts and unspent funds to the Trust Fund Custodian within three business days. Our testwork included nine requests with unspent funds for the period September 30, 2011, through March 31, 2012, and we found no problems related to the purchaser’s return of any unspent funds.

Continuing Issues Over Personal Inventory Controls

Based on our testwork, we found that cottage staff and supervisors did not always account for individuals’ personal inventory items properly.

- The cottage staff and supervisors did not promptly and correctly log the inventory item purchased for residents into the Individual Inventory Sheet for 41 of 75 inventory items tested (55%). According to the Trust Fund Policy, Part D.7.4.1, “. . . the Originator shall ensure that the item(s) purchased are immediately placed on the individual’s inventory of personal or clothing items, to include the date, source, serial number when applicable, and description of the purchase made.” According to the Trust Fund Policy, Part IV. Definitions, the originator is defined as follows: “Originator - Staff member who initiates a Request for funds.” The cottage

supervisors stated that prior to June 2010, the clothing clerk maintained the records for an individual's inventory items. A reduction in work force in June 2010 eliminated all the clothing clerk positions, thus redistributing the inventory responsibilities back to cottage staff and supervisors.

- The cottage staff and supervisors could not find 17 of 75 inventory items that we selected for testwork (23%). The cottage staff stated that since the Individual Inventory Sheet was not completed at all or did not have adequate information for inventory items, they were unsure where the items were located or if the item had been discarded. Based on our review of the Individual Inventory Sheet form, there is a column for the location and discard date of the inventory item, and any location change/discard could have been tracked.
- We found no evidence that cottage staff or supervisors performed a regular inventory of individuals' personal items. According to *Residential Auditing Procedures* (revised 10/3/11), "Each Cottage will be responsible for inventorying each individual's clothing and personal items on a monthly bases [basis]." The cottage staff and supervisors stated they were not trained on how to properly account for an individual's inventory items; therefore, they did not take inventory on a monthly basis.
- For the period January 1, 2011, through March 31, 2012, the Trust Fund Custodian did not perform monthly audits of the individuals' inventory items for 13 of 15 monthly audits tested (87%). Although the Custodian sent a memo to management regarding each month's inventory, our examination of his working papers showed that he did not actually inventory the items. In addition, the Trust Fund Custodian did not complete the monthly audit for the individuals' inventory items promptly and submit the results to management within 30 days for any of the 15 months tested. According to the Trust Fund Policy, Part D.7.4.3, "Accounting will audit purchases from the Individual Trust Fund Accounts on monthly bases [basis] for proper recording of items on the Personal Item Inventory sheets to insure [ensure] that merchandise has been recorded properly in accordance with the Residential Auditing Procedures." The Trust Fund Custodian stated that he was not aware that he was supposed to complete the monthly audits of the Individual Inventory Sheets until August 2011 because of a miscommunication between himself and upper management.

When staff do not maintain adequate records, it is impossible for management to match the inventory records to the actual physical items purchased, which is critical for proper control over individuals' property. The failure of staff to maintain a complete and current inventory, complete monthly audits promptly, and submit the results to management increases the risk of theft or loss of the individuals' personal property.

New Issues Related to Unspent Funds and Personal Inventory Items

Effective March 1, 2012, CBDC introduced a new policy that included new procedures for securing unspent funds after hours. This policy is called the Flow of Accountability of Personal Funds. In the section titled “Leftover Funds from Personal Requests Forms,” the policy states,

When not all of the money was spent for a planned outing (via a Personal Funds Request), that money may be stored in a separate zippered, locked bag in the locked file cabinet in the supervisor’s office until it can be turned in to Accounting (on the next available business day).

This policy also states, “These funds should also be reviewed against the accompanying receipts on 1st shift each day by the Home Manager or supervisor until they can be turned back in to Accounting.”

Based on our discussion with three of the CBDC Cottage Supervisors, they were not aware of this new policy and continued to use the old policy (Trust Fund Policy Parts D.7.3.4 and D.7.3.4.2, mentioned above). We also reviewed the Drop Box Control Log located in the Fir Building and the March 2012 Requests for Funds forms that indicated that purchasers had leftover funds after accounting office hours. We found no evidence on the Drop Box Control Log that the unspent funds were secured as required by the new policy. Based on our discussion with the fourth Cottage Supervisor, she used the new policy and the old policy interchangeably. Based on our review of the Key Control Log (worksheet used at shift change to document the transfer of keys for the locked petty cash funds from the departing supervisor to the arriving supervisor), we could not determine if the unspent funds were secured each day because the amount of money was not listed. The HJC Supervisor stated that he used the new policy, but there was no Key Control Log to indicate when leftover funds were secured. Failure to maintain the chain of custody of an individual’s unspent funds increases the risk that funds may be stolen or lost.

We also found that the supervisory staff member did not properly document the verification of items purchased for 10 of 33 Requests for Funds forms tested (30%). Four of the forms were signed but not dated by the supervisory staff member. Six of the forms were neither signed nor dated by the supervisory staff member. The Trust Fund Policy, Part D.7.2 Post Purchase Procedures-Verification of Purchase, Part D.7.2.1, states,

Upon returning to campus, the purchaser must present the receipt and all items purchased immediately to a supervisory staff member for verification that the items match the receipt. (The supervisory staff member who makes the verification may include one of the following: Unit Director or Supervisor). Under no circumstances can the purchaser and supervisor verifying the purchase be the same person. The staff member making the verification shall sign and date the Request for Funds in the space provided indicating that the verification has been made.

Failure to document the supervisory staff member's verification increases the risk that items purchased were not properly matched with the receipt.

Management's risk assessment identified the risk that trust fund accounts may not be properly dispensed and back up documentation may not be maintained for trust fund transactions or individuals' inventory items. To mitigate this risk, management stated that a review of policies and procedures was performed regarding trust funds and individuals' inventory items and annual audits were conducted of all trust fund monies; however, management's mitigating controls were still inadequate.

Recommendation

The Trust Fund Custodian should ensure that the Clover Bottom Developmental Center Cottage Supervisors and the Harold Jordan Center Supervisor consistently follow the policies and procedures in regard to maintaining the chain of custody of an individual's unspent funds.

The cottage staff and supervisors should ensure that individual inventory records are completed and maintained with adequate information and ensure that the date and reason are written for inventory items that are discarded. In addition, cottage staff and supervisors should perform a personal items inventory regularly. The Chief Officer should ensure that the Trust Fund Custodian performs monthly audits of the individuals' inventory items and that these audits are completed promptly with the results sent to management within 30 days.

Even though the department is scheduled to close the CBDC facility with the opening of community homes and is considering electronic benefit transfer cards for each individual, management internal controls still need to be addressed to mitigate the risk of mishandling individuals' monies and personal property.

Management's Comment

We concur.

In December 2012, all DIDD Fiscal Offices were consolidated into one Central Fiscal Office. At that time, all Developmental Center and Regional Office policies, procedures, and guidelines were voided. From that date forward, official policies are those issued by the Department of Finance and Administration, the Department of General Services, and other state authoritative bodies, and internal DIDD policies and procedures which are approved by the DIDD Policy Committee and the DIDD Commissioner.

As the auditors noted, DIDD has issued Policy 209 in order to make trust fund policies consistent in each region of the state. The Office of Fiscal Services staff will continue working with program staff to ensure that all affected staff are adequately trained on Policy 209 and required documentation. Fiscal Services staff will work with program staff to ensure that monthly audits of resident monies are conducted timely and missing monies are reported

promptly to management. The Trust Fund Custodian will monitor paperwork to ensure forms are completed as per policy.

Fiscal Services staff has implemented unannounced monthly audits of the monies kept in the cottages and at HJC. The unannounced audits will be documented on the log kept in the cottage/HJC lockboxes.

The new policy does not require Security involvement or the use of a drop box for unspent funds. When unspent funds have not been returned, the Trust Fund Custodian notifies the supervisor and the Chief Officer via email by the 3rd business day. The supervisor must confirm the return of funds by the close of business that day or may be subject to disciplinary action for failure to follow the policy.

The Key Control Log does not adequately state the amount of money in unspent funds secured each day. This Log will be revised to include a column accounting for the funds in the locked boxes at the time the key changes hands from a departing to an arriving supervisor. In this way, we will strengthen the chain of custody. Any purchases from a person's funds are reconciled and verified daily by the residential supervisor/manager at the time the funds and receipts are returned to the home. We plan to tighten the verification process further by requiring a supervisor's initials on the receipts and the Personal Funds Request form.

Following two reductions in force, CBDC and the Fiscal Office had inadequate monitoring of the personal inventories for people supported. All residential managers and supervisors were trained on Policy 100.1.5. At CBDC, the designated staff members responsible for completing the personal property inventories are residential managers and supervisors. These inventories are monitored at least quarterly by the Residential Services Coordinator and the HJC Building Manager, who submit reports to the Director of Residential and Case Management Services.

The Office of Risk Management and Licensure's annual internal audit of the Region will test the controls and procedures in place involving the risks noted in the finding.

GREENE VALLEY DEVELOPMENTAL CENTER AND EAST TENNESSEE COMMUNITY HOMES OPERATIONS

Resident Trust Funds, Petty Cash, and Special Accounts

The Greene Valley Developmental Center (GVDC) accounting office maintains trust funds for individual residents, including those residing at the East Tennessee community homes, which were constructed subsequent to the prior audit. The trust funds are used to receive and disburse funds on behalf of the residents. Individuals receive money from various sources, such as the Social Security Administration, relatives, and jobs, and employees of GVDC often make purchases on behalf of the individual with this money. Center staff have a fiduciary duty to ensure proper protection of and reasonable access to the trust funds, and management has

established policies and procedures to provide for the safeguarding of these funds and accountability for the use of these funds.

Subsequent to the prior audit, the center implemented a petty cash system, which provides a small amount of money for each resident (typically \$5), which can be used for impromptu spending such as vending machine purchases or out on a scheduled field trip. In accordance with the central office's "Personal Fund and Special Fund Accounts" policy, the petty cash funds are secured in individual envelopes that are kept in safes at the center and at the community homes. An Individual Accounting Form is used to record petty cash fund activity.

The center also maintains special accounts, which contain funds that have been donated to the center to be used for residents. Donations to these accounts are supposed to be supported by documentation showing the source of the funds and any restrictions placed on the funds.

The objectives of our review were to follow up on the prior audit finding and to determine whether staff at the Greene Valley Developmental Center

- followed the policies and procedures regarding the trust fund accounts;
- followed the policies and procedures over individuals' petty cash funds;
- maintained documentation for the special accounts; and
- either closed or consolidated special accounts that were inactive.

To gain an understanding of the controls over the trust funds, individuals' petty cash funds, and the special accounts, we obtained and reviewed the policies and procedures, interviewed key personnel, and performed walkthroughs of the procedures with staff. In addition, we reviewed the department's most recent Greene Valley Developmental Center internal monitoring reports.

To determine whether staff followed the trust fund policies and procedures, we obtained the range of Greene Valley Developmental Center check numbers for the period January 15, 2011, through March 29, 2012, and selected a random sample of 60 individual trust fund transactions from a population of 2,654. For the sample items, we reviewed the Request for Funds forms and corresponding receipts, check registers, check sign-out sheets, and bank statements to determine whether funds were properly safeguarded between the date the trust fund check was cashed and the date the related trip was taken or purchase was made; for unspent funds of more than \$10, we also determined whether funds were properly safeguarded between the date of the trip/purchase and the date the money was returned to accounting staff.

We obtained a list of 173 active residents at the Greene Valley Developmental Center and East Tennessee community homes as of March 29, 2012, and randomly selected a sample of 72 individuals. The sample included 10 individuals from each of the Greene Valley Developmental Center's six cottages and all four individuals residing in three of the five East Tennessee community homes. To test for compliance with the policies and procedures related to

petty cash, we performed unannounced testwork to determine whether the selected individual had petty cash available to him or her in the residence, petty cash funds were properly secured, and cash counts agreed to supporting documentation.

We obtained a list of the Greene Valley Developmental Center special accounts and related balances as of May 15, 2012, and reviewed available documentation supporting the accounts' creation. We obtained and analyzed the special accounts consolidation worksheet as of July 17, 2012, to evaluate management's efforts to close or consolidate inactive accounts.

Based on the procedures performed, we determined that staff at the Greene Valley Developmental Center

- did not always adhere to the policies and procedures regarding the trust fund accounts (see finding 4);
- followed the policies and procedures over individuals' petty cash funds;
- maintained documentation for the special accounts, with minor exceptions; and
- either closed or consolidated special accounts that were inactive.

4. Controls over individual residents' trust funds at Greene Valley Developmental Center and East Tennessee community homes were inadequate, increasing the risk for misuse or loss

Finding

As noted in the prior audit, the Greene Valley Development Center (GVDC) management and staff did not always adequately safeguard individual residents' money. Management concurred with the prior finding and has taken steps, which included policy revisions and additional staff training, to correct the deficiencies. We reviewed the trust fund process at GVDC and found that although the controls over this process have improved, employees at GVDC did not always secure trust fund money in the safes at the cottages before the planned trip or purchase and/or after the trip or purchase. We also looked at procedures at the East Tennessee community homes and found that the Community Home Supervisors did not retain the Safe Logs, which track the movement of money into and out of the safe and establish accountability for the funds.

Continuing Issues Over the Safeguarding of Individuals' Funds at GVDC

According to the policy entitled Spending Money of Persons Living at Greene Valley Developmental Center, Section V, Part C, "All monies totaling \$10.00 or more and any receipts that are not turned in to accounting the day the checks are cashed or after the event must be placed in a safe in the home." We reviewed the bank statements and safe logs at GVDC to determine if employees were securing individuals' money in the cottage safe prior to the date of

purchase. We also reviewed the receipt dates and the check log to determine if all unspent money (above \$10) was secured at all times until the money was returned to the accounting office. We noted the following issues.

- The cashier did not properly log cash into the cottage safe between the date the check was cashed and the date of the purchase for 9 of 47 Request for Funds forms tested (19%). Therefore, we were unable to determine if the cash was adequately safeguarded at all times prior to the purchase.
- The cashier did not properly log cash into the cottage safe between the date of the purchase and the date the money was returned to accounting for 5 of 32 Request for Funds forms tested (16%). Similarly, we could not determine that the cash was properly safeguarded until it was returned to the accounting office.

New Issues Over Safe Logs at the East Tennessee Community Homes

Each community home has a safe to secure individuals' funds, and a Safe Log is kept to provide accountability for money put into the safe and money removed from the safe. Based on our review of the actual Safe Log, we found a notation at the top which stated to "(Maintain for 2 years)." However, as of our fieldwork in June 2012, we found that for four of nine East Tennessee community homes that were open as of March 29, 2012 (44%), the Community Home Supervisor did not retain all of the Safe Logs. Three of the homes opened in January 2012, but the earliest available Safe Logs were in March and April 2012. The other home opened on March 1, 2012, but the earliest available Safe Log was April 12, 2012. The Community Home Supervisors stated that they could not find all of the Safe Logs from the time the home was first opened and that accounting staff should have them. However, the accounting staff stated that they did not have the logs. In addition, one of nine Community Home Supervisors (11%) did not adequately complete the Safe Log; check numbers and cashier information were not included.

Failure to maintain documentation of the chain of custody of an individual's funds increases the risk that funds may be stolen or lost.

Management's risk assessment identified the risk that trust fund accounts may not be properly dispensed and back up documentation may not be maintained. To mitigate this risk, management stated that receipts are audited monthly. However, management's mitigating control is still inadequate because cash thefts cannot be properly prevented or detected through cash receipt audits alone.

Recommendation

The Trust Fund Custodian should ensure that Greene Valley Developmental Center staff consistently follow department policies in regard to maintaining the chain of custody of an individual's funds. The Home Supervisors for the East Tennessee community homes should ensure that staff in the community homes properly complete and maintain the Safe Logs to document the safeguarding and chain of custody of an individual's funds. In addition,

management should reassess the mitigating control related to trust fund accounts and back up documentation.

Management's Comment

We concur.

In December 2012, all DIDD Fiscal Offices were consolidated into one Central Fiscal Office. At that time, all Developmental Center and Regional Office policies, procedures, and guidelines were voided. From that date forward, official policies are those issued by the Department of Finance and Administration, the Department of General Services, and other state authoritative bodies, and internal DIDD policies and procedures which are approved by the DIDD Policy Committee and the DIDD Commissioner.

As the auditors noted, DIDD has issued Policy 209 in order to make trust fund policies consistent in each region of the state. The Office of Fiscal Services staff will continue working with program staff to ensure that all affected staff are adequately trained on Policy 209 and required documentation. Routine in-service staff training will be held with emphasis on securing, safeguarding, and documenting the individuals' monies within the cottages/Community Homes.

The Office of Fiscal Services staff will work with staff from both GVDC and ETCH to ensure that monthly audits of resident monies are conducted timely and missing monies are reported promptly to management. The Trust Fund Custodian will monitor paperwork submitted by both GVDC and ETCH to ensure forms are completed as per policy.

Fiscal Services staff has implemented unannounced monthly audits of the monies kept in the cottages and at Community Homes. The unannounced audits will be documented on the log kept in the cottage/Community Homes safes.

The Home Managers for the East Tennessee Community Homes (ETCH) will be retrained in the accurate use of Safe Logs and the importance of such logs. Retraining will be completed by April 2013 with documentation of such training filed in the employee training record.

It is not the policy of ETCH to maintain Safe Logs in the home for two years. The Safe Log form will be reviewed for content with the requirement for two year retention at the home site removed. The purged Safe Logs will be maintained in the ETCH main office.

The Office of Risk Management and Licensure's annual internal audit of the Region will test the controls and procedures in place involving the risks noted in the finding.

Inventory

The Greene Valley Developmental Center is responsible for maintaining records for supply items stored in its warehouse, as well as operating its own pharmacy. Examples of the center's supply items include detergent, gloves, and envelopes. Pharmacy staff administer medication as needed to the center's residents. Therefore, the center must maintain records related to the purchase and dispensing of pharmacy items.

The objectives of our review were to determine whether

- a perpetual inventory system was used to properly account for inventory and determine replacement needs;
- custodial, purchasing, and recordkeeping duties were adequately segregated;
- physical inventory counts were performed at least once a year;
- inventory records matched the inventory items on hand; and
- inventory records were appropriately adjusted to reflect the results of inventory counts.

To gain an understanding of the controls over inventory, we conducted interviews and performed walkthroughs with key personnel responsible for the supply and pharmacy inventories. We also obtained and reviewed relevant inventory procedures, and we reviewed the department's Office of Risk Management's most recently completed Greene Valley Developmental Center audit report.

We observed the center's comprehensive supply and pharmacy inventory counts, which were performed during the week of June 25 through 28, 2012, and we counted along with the center's counters. When we noted differences between the physical counts and inventory records, we obtained explanations for those variances. We documented and investigated instances where we observed that the supply physical count results were not properly reflected in the Edison inventory system. Additionally, we performed testwork on a nonstatistical sample of 25 supply items from a population of 1,179 to determine whether the physical count results were appropriately recorded in Edison.

Based on the procedures performed, we determined that

- a perpetual inventory system was used to properly account for inventory and determine replacement needs;
- custodial, purchasing, and recordkeeping duties were not adequately segregated, as described in finding 5;

- physical inventory counts were performed at least once a year;
- inventory records did not always match the inventory items on hand, as noted in finding 5; and
- inventory records were not appropriately adjusted to reflect the results of inventory counts (see finding 5).

5. Management has not mitigated the risks associated with inadequate controls over the Greene Valley Developmental Center pharmacy and supply inventories, increasing the likelihood of asset misappropriation or loss

Finding

The Department of Intellectual and Developmental Disabilities has not adequately addressed the risks associated with the Greene Valley Developmental Center (GVDC) pharmacy and supply inventories. We observed the year-end pharmacy and supply inventory counts performed by the GVDC staff on June 25 through June 28, 2012. During our observation, we identified weaknesses involving both inaccurate pharmacy and supply inventory records and inadequate segregation of duties for supply inventory functions.

Pharmacy and Supply Inventory Physical Counts Differed From Inventory Listings

GVDC uses perpetual inventory systems to maintain up-to-date information regarding the amounts of inventory on hand. Under these systems, staff update the inventory records at the time items are added to or removed from the inventory. We and the GVDC staff performed inventory test counts on all of the pharmacy and supply items and found that the quantity on hand did not always match the number of items shown on the inventory listing as detailed below.

Pharmacy Inventory Counts

For 464 of 1,039 pharmacy items counted (45%), the quantity on hand did not match the number of items shown on the inventory listing. Details are presented below.

Condition	Number of Items
Quantity on hand > quantity on listing	238
Quantity on hand < quantity on listing	226
Smallest difference	1
Largest difference	12,000

The Assistant Superintendent for Administrative Services explained that the discrepancies occurred due to multiple factors. The developmental center's former pharmacy

inventory system, the Accounting Cost Accounting Management Information System (ACAMIS), ceased to function properly and became inoperable in July 2011, leading to an increase in human errors by staff manually entering six months of data into the new Atrex pharmacy system, which GVDC implemented in December 2011. In addition, ACAMIS only allowed the Information Resource Support Specialist 2 to enter quantities in whole numbers and did not allow for decimals for products packaged as non-whole numbers. For example, GVDC entered 3.5 grams of pre-packaged ophthalmic ointment as 4 grams. Since Atrex allows decimals, the Assistant Superintendent for Administrative Services stated that these errors should no longer exist going forward.

In its report issued on October 10, 2011, for the period of March 1 through August 31, 2010, the department’s Office of Risk Management (ORM) reported a repeat finding on GVDC for inaccurate pharmacy inventory. GVDC management responded in part to the finding stating, “A complete physical inventory will be taken when the new system becomes fully operational to ensure the accuracy of the beginning inventory in the new system.” However, GVDC management did not perform a complete physical inventory until June 25, 2012, six months after the new Atrex pharmacy inventory system was implemented, increasing the risk that inventory items in the new system had an incorrect beginning balance.

Supply Inventory Counts

For 140 of 550 supply items counted (25%), the quantity on hand did not match the number of items shown on the inventory listing, as detailed below.

Condition	Number of Items
Quantity on hand > quantity on listing	66
Quantity on hand < quantity on listing	74
Overage of 1 unit	18
Shortage of 1 unit	23
Smallest difference	1
Largest difference	1,400

The Warehouse Storekeeper II provided explanations for the supply inventory overages and shortages. He believes that some of the overages were caused by his failure to update the Edison perpetual inventory to reflect obsolete items that had been discarded. The Warehouse Storekeeper II added that the shortages may have occurred because item quantities were miskeyed when initially entered into the Edison system.

In the ORM October 10, 2011, report, the office also took a finding on GVDC for inaccurate supply inventory records. GVDC management responded in part to the finding stating that they would “begin conducting more frequent inventory spot checks than our current practice of once monthly and by pinpointing errors through the fiscal year. This increased oversight should lessen as well as correct errors in a more timely manner and yield a more accurate inventory at any point in time.” However, the additional controls that GVDC

management listed were not adequate to prevent or detect the inaccurate supply inventory records because management failed to implement those controls as noted above by the Warehouse Storekeeper II.

Supply Inventory Duties Were Inadequately Segregated

During the supply inventory count, we observed that the Warehouse Storekeeper II served as both the custodian of supplies and the recordkeeper as inventory was entered and adjusted in the Edison perpetual system, resulting in inadequate segregation of duties that led to the Warehouse Storekeeper II's alteration of physical count records without independent verification. At the time the inventory counts were conducted, the Warehouse Storekeeper II had the following responsibilities:

- requested inventory purchases to be made;
- physically disposed of obsolete, unusable, and overstocked items;
- adjusted Edison records for disposals;
- participated in the year-end inventory count;
- performed recounts and investigations;
- provided explanations for supply inventory discrepancies;
- oversaw the personnel who updated the Edison records for shortages and overages after the inventory count was completed; and
- created the final variance report showing the differences between the physical count and perpetual records.

Based on our review of the year-end inventory process at GVDC, we found that the Administrative Services Assistant II, who coordinated the GVDC year-end inventory counts, had staff perform multiple recounts to verify that variances actually existed between the quantities of items on hand and inventory records. Following the conclusion of the inventory counts, she provided the Warehouse Storekeeper II with a listing which showed the variances between the physical count results and the Edison inventory records. Rather than updating the inventory records to reflect the actual count results, though, the Warehouse Storekeeper II realized that he was "familiar" with some of the items and did not think that a variance existed. Therefore, he performed separate recounts by himself to ensure that he was correct and that a variance should not be noted for the listed items. Then, the Warehouse Storekeeper II altered the physical count for five items. Of the five items for which he altered the count, the totals for three items were adjusted down, while the totals for two items were adjusted up. The adjustments ranged from one to 29 items. Although the Administrative Services Assistant II gave the Warehouse Storekeeper II approval over the telephone to change the count, neither she nor another GVDC

employee independently verified the accuracy of the Warehouse Storekeeper II's recounts. The Administrative Services Assistant II stated that she was unaware that the inventory custodian should not perform recordkeeping functions. She added that the warehouse personnel consist of a small team, but for future inventory counts, GVDC will have a separate person responsible for recordkeeping.

Without mitigating the risks associated with inaccurate inventory records, the department cannot ensure that inventory items are adequately safeguarded from misappropriation or loss. Pharmacy items in particular are sensitive in nature and, consequently, inherently susceptible to misappropriation. In addition, improper segregation of duties heightens the risk that errors, fraud, waste, and abuse may occur and remain undetected.

Given the problems identified in our testwork, we also reviewed the department's risk assessment. Although management both identified risks for system failure or malfunction and disposal of damaged or unusable items and listed mitigating controls, they did not develop and implement controls that were sufficient to compensate for the issues noted.

Recommendation

The Chief Financial Officer at the Department of Intellectual and Developmental Disabilities should ensure that perpetual inventory records are kept up-to-date and that periodic physical inventory counts are performed—including immediately following the implementation of new inventory systems—and necessary adjustments are made to inventory records. He should also ensure that significant overages and shortages are promptly investigated. The Chief Financial Officer should ensure that the Warehouse Storekeeper II does not perform recordkeeping duties for the same inventory for which he serves as custodian. Additionally, he should require that approvals for disposals be provided in writing. The Administrative Services Assistant II should ensure that all adjustments to the physical count records are independently verified.

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

Management's Comment

We concur.

The Chief Officer of GVDC will ensure that pharmacy staff implement stock controls and keep the computer inventory system up to date. As regards the item with the quantity discrepancy of 12,000, we would note that this item is IV fluid with a unit of measure of

“milliliter” and that the total value of the 12,000 unit discrepancy is \$19.20. The Chief Financial Officer will ensure that Fiscal Services staff perform periodic, announced inventories of the pharmacy as well as a minimum of one unannounced inventory per year.

As regards supply inventories, the Chief Financial Officer will ensure that these are kept up to date, have periodic and unannounced cycle counts, and have proper segregation of duties.

The Director of Risk Management and Licensure in conjunction with the Chief Financial Officer will revise the 2013 Risk Assessment to address the areas noted.

TELEPHONE BILLING

Each month the Department of Finance and Administration’s Office for Information Resources (OIR) bills the Department of Intellectual and Developmental Disabilities and other state departments and agencies for their use of information system and telecommunication services. Each department/agency is responsible for monitoring its telephone lines and ensuring that service to unused lines is promptly terminated.

The objectives of our review were to follow up on the prior audit finding and to determine whether

- the department maintained a current, comprehensive list of all its phone numbers;
- management performed reviews on the telephone lines; and
- the services for unused telephone lines were terminated in a timely manner.

We interviewed responsible employees about the telephone billing process and the department’s controls over this process. We obtained and inspected telephone listings for the department’s central office and east, middle, and west regions. We obtained the department’s portion of OIR’s telecommunications billing detail report for April 1, 2012, and selected a random sample of 60 telephone numbers to test from a population of 1,555. To determine the status of the telephone lines, we called each number in our sample and obtained the name and title of the employee to which the line belonged. If we could not determine the telephone line’s status by making calls, we consulted department personnel to obtain this information.

Based on the procedures performed, we determined that

- the department maintained a current, comprehensive list of all its phone numbers;
- management performed reviews on the telephone lines; and
- the services for unused telephone lines were terminated in a timely manner, with minor exceptions.

RISK ASSESSMENT

Section 9-18-104(b), *Tennessee Code Annotated*, requires the head of each state agency to conduct an assessment of the risks and systems of internal control in accordance with the guidelines prescribed under Section 9-18-103, *Tennessee Code Annotated*, and submit a report by December 31 of each year to the Commissioner of Finance and Administration and the Comptroller of the Treasury, which states that (A) the agency acknowledges its management's responsibility for establishing, implementing, and maintaining an adequate system of internal control and (B) a management assessment of risk performed by the agency provides or does not provide reasonable assurance of compliance with the objectives of the assessment. In the event that the agency's assessment does not provide reasonable assurance of compliance with the objectives of the assessment, the report should include a corrective action plan that identifies (A) any significant deficiencies or material weaknesses in the agency's system of internal control and/or lack of risk mitigating control activity and (B) the plans and the schedule for correcting the weaknesses.

The objectives of our review were to follow up on the prior audit finding and to

- determine whether management had fulfilled its responsibilities to formally assess the department's risks of errors, fraud, waste, and abuse;
- evaluate whether management included risks for each departmental location, known Community Services Tracking risks, and risks related to prior audit findings; and
- ascertain if management listed control activities to prevent or minimize risk for each risk item.

We interviewed key personnel involved in the risk assessment process. We also reviewed documentation related to the department's fiscal year 2009, 2010, and 2011 risk assessments. For each risk where management answered that no control activity was in place or that the control in place was not operating effectively, we performed additional inquiries and reviews to determine whether, after the 2011 risk assessment was compiled, the department either implemented further controls to effectively mitigate the identified risk or developed plans to apply such controls at a defined future date. In completing our testwork in other areas, we evaluated certain risks and controls to determine whether the corresponding control activities were adequately designed and placed in operation.

Based on the procedures performed, we determined that management

- partially fulfilled its responsibilities to formally assess the department's risks of errors, fraud, waste, and abuse (see findings 1 through 7);
- included risks for each departmental location, known Community Services Tracking (CS Tracking) risks, and risks related to prior audit findings, although risks involving

provider monitoring and CS Tracking were only partially identified, as discussed in findings 1 and 2, respectively; and

- did not develop control activities to prevent or minimize risk for every risk item. For those risk items where control activities were not listed to prevent or minimize the identified risk, though, management either implemented more controls to effectively mitigate the risk or developed plans to apply such controls at a defined future date, with the exception of risks identified in findings 1 through 7.

MEDICAID COST REPORTS

Through provider agreements with the Bureau of TennCare in the Department of Finance and Administration, the department's Clover Bottom Developmental Center (CBDC) and Greene Valley Developmental Center (GVDC) receive funding under Title XIX of the Social Security Act (Medicaid) for those individuals who are Medicaid-eligible. As Intermediate Care Facilities for Individuals with Intellectual Disabilities and Level I nursing facilities, both developmental centers must submit annual cost reports that are used in conjunction with budgeted information and other data to determine each facility's reimbursement per diem rates. The cost reports contain a list of expenditures related to patient care and administration that are eligible for Medicaid reimbursement. DIDD invoices TennCare for those developmental center costs that are reimbursable from TennCare; TennCare then requests reimbursement for allowable amounts from the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS). CMS is responsible for administering the Medicaid program.

The objectives of our review were to

- determine whether the department's central office had a documented process for allocating the central office administrative costs to the CBDC and GVDC for which the department requested Medicaid reimbursement in fiscal years 2010 and 2011;
- ensure that the cost allocation methodology that the central office used was approved by both the federal Centers for Medicare and Medicaid Services and the state Bureau of TennCare;
- ascertain if the central office administrative costs that were included in the fiscal year 2010 and 2011 CBDC and GVDC cost reports reconciled to the corresponding amounts in the cost allocation plan;
- determine whether the department submitted revised cost reports to appropriate state officials as necessary;

- assess the reasonableness of including the salary and benefit expenditures related to certain positions in the fiscal year 2011 central office administrative cost allocation; and
- determine whether the non-personnel costs included in the allocated fiscal year 2011 central office administrative costs were adequately supported and allowable to be included in the department's cost allocation.

To gain an understanding of the cost allocation and cost report process, we obtained the department's fiscal year 2010 and 2011 CBDC and GVDC Medicaid cost reports, cost allocation plans, and related documentation. We also conducted interviews and performed walkthroughs with key personnel responsible for compiling the cost reports and cost allocation plans. In addition, we researched relevant Medicaid rules and regulations and reviewed audit reports involving other states' Medicaid cost reports recently released by the federal government.

We obtained and reviewed evidence showing the approval of the department's fiscal year 2010 and fiscal year 2011 allocation methodology by the Centers for Medicare and Medicaid Services and TennCare. For both fiscal years, we compared the central office expense amount in the CBDC and GVDC cost reports to the corresponding expense reported in the cost allocation plan. We requested any revised CBDC and GVDC cost reports that the department had submitted.

We obtained a list of salary and benefit costs related to the 132 established positions included in the department's 2011 cost allocation plan, and we identified the job duties of the employees incorporated in the listing.

We obtained a list of expenditures for the two department IDs comprising the fiscal year 2011 central office cost allocation plan amounts. We eliminated the payroll costs associated with each department ID, and we performed testwork on the remaining amounts. For one department ID, we selected and tested a nonstatistical sample of 25 expenditures greater than or equal to \$1,000 from a population of 400 expenditures that were a part of the department's central office cost allocation amount. We also tested all expenditures totaling \$100,000 or more. For the other department ID, we tested all transactions greater than or equal to \$1,000.

Based on the procedures performed, we determined that

- the department's central office had a documented process for allocating the central office administrative costs to the CBDC and GVDC for which the department requested Medicaid reimbursement in fiscal years 2010 and 2011;
- the cost allocation methodology that the central office used was approved by both the federal Centers for Medicare and Medicaid Services and the state Bureau of TennCare;

- the central office administrative costs included in the fiscal year 2010 and 2011 CBDC and GVDC cost reports did not reconcile to the corresponding amounts on the cost allocation plan, as discussed in finding 6;
- the department submitted revised cost reports for fiscal year 2011 but not for fiscal year 2010 (see finding 6);
- including the salary and benefit expenditures related to certain positions in the fiscal year 2011 central office administrative cost allocation was reasonable; and
- non-personnel costs included in the allocated fiscal year 2011 central office administrative costs were adequately supported and allowable.

6. Management failed to establish controls governing the preparation of developmental center cost reports, increasing the risk that the department may receive improper Medicaid reimbursements from the TennCare program

Finding

Management of the Department of Intellectual and Developmental Disabilities (DIDD) did not implement adequate controls over its process for preparation of the developmental center cost reports, which are used to request Medicaid reimbursement from the Bureau of TennCare. As a result, the department may have received more or less Medicaid reimbursement funds than it was entitled to receive.

Residents served by the department's Clover Bottom Developmental Center (CBDC) and Greene Valley Developmental Center (GVDC), along with those in other Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID) the department operates, financially qualify for the federal Medicaid program. DIDD receives reimbursement from the state's TennCare program for services the development centers provide to Medicaid enrollees. The TennCare Bureau is responsible for obtaining reimbursement from the United States Department of Health and Human Services for allowable Medicaid expenditures. To determine the expenditures eligible for reimbursement under the Medicaid program, DIDD's developmental centers and other ICF/ID facilities prepare annual cost reports. DIDD's central office also incurs administrative costs that are included as a cost component of the cost reports. The activities of the central office are administrative in nature and benefit multiple organizational units within the department; therefore, the central office fiscal staff prepare annual cost allocation plans (CAPs) based on various statistical methodologies to allocate the administrative costs among the department's developmental centers and its other federally-funded and state-funded programs.

For fiscal year (FY) 2011 and previous fiscal years, the department's central office fiscal staff sent the fiscal staffs at CBDC and GVDC the amounts for their respective portions of the allocated central office administrative expenditures for their use in preparing the centers' cost

reports. To ensure that the central office's fiscal staff provided the centers with accurate administrative costs supported by the cost allocation plans, we compared the CAP amounts to the amounts reported in the centers' cost reports. Based on our review of the FY 2010 and 2011 CBDC and GVDC cost reports and related CAP amounts, we found that the central office's fiscal staff made errors in the CAP and had used preliminary expenditures rather than final expenditures. The details are described below.

Allocation Number Miskeyed in FY 2010 CAP

When tracing the department's FY 2010 central office's CAP to supporting documentation, we found that the central office Fiscal Director 1 miskeyed a number in the supporting schedule used to allocate central office administrative costs, resulting in inaccurate central office expenditure amounts in the CAP for both CBDC and GVDC. Specifically, we found that the Fiscal Director 1 incorrectly recorded the number of CBDC employees as 406; the correct number was 706, resulting in an understatement of 300 employees. Due to this error, he calculated CBDC central office expenditures as \$1,827,409 rather than the correct amount of \$2,529,737, resulting in an understatement of \$702,328 of administrative costs reported to CBDC. The error that he made in the CBDC allocation effected the allocation to GVDC, and as a result, the Fiscal Director 1 incorrectly computed the GVDC central office expenditures as \$4,781,858, when the costs should have totaled \$4,353,058, resulting in an overstatement of \$428,800. Combined, the CBDC and GVDC discrepancies resulted in a net understatement of \$273,528 in administrative costs reported to the developmental centers.

DIDD staff were not aware of this error until we brought it to their attention. The central office's Accountant/Auditor 1 agreed that the number of CBDC employees had been entered incorrectly, most likely due to a typographical error. Since the employee numbers in the allocation schedule are updated annually, the Accountant/Auditor 1 noted that the discrepancy was corrected for the FY 2011 cost allocation plan, and we did not note any discrepancy involving CBDC employee numbers during our review of that plan.

Central office expenses are an essential component of the developmental centers' Medicaid cost reports. Using an incorrect number when calculating the proper cost allocations could result in DIDD requesting improper Medicaid reimbursement from TennCare, leading to the state receiving more or less Medicaid funds than actually due. Even minor errors could have a significant impact on reimbursement amounts.

FY 2010 and FY 2011 CBDC and GVDC Cost Reports and CAPs Did Not Reconcile

During our review of the CBDC and GVDC FY 2010 and FY 2011 cost reports, we found that the centers' cost reports included central office expenditure amounts that did not reconcile with the corresponding central office CAP amounts, in violation of F&A's rules requiring the use of accurate financial data for cost report compilation. According to Chapter 1200-13-6.15 of the *Rules of the Tennessee Department of Finance and Administration*, "The cost reports filed . . . must provide adequate cost and statistical data. This data must be based on and traceable to the provider's financial and statistical records and must be adequate, accurate and in sufficient detail to support payment made for services rendered to beneficiaries." For

both fiscal years, the central office fiscal staff provided the CBDC and GVDC cost report preparers with incorrect central office expenditure amounts, and as a result, the developmental centers' fiscal staff through no fault of their own prepared and submitted inaccurate cost reports. DIDD fiscal staff did not review the cost reports prior to submission to appropriate state officials to ensure that the central office administrative costs listed in the cost reports matched the related CAP costs.

FY 2010

For FY 2010, the central office fiscal staff told the CBDC cost report preparer that the developmental center's share of central office administrative costs totaled \$2,481,525; however, this amount did not match the supporting CAP amount of \$1,827,409, leading to an overstatement of \$654,116. Additionally, central office fiscal staff gave the GVDC cost report preparer the amount of \$4,161,788 to use for central office administrative costs, which did not agree with the supporting CAP amount of \$4,781,858 and created an understatement of \$620,070. As a result of the errors noted above, CBDC requested Medicaid reimbursement of \$48,212 less than it was due, while GVDC requested Medicaid reimbursement of \$191,270 less than it was entitled. In total, because of the errors we noted, the state as a whole and the developmental centers in particular failed to claim allowable expenditures of \$239,482 for federal reimbursement.

Neither the Central Financial Officer (who became the Chief Financial Officer effective October 1, 2012), the Fiscal Director 2, nor the Fiscal Director 1 provided an explanation for these differences. The Central Financial Officer thought that the developmental centers may have submitted revised Medicaid cost reports as allowed per F&A rules, but he did not know for sure since compiling the original FY 2010 cost report and submitting any necessary revisions were functions of each developmental center's fiscal office rather than the centralized fiscal office. Chapter 1200-13-6.07 of the F&A rules stipulates, "In the event that a provider discovers a significant omission of costs, it may file an amended cost report at any time prior to the due date of its next annual cost report. After that time, the cost report cannot be amended for cost omissions." We determined that neither CBDC nor GVDC submitted revised FY 2010 cost reports since based on our inquiries, the developmental center cost report preparers were unaware that central office fiscal staff had provided them with incorrect data. The Central Financial Officer noted that with the department's transition from decentralized fiscal offices to a centralized fiscal office, the centralized fiscal office will be responsible for compiling and revising the developmental center cost reports starting with FY 2012, thereby enhancing oversight for these tasks.

FY 2011

For FY 2011, the central office fiscal staff provided the CBDC cost report preparer with the amount \$1,390,779 for central office administrative expenditures, which did not match the supporting CAP amount of \$1,276,180 and caused an overstatement of \$114,599. In addition, the central office fiscal staff gave the GVDC cost report preparer the amount of \$5,621,252 to use for central office administrative costs, which did not agree with the supporting CAP amount of \$5,416,768 and resulted in an overstatement of \$204,484. The net difference between the

central office expenditures on the developmental center cost reports and the CAP totaled \$319,083. Thus, if the department had not corrected the developmental center cost reports once we told them of the errors, the state would have received excess Medicaid reimbursements equivalent to the net difference.

The DIDD Fiscal Director 2, Fiscal Director 1, and Accountant/Auditor 1 all stated that the differences arose because the developmental centers prepared the cost reports based on preliminary expenditure figures, while the central office prepared the CAP based on final fiscal year expenditures. Central office staff claimed that they had to provide the developmental centers with preliminary numbers in order to complete the cost reports by the September 30, 2011, submission deadline, although they added that they usually request and receive a 30-day extension as allowed by F&A Chapter 1200-13-6-.07. For FY 2011, the central office Fiscal Director 1 provided the developmental center cost report preparers with the applicable central office expenditure amounts on September 2, 2011; the central office Accountant/Auditor 1 obtained the final CAP expenditure amounts from a report generated on September 12, 2011. When we asked why the report used for the CAP was not also used for the cost report since it was run before the cost report deadline, the central office Fiscal Director 1 reiterated that DIDD has to “draw a line” somewhere to complete the cost reports timely. Neither the Fiscal Director 2 nor the Fiscal Director 1 was aware that the differences between the cost report and CAP amounts were so large; they said that the preliminary numbers used for the cost report and the final numbers used for the CAP are usually much closer. Based on our discussions with developmental center staff, the central office fiscal staff failed to follow up and notify the cost report preparers that revised central office administrative costs were forthcoming.

Origin of FY 2011 Cost Report and CAP Amount Differences

Upon further questioning, central office fiscal staff were able to explain the origin of most of the difference between the cost reports and CAP amounts. According to the Accountant/Auditor 1, of the total differences, all but \$12,066 of the CBDC difference and \$57,904 of the GVDC difference arose from a change in cost allocation methodology during the CAP preparation process. Although the Accountant/Auditor 1 retained supporting documentation for the final CAP, he did not maintain the earlier version of the CAP showing the calculation of the central office administrative cost amounts provided to the developmental center cost report preparers. Failure to preserve documentation supporting the cost allocation amounts that were used to prepare the cost reports breaches the record retention requirements delineated in Chapter 1200-13-6.16 of the F&A rules, which state, “Each provider of Level I nursing facility services is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than five years from the date of the submission of the cost report.”

Based on our discussion with the Central Financial Officer at the time of our testwork, the department had until the next cost report due date of September 30, 2012, to submit revised FY 2011 cost reports in accordance with F&A Chapter 1200-13-6.07. He said that DIDD would submit revised cost reports for CBDC and GVDC before the deadline. According to the Central Financial Officer and the Accountant/Auditor 1, with the recent centralization of the

department's fiscal and administrative functions, they expect the cost report amounts and CAP amounts to more closely resemble each other in the future.

Because we brought the errors to their attention, the department did in fact submit revised cost reports for FY 2011 for the developmental centers prior to the September 30, 2012, deadline. At the time of our testwork, though, our discussion with the Fiscal Director 1 who prepared the original FY 2011 CBDC cost report disclosed that no revisions were forthcoming prior to our inquiries. Also, in subsequent meetings with the Central Financial Officer, he asserted that the department had consistently submitted revised cost reports in the past; however, when we researched this assertion, we found that no revisions were submitted for CBDC and GVDC for either FY 2008 or FY 2009. As noted earlier, our audit disclosed that no revisions were submitted for FY 2010.

Without proper internal controls in place to provide reasonable assurance that the department's objective of preparing accurate cost reports is met, DIDD may collect Medicaid funds either in excess of or less than allowable expenditures.

Given the problems identified in our testwork, we also reviewed the department's risk assessment. Although management identified the risks associated with noncompliance with Medicaid regulations in the department's risk assessment, they did not establish controls for the proper review of the cost reports or CAPs.

Recommendation

The DIDD Chief Financial Officer should ensure that adequate controls over the cost report compilation and revision processes are developed and implemented and that the CAPs are accurate. Specifically, he should ensure that

- he assesses the cumulative effect of the errors noted on DIDD's Medicaid reimbursements and either returns overpayment amounts to TennCare, which will then reimburse the Centers for Medicaid and Medicare Services, or requests additional funds the department is due from these entities within the designated time frame;
- the DIDD fiscal staff exercise greater care when compiling the cost reports and developing the cost allocation plans;
- adequate documentation is maintained to support the central office expenditure amounts reported in the CAP, as well as all cost report amounts;
- any changes to the CAP amounts are communicated to the cost report preparers as necessary;
- he performs documented reviews of both the cost reports and CAPs before they are finalized and submitted to the appropriate authorities, including comparing the central

office expenditure amounts in the cost reports to the corresponding amounts in the CAP; and

- he monitors the department's compliance with applicable F&A cost report rules and other Medicaid regulations.

Management should reassess the risks of noncompliance with Medicaid regulations particularly in regards to submitting inaccurate cost reports and preparing inaccurate cost allocation plans and ensure controls are in place to mitigate those risks.

Management's Comment

We concur. DIDD's management has implemented the following based on the auditors' recommendations:

1. All cost reports are now prepared in the DIDD Central Fiscal Office and undergo two reviews: supervisory review and by an independent fiscal staff who is not responsible for the cost reporting process.
2. All spreadsheets used to support the DIDD cost reports have been checked to ensure accuracy of formulas. A similar review will be done annually.
3. DIDD has researched and found adequate, third-party prepared documentation to support its depreciation, interest, and other costs that are a part of the cost reports.
4. The CAP preparers and the ICF cost report preparers are now the same group of staff. All their work is subject to two levels of review before cost reports and CAPs are submitted to the Comptroller and to TennCare.
5. DIDD will devote approximately 50% of one FTE to ensure that DIDD is familiar with CMS changes, TennCare changes, and other state or federal rule, policy, and procedure changes that may have an effect on cost reporting.

Federal ICF auditors have recently concluded an audit of DIDD's 2010 and 2011 cost reports. The report of this audit is still being written; however, they have verbally indicated that they will not be questioning any costs. Therefore, it appears there is nothing further to do on the reports for those two years.

The Office of Risk Management and Licensure will revise the 2013 Risk Assessment to address the areas noted.

INVESTIGATIONS UNIT

The Department of Intellectual and Developmental Disabilities' Protection from Harm Investigations Unit conducts internal administrative investigations into allegations of abuse, neglect, exploitation, unexplained serious injuries, and questionable or suspicious deaths for people receiving services through the department. The department maintains investigative teams in the east, middle, and west regions.

The objectives of our review were to

- determine if the Investigations Unit had written policies and procedures in place to govern the process for resolving allegations of harm to service recipients;
- evaluate the adequacy of the Investigation Unit's system for tracking the resolution of allegations; and
- assess the reasonableness of the Investigation Unit's resolution turnaround period.

We interviewed key personnel involved with the Investigations Unit and performed walkthroughs involving the allegation resolution process. We obtained and reviewed relevant policies and procedures. We obtained a list of all investigation cases for each region for the period January 15, 2011, through July 15, 2012. The lists included the date the incident occurred, the date it was reported to the Investigations Unit, and the date it was resolved. We selected and tested a random sample of 25 cases covering all three regions from a population of 578 to ensure that the open, closed, and report dates in the department's tracking system matched the dates from the final report drafted by the investigator. To analyze the turnaround period, we also used the lists to perform an analysis showing the percentages of those cases open over 30 days for each region for both open and closed cases. For each region, we analyzed the investigation cases to determine the average number of days closed cases were outstanding, the average number of days open cases had been outstanding, and the highest number of days a case was open. We selected a nonstatistical sample of 25 investigation cases across all three regions that were open more than 30 days from a population of 109 cases to determine whether the resolution time frame for the case was reasonable.

Based on the procedures performed, we determined that

- the Investigations Unit had written policies and procedures in place to govern the process for resolving allegations of harm to service recipients;
- the Investigation Unit's system for tracking the resolution of allegations was adequate; and
- the Investigation Unit's resolution turnaround period was reasonable.

ACCESS TO COMPUTER APPLICATIONS

The objective of our review was to determine whether management followed information systems' industry best practices regarding computer access. To determine whether management followed information systems' industry best practices, we compared management's internal control activities to the industry's best practices. Based on the procedures performed, we determined that management did not follow information systems' industry best practices regarding computer access (see finding 7).

7. **The department did not follow information systems' industry best practices regarding computer access, resulting in the increased risk of fraudulent activity or loss of data**

Finding

Based on our computer access testwork, the Department of Intellectual and Developmental Disabilities did not follow information systems' industry best practices, resulting in increased risk of fraudulent activity or loss of data. The wording of this finding does not identify specific vulnerabilities that could allow someone to exploit the department's systems. Disclosing those vulnerabilities could present a potential security risk by providing readers with information that might be confidential pursuant to Section 10-7-504(i), *Tennessee Code Annotated*. We provided department management with detailed information regarding the specific vulnerabilities we identified as well as our recommendations for improvement.

Recommendation

The Commissioner and the Chief Information Officer should ensure that these conditions are remedied through procedures that encompass all aspects of effective access controls. Management should reassess controls to include the risks noted in this finding in management's documented risk assessment. The risk assessment and the mitigating controls should be adequately documented and approved by the Commissioner. The Commissioner 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.

Management's Comment

We concur.

In January 2013, DIDD published a revised Employee Network and Computer Access Policy. This policy clearly defines the steps to be followed whenever an employee's access to the network needs to be deleted or changed.

Staff from DIDD Information Systems and Risk Management and Licensure will work together to conduct internal assessments to verify if the new processes are being correctly followed.

The Office of Risk Management and Licensure will revise the 2013 Risk Assessment to address the areas noted.

OBSERVATIONS AND COMMENTS

FOLLOW-UP ACTIONS ON MONITORING REVIEWS COULD BE STRENGTHENED

The Department of Intellectual and Developmental Disabilities (DIDD) has the immense responsibility of monitoring agencies that provide services to some of the state's most vulnerable citizens. The department could bolster its monitoring processes by applying the recoupment option for Quality Assurance (QA) reviews, which would allow the department to request that funds be repaid, and imposing sanctions for Fiscal Accountability Reviews (FAR).

Recoupment Option Not Exercised for Quality Assurance Reviews for Problems Found With Staff Qualifications and Training

The department's QA monitoring consists of two parts, staff qualifications and training. The staff qualifications category includes abuse registry checks, sex offender registry checks, felony offender registry checks, and Cardiopulmonary Resuscitation (CPR) and First Aid certifications. The training category includes maltreatment, introduction to mental retardation/developmental disabilities, safety in the home and community, sensitivity and ethics, specific needs, rights under the Americans with Disabilities Act, Individual Support Plan (ISP) overview, positive behavior supports, ISP implementation, medication administration, and fire safety/evacuation. If provider compliance for one of these QA areas falls below 85%, DIDD sends a warning letter to the provider to give notification of sanction.

During our review of all 65 QA sanction warning letters issued by the department from January 15, 2011, through April 25, 2012, we found that DIDD did not exercise the option included in its *Provider Manual* and Recoupment and Sanctions Policy to also recoup payments from the providers. The problems for which providers were issued sanction warning letters included allowing a nurse to provide services without a valid Tennessee license, not ensuring that new employees had the proper background checks performed, and failing to ensure that the background checks were performed by a company licensed in Tennessee. Section 1912.a of the *Provider Manual* states, "Recoupment means recovery of money paid to a provider due to the provider's failure to comply with TennCare or [DIDD] requirements for service provision or documentation of such. Reasons for recoupment by the [DIDD] shall include but not be limited to: . . . Provision of a service by a provider that did not meet [DIDD] or TennCare/Medicaid provider qualifications applicable to HCBS [Home and Community Based Services] waiver

services or other [DIDD], state, or federal provider qualifications applicable to state-funded services, including services performed by staffs who have not completed background or registry checks, or who have not completed all applicable training requirements.” In addition, Section D 6. of the department’s Recoupment and Sanctions Policy, effective October 2006, states, “The application of a recoupment shall be independent of the application of a sanction. Where applicable, both a recoupment and a sanction may be applied in accordance with this policy.”

Despite the *Provider Manual’s* and the policy’s explicit allowance of recoupments for problems that would be identified in QA reviews, the Office of Risk Management Director stated that the department’s practice has been to request recoupments exclusively for problems found during the department’s FAR monitoring. He noted that the department’s current Recoupment and Sanctions Policy states that both recoupments and sanctions “may” be issued, not “shall” be issued. However, he agreed that some situations may merit the application of both recoupments and sanctions. The Assistant Commissioner for Quality Management added that DIDD does seek recoupment for other problems identified during QA reviews, such as instances of incorrect billing; the department has just not been applying recoupments to noncompliance with staff qualifications and training requirements. The Office of Risk Management Director further explained that in the past, the time and effort it would take to pinpoint the monetary amount associated with noncompliance was prohibitive to the issuance of recoupment requests for Quality Assurance reviews. Additionally, DIDD is in the process of revising its sanction process. The department’s draft sanction policy, which has already been approved by the Bureau of TennCare but not issued for stakeholder comment, adds a central office-level review to ensure consistency with the application of sanctions among the department’s regional offices.

Problems identified in the QA reviews directly relate to individuals’ quality of care, and therefore, a provider’s violation of staff qualification and training provisions may potentially endanger the lives of the very individuals the provider is entrusted with protecting. For example, unlicensed nurses could run a higher risk of administering incorrect medication dosages.

Sanctions Still Not Issued for Repeat Findings Discovered Through the FAR Monitoring Process

Sanctions are measures imposed on a provider for noncompliance with TennCare/Medicaid or departmental regulations or policies. In addition to financial sanctions, DIDD may impose non-monetary sanctions, including written warnings to correct deficiencies, mandated technical assistance, a moratorium on providing services to other than existing service recipients, a moratorium on providing additional services or expansion of the provider’s service area, termination of the DIDD provider agreement for cause or for convenience, and the department’s assumption of management responsibility and control directly or through a DIDD-designated entity.

We reviewed the monitoring reports and supporting documentation for 25 providers monitored during the 2011 FAR monitoring cycle, including the top 10 providers. We discovered that 17 of the providers had the same finding for both 2010 and 2011, but the department did not issue sanctions for these providers even though the *Provider Manual* and the Recoupment and Sanctions Policy contain provisions authorizing this action. Our review did show that the department obtained recoupments from those providers with questioned costs.

According to the *Provider Manual*, section 19.12, DIDD “may directly impose sanctions or may recoup funds based on findings identified through [DIDD], TennCare, and/or other external monitoring processes.” Furthermore, as described above, the department’s Recoupment and Sanctions Policy states that the application of recoupments and sanctions are not mutually exclusive actions.

The Office of Risk Management Director agreed that in some cases, providers who have funds recouped based on FAR findings should also be sanctioned, although the department has not been doing so. However, he believed that both requesting recoupments and issuing sanctions was sometimes akin to punishing the provider twice for the same deficiency. He added that DIDD already issues sanctions for QA reviews. In addition, he said that providers may appeal sanctions to an Administrative Law Judge, but recoupments are not appealable. He considered the extra time and personnel resources involved in administering sanctions to surpass any benefits the department would receive in some instances. Furthermore, the Office of Risk Management Director believed that the current disciplinary actions that DIDD imposes for problems identified through the FAR monitoring process were effective, leading to a decrease in the number of problems found in subsequent years for those providers from which the department recouped funds. His viewpoint was that sanctions should only be used as a last resort.

In order to convey the seriousness of problems found by the QA surveyors in the hopes of preventing future violations while also staying within the boundaries established by the *Provider Manual*, the Assistant Commissioner for Quality Management should consider requesting recoupments for QA problems found with staff qualifications and training as situations warrant. She should also consider using sanctions, whether monetary or non-monetary, as a FAR monitoring tool as situations warrant to encourage the providers to improve their billing process and to ensure that the services provided comply with the ISP and are sufficiently documented.

APPENDIX

BUSINESS UNIT CODES

Department of Intellectual and Developmental Disabilities business unit codes

- 344.01 Intellectual Disabilities Services Administration
- 344.02 Community Intellectual Disability Services
- 344.04 Quality Assurance Program
- 344.10 Arlington Developmental Center
- 344.11 Clover Bottom Developmental Center
- 344.12 Greene Valley Developmental Center
- 344.15 Harold Jordan Center
- 344.20 West Tennessee Regional Office
- 344.21 Middle Tennessee Regional Office
- 344.22 East Tennessee Regional Office
- 344.30 West Tennessee Resource Center
- 344.31 Middle Tennessee Resource Center
- 344.32 East Tennessee Resource Center
- 344.40 West Tennessee Community Homes
- 344.41 Middle Tennessee Resource Center
- 344.42 East Tennessee Community Homes
- 344.50 Major Maintenance
- 344.81 Developmental Disabilities Council
- 344.82 Mental Retardation – Capital Projects