

Finding Number 98-DCS-11
CFDA Number 93.659
Program Name Adoption Assistance
Federal Agency Department of Health and Human Services
State Agency Department of Children's Services
Grant/Contract No. 9001TN1407 through 9801TN1407
Finding Type Material Weakness, Eligibility
Questioned Costs \$549.00

Controls over disbursements were still weak

Finding

As noted in four previous audits covering the period July 1, 1993, to June 30, 1997, Children's Services did not have sufficient controls to ensure that disbursements were properly processed. Management concurred with the prior finding and stated that senior management agreed to designate staff to identify DCS employees who will approve claims and invoices before they are submitted to the fiscal office. In the areas of residential and detention centers claims using Title IV-E funding, the approval process appears to be in place. However, designated approvers were not put in place for claims for foster care and child protective services funded with the Social Services Block Grant (SSBG) and Title IV-E. Problems included lack of supporting documentation, incorrect rates used, and insufficient approvals. Examples:

- Lack of Supporting Documentation - Children's Services does not maintain copies of foster care and adoption assistance contracts in the central office. Instead, the central office relies on information in the Children's Plan Financial Information System (ChipFins) to generate foster care and adoption assistance payments to vendors. Through testwork performed for the SSBG and Title IV-E sections, it was determined that the information in ChipFins is not always reliable or accurate (See finding #98-DCS-02

For SSBG, twelve of 40 expenditures tested (30%) were not allowable based on the actual foster care contract; however, the information in ChipFins showed the expenditure as being allowable. Five did not have valid foster care contracts, and for seven the foster care contract did not provide for therapeutic bonus fees paid by the department. These payments, totaling \$2,130.07, are included in the Schedule of Findings and Questioned Costs in the Single Audit Report for the year ended June 30, 1998. For the Title IV-E federal program, various problems were noted, such as:

- incorrect rates used to determine payment,
- payments not reimbursable under Title IV-E,
- incorrect number of days of service being paid to vendors, and
- payment not reasonable based on placement and goods or services received by the child.

These payments, totaling \$825.13, are included in the Schedule of Findings and Questioned Costs in the Single Audit Report for the year ended June 30, 1998.

- Insufficient Approval - Neither caseworker nor other knowledgeable party verified that goods or services had been provided to children before payments were made, and underlying records were not checked to ensure they reflect appropriate activities and allowable costs. This means that the department's central office paid vendor invoices with no knowledge that the invoices reflect actual expenditures. Because of the seriousness of this weakness in the department's internal controls, it will be reported as a material weakness in the 1998 Tennessee Single Audit report. For all 40 of the SSBG expenditures tested and 55 of 60 Title IV-E expenditures tested (91.6%), the receipt of goods or services was not verified, and underlying records were not checked to ensure they reflect allowable costs.

Effective internal controls are essential to account for government resources and to ensure that payments are appropriate. Management has the responsibility to institute control procedures that will ensure all transactions are properly authorized and supported. Management's responsibility for establishing effective internal controls includes effective supervisory review procedures to provide reasonable assurance that errors and irregularities will be detected timely. When there are no controls, payments may be made for goods or services that were not received.

Recommendation

The Commissioner should immediately determine why the Assistant Commissioner of Fiscal and Information Services and the Director of Fiscal Services did not take appropriate measures to strengthen the controls over the processing of all disbursements as assured in the department's responses to the last audit. If the department intends to rely on ChipFins to process foster care and adoption assistance payments, procedures should be in place to ensure ChipFins information is reliable and accurate. The Director of Fiscal Services should also ensure that proper supervisory approvals are obtained to minimize the likelihood of mistakes in processing transactions. The internal audit unit should continue to review the department's payment process to determine what changes need to be made to ensure that proper documentation exists for every payment.

Management's Comment

We concur. Program staff have been instructed and are cooperating in a review of all foster care contracts to make sure they are a valid and appropriate foster care contract based on current requirements. This corrective process began in early 1999 and will be completed by the end of this fiscal year for the foster care contracts funded with SSBG. As those foster care contracts are modified, fiscal staff are working to ensure they are correctly funded. A departmental policy has been developed for the review of all foster care contracts within a 12 month period which will also help facilitate the determination of contractual problems. This latter process will be occurring in conjunction with the SSBG process.

The Internal Audit Division, in conjunction with the Planning and Research Division have developed an authorization and approver process for a significant number of non-residential service contracts that are or will be part of the new network system. These controls were to have been implemented April 1999. The goal of the department is to have all claims go through an authorization and approval process before coming to fiscal for payment. After the April 1999 date, the Director of Fiscal Services is to be notified by payables staff of any claims for payment without a signed approval. Information concerning the lack of the required designated approver's signature will be accumulated and reported to management for appropriate corrective action.

Use of a standard claim process to insure that the rates paid agree with the rates contained in the designated contract was started in May of 1997 with improvements being made as determined necessary. We will continue to develop more adequate methods of controls for other contract payments.

In addition, please see the response to finding 98-DCS-02 for additional controls put in place for foster care contracts.

Finding Number	98-DCS-03
CFDA Number	93.667
Program Name	Social Services Block Grant
Federal Agency	Department of Health and Human Services
Pass Through Agency	Department of Human Services
State Agency	Department of Children's Services
Grant/Contract No.	Various
Finding Type	Reportable Condition, Allowable Costs/Cost Principles
Questioned Costs	\$8,313.29

Failure to resolve disciplinary issues in a timely manner resulted in the inappropriate use of state and federal funds for administrative leave with pay

Finding

The Department of Children's Services did not resolve disciplinary issues within a timely manner. In three instances, employees of the department were put on administrative leave with pay while investigations into alleged wrongdoing were being conducted. These employees remained on administrative leave with pay for 1,247 hours, 1,316 hours, and 1,285 hours, for an average of eight and a half months each. Review of the investigation files and the employees' personnel files, revealed that in all three cases, sufficient evidence existed early in the investigation either to remove the employee from administrative leave with pay or to dismiss the employee. There were many consecutive months during each investigation when no action was taken to resolve the matter. Therefore, the employees were not reporting to work, but were being paid even after there appeared to be sufficient evidence at least to put the employees on administrative leave without pay until resolution of the disciplinary issues. Two of the employees were eventually terminated and the other employee was reassigned to different job duties.

One of the employees was investigated for not performing her job duties adequately. It was found that the employee had not performed her job duties satisfactorily and the employee was reassigned to different job duties. Another employee was investigated for falsifying her employment application by not including a previous employer on her application. The employee had been criminally charged with grand larceny from this previous non-state government employer. In addition, the employee took sick leave when she was arrested on these charges. This employee was eventually terminated. The third employee was investigated for misappropriation of state funds and misuse of state property; this employee was eventually terminated for gross misconduct.

Two of the employees' salaries were paid with federal program funds. Since these employees were not benefiting the program during the investigation, it does not seem reasonable that the department continued to use federal funds to pay their salaries. The programs charged are Title IV-E Adoption Assistance (\$487.98), Title IV-E Foster Care (\$10,163.16), Title IV-B (\$776.33), Social Services Block Grant (\$8,313.29), and Title XIX (TennCare) (\$18,072.76). These payments are included in the Schedule of Findings and Questioned Costs in the Single Audit Report for the year ended June 30, 1998.

According to management, the disciplinary process was not handled timely because there were problems scheduling due process hearings and because of the number of investigations occurring at the same time. By not acting in a timely manner to resolve the disciplinary issues, the department misused federal and state funds.

Recommendation

The Commissioner should take appropriate steps to ensure that investigations and due process hearings are held in a timely manner. Employees under investigation should be taken off of administrative leave with pay as soon as there is sufficient evidence. In addition, the Assistant Commissioner of Fiscal and Information Services should be instructed not to use federal funds to pay salaries while an employee is on extended administrative leave with pay.

Management's Comment

We concur. Efforts are being made to ensure that investigations and due process hearings are held in a timely manner for a department with over 3,000 employees. A departmental policy will be developed so the Director of Fiscal Services will be notified when staff are on administrative leave with pay. Steps will then be taken to ensure that federal funds are not used to pay salaries while an employee is on administrative leave with pay status. The Commissioner has encouraged staff to proceed with appropriate action based on the testimony of investigators rather than wait for the release of written investigative reports.

In at least 50% of the cases handled by the department a grievant doesn't obtain an attorney or other representative in a timely manner to allow the hearing to go forward at the time and date set. This results in numerous delays and continuances in an attempt to coordinate all individual's (the grievant, the grievant's attorney, and the department's representative) schedules and that of the hearing officer's docket. During this time placing an employee on leave without pay could be considered as "taking action" which the department feels in most cases would be improper until the culmination of the investigation. The department will, however, make every effort to complete all investigations in a timely manner.

Finding Number 98-DCS-04
CFDA Number 93.667
Program Name Social Services Block Grant
Federal Agency Department of Health and Human Services
Pass Through Agency Department of Human Services
State Agency Department of Children's Services
Grant/Contract No. Various
Finding Type Material Weakness
Questioned Costs None

**The department continues to issue duplicate payments and overpayments to vendors;
\$185,288.52 was returned or refunded voluntarily by vendors**

Finding

As noted in four previous audits covering the period July 1, 1993, to June 30, 1997, the Department of Children's Services issued many duplicate payments and overpayments to vendors for goods and services provided to children. During fiscal year 1998, vendors voluntarily made over 140 refunds totaling \$101,759.63 and returned 305 original checks totaling \$83,528.99. Management concurred with the prior audit finding and stated that computer system edit changes were made to certain programs and that accounting and receivable staff would be providing fiscal management information explaining why the original checks and refunds were being returned to the department. According to management, the edit changes were made to the residential, prevention, and wraparound programs in fiscal year 1998. Reports concerning returns of original checks were provided to fiscal management starting in fiscal year 1999. However, it does not appear that the corrective action taken by the department was timely or completely effective. While the total dollar amount of duplicate payments and overpayments is significantly lower than the total in prior findings, the total number of original checks returned increased. This suggests that the significant decrease in the total dollar amount was not due to the implementation of good internal controls. Because of the seriousness of this weakness in the department's internal controls, it will be reported as a material weakness in the 1998 Tennessee Single Audit report.

Examples of some of the duplicate payments and overpayments are as follows:

- Nineteen overpayments were made to a discount store.
- Twelve duplicate payments were made to a mail delivery service.
- Six overpayments were made to deceased vendors. Four of these payments were made to the same vendor over a two month period.

The duplicate payments for goods or services could not be precisely explained. Vendors may have unintentionally submitted claims twice; vendors may have resubmitted original claims because they had not received prompt payment; or two separate parties involved with securing goods and services for the child may each have submitted the claim, unaware the other party had already submitted the claim.

Implementing computer system controls would decrease duplicate payments and overpayments to vendors and reduce the staff time required to process refunds and cancel warrants.

Recommendation

The Assistant Commissioner of Fiscal and Information Systems should take appropriate measures to establish adequate internal controls that will eliminate duplicate payments and overpayments. These controls should include ongoing procedures and processes to monitor the effectiveness of the controls and to ensure appropriate compliance with control procedures.

In addition, responsibility should be assigned to a specific person to monitor the reasons why duplicate payments and overpayments are being made and take appropriate action to greatly reduce these payments. Computer edit checks should be developed for expenditures other than residential, prevention, and wraparound.

Management's Comment

We concur. It is important to point out that overpayments for 1997-98 are less than .05% of the budget for the department. There were a total of 73,214 warrants issued in 1998 and only 305 were canceled according to the finding. This represents .4% of the warrants issued. This is not to indicate that the department is not continuing to address additional improvements in this area but the amount in the finding is only .07% (\$185,288.52/241,579,013.95) of the department's total disbursements.

Beginning April 1999, comprehensive reports on canceled warrants and refund checks are being prepared by fiscal staff and shared with the Director of Fiscal Services on a regular basis. Analysis of these reports will indicate the areas that should be targeted for improvement and the type of action that should be taken. A request has been sent to Information Resources to establish a database program to help locate duplicate entries for TOPS/STARS invoices. This program would list the invoice number, date, vendor name and the amount of the invoice. As new invoices are entered the system would check for any duplicates based on the invoice number and/or the amount.

Auditor's Comment

It should be noted that the dollar amounts and number of refunds and returns in the finding only represent the known overpayments. The actual amount of overpayments that have not been returned by the vendors is unknown.

Finding Number	98-DCS-06
CFDA Number	93.667
Program Name	Social Services Block Grant
Federal Agency	Department of Health and Human Services
Pass Through Agency	Department of Human Services
State Agency	Department of Children's Services
Grant/Contract No.	Various
Finding Type	Material Weakness, Subrecipient Monitoring
Questioned Costs	None

Children's Services subrecipient monitoring system is inadequate

Finding

The department did not have all monitoring reports and did not examine audit reports as part of the monitoring process for its subrecipients. The department has contracted with the Department of Finance and Administration (F&A) to perform monitoring of the department's subrecipients. The contract requires the department to approve corrective action plans submitted by the subrecipient responding to audit findings from the monitoring reports. However, no one in the department has been reviewing the monitoring reports, approving corrective action plans submitted by the subrecipients, or taking any further action that may be deemed necessary by the program specialists.

Not only has the department not been approving corrective action plans, but in many cases, the department did not even have a copy of the monitoring report on file. Office of Management and Budget Circular A-133 states that a pass-through entity is responsible for monitoring the subrecipient's activities to provide assurance that the subrecipient administers Federal awards in compliance with Federal requirements. In addition, the circular states that the entity is to ensure that required audits are performed and require the subrecipient to take prompt corrective action on any audit findings. The department did have audit reports on file for subrecipients, but the personnel responsible for subrecipient monitoring did not have access to these reports. If the department does not have the monitoring reports and does not examine audit reports as part of the monitoring process, the department cannot ensure that its subrecipients are administering the federal awards in compliance with federal requirements.

The department could not provide five of 15 (33%) subrecipients' monitoring reports or corrective action plans for subrecipients monitored during the audit period. In addition, the department could not provide documentation indicating approval of the corrective action plans for eight of 15 subrecipients (53%) monitored during the audit period. Because of the seriousness of the internal control weaknesses associated with subrecipient monitoring, this will be reported as a material weaknesses in the 1998 Tennessee Single Audit report.

Recommendation

The Assistant Commissioner of Programs and the Director of Programs should establish a tracking system to ensure all monitoring reports have been received and are on file at the department. The tracking system should document the name of the person who is responsible for reviewing the report and whether the corrective action plan was submitted by the subrecipient. The tracking system should also document whether the corrective action plan was acceptable and the date the subrecipient was made aware of the acceptance or denial of the corrective plan. There should be periodic reviews of these tracking reports by someone in upper management to ensure that corrective plans are being received and reviewed.

Management's Comment

We concur. The department will take action to insure that monitoring reports are reviewed and that corrective action plans are submitted. Corrective action plans will be reviewed for appropriateness with documented notification made to the subrecipient of acceptance or rejection of the plan. Internal Audit shall obtain from the Department of Finance and Administration a listing of all monitoring activities scheduled and verify that the reports are received by the department.

Finding Number	98-DCS-09
CFDA Number	93.667
Program Name	Social Services Block Grant
Federal Agency	Department of Health and Human Services
Pass Through Agency	Department of Human Services
State Agency	Department of Children's Services
Grant/Contract No.	Various
Finding Type	Material Weakness, Cash Management
Questioned Costs	None

The department has improperly managed state cash by not charging the appropriate federal grant at the time the initial expenditure transaction is made

Finding

As noted in three previous audits covering the period July 1, 1994, to June 30, 1997, the Department of Children's Services pays expenditures with state dollars initially and later reallocates the expenditure to the appropriate federal grant, creating significant time lapses between disbursements of state funds and actual drawdowns of federal funds. As a result, the state is losing interest income on and the use of state money used to fund federal expenditures. Because of the seriousness of these inadequate cash management policies and procedures, a material weakness in internal controls will be reported in the 1998 Tennessee Single Audit report.

Management concurred with the prior finding and stated a new computer system was put into place that would facilitate the drawdown process. According to management, the new system has been put into place; however, the system will not completely eliminate the problems noted in the prior audit. Management also stated in the prior audit report that the proposed financial management system of TnKids would be needed to fund expenditures by each child from multiple grants based on different eligibility requirements. However, as stated in previous findings in this report, the financial management part of TnKids has not even been approved by the Management Advisory Committee and has no timetable for implementation. Management also stated in prior comments that it is evaluating the practicality of developing computer programs to improve the current processing until the implementation of TnKids. According to management, the evaluation determined that changes could be made to the system to improve the processing of drawdowns until the implementation of TnKids. However, these changes have not been made.

According to the Department of Finance and Administration's Policy 20, "Recording of Federal Grant Expenditures and Revenues," Section 20-02-203, all grant-related expenditure transactions must be coded to the appropriate grants at the time the initial transaction is recorded.

During testwork on the department's two major federal programs, the following was noted:

- Title IV-E - All 60 expenditures tested were charged to the federal grant from three to 46 days after the initial transaction was paid with state dollars.
- SSBG - Twenty-two of 40 expenditure items tested (55%) were charged to the federal grant from ten to 61 days after the initial transaction was paid with state dollars.

The Foster Care Title IV-E program requires child-specific eligibility, but the SSBG grant does not. However, until the department charges all grants at the time the transactions occur, it will have

problems with all grants, child-specific or not, due to their methods of funding. This will in turn cause improper management of the state's cash.

Recommendation

The Assistant Commissioner for Fiscal and Information Systems should ensure policies and procedures are developed and implemented to improve its cash management activities. These policies and procedures should specifically provide for charging the appropriate federal grant at the time the initial transaction is recorded as required by Policy 20. Also, monitoring procedures should be developed to ensure the above procedures are implemented. Since the financial management part of TN KIDS has no implementation timeline, the department should implement changes in their funding process immediately to better manage the state's cash.

Management's Comment

We concur. Information Resources has indicated that staff will be available in May 1999 to begin the analysis for the fiscal funding project. The fiscal funding project will greatly assist in the cash management process. In addition, minor computer improvements have been requested to the drawdown program which will be ranked as a small project when Information Resources staff are available before the end of this fiscal year. It is a priority for fiscal policies and procedures to be developed which will include cash management activities. Please see the response to finding 98-DCS-10 for additional information.

Finding Number	98-DCS-10
CFDA Number	93.667
Program Name	Social Services Block Grant
Federal Agency	Department of Health and Human Services
Pass Through Agency	Department of Human Services
State Agency	Department of Children's Services
Grant/Contract No.	Various
Finding Type	Material Weakness
Questioned Costs	None

Controls over computer programming used for payment processing are not adequate

Finding

As noted in the prior three audits covering the period July 1, 1994, to June 30, 1997, computer programming controls associated with the payment system are not adequate. Management concurred with each of these findings and stated that the department is developing TnKids to support all department functions, including a comprehensive financial management system.

The design and implementation of TnKids was started January 17, 1997, and completion was initially estimated to be April 1998. The expected implementation date was changed from April 1998 to August 1998 to December 1998. The first phase of the new system, which only involves the Southeast region, has now been scheduled for implementation in March 1999 with all other regions expected to be implemented by September 1999. The payment processing functions are to be included in the financial management system of TnKids. However, the financial management portion has not even been approved by the department's Management Advisory Committee. Therefore, there is no timetable for design and implementation of this very important portion of the system.

Until the financial management portion of TnKids is designed and implemented, programs written using dBase or Foxpro software will continue to allow a single user to modify the program, manipulate files, enter data, and prepare reports. Because of the seriousness of these inadequate computer controls, a material weakness in internal controls will be reported in the 1998 Tennessee Single Audit report.

Inadequate controls over computer programming used for payment processing decrease the probability that errors or irregularities will be identified in a timely manner and increase the risk that employees will be able to inappropriately manipulate data.

Recommendation

The Assistant Commissioner for Fiscal and Information Systems should ensure adequate controls over computer programs are used for payment processing until the financial management portion of TN KIDS is working. Since there is no timetable for the financial management portion of the TN KIDS System, controls should be incorporated into the existing system and processes. Also, the Commissioner should continue to work with the Office for Information Resources to ensure the design and implementation deadlines for the TN KIDS System are met. The financial management portion of TN KIDS should be made a high priority in the implementation of the TN KIDS System.

Management's Comment

We concur. The date of completion for the development of the TnKids system has been moved back to accommodate necessary changes resulting from elements that have become requirements due to changes in legislation, etc. In addition, the department is determined that this system be beneficial to the end user and provide accurate information concerning children. In this effort, staff from the field level to the central office have been involved in the development of the system. The department is verifying federal compliance requirements prior to implementation. The department continues to move forward and has approved the financial management phase for development (phase 2.3). See finding 98-DCS-05 for additional information about this phase of the systems development.

The medical payment system does not have adequate computer programming controls. Fiscal staff and Information Resources staff are working in conjunction to address this problem. It is anticipated these changes will be in place by the end of this calendar year. Fiscal staff continue to use the standard claim invoice system developed by Information Resources to process residential and prevention claims. This system provides better controls for the payment process by preventing users from modifying the programs or manipulating the files.

Finding Number	98-DCS-11
CFDA Number	93.667
Program Name	Social Services Block Grant
Federal Agency	Department of Health and Human Services
Pass Through Agency	Department of Human Services
State Agency	Department of Children's Services
Grant/Contract No.	Various
Finding Type	Material Weakness, Eligibility
Questioned Costs	\$2,130.07

Controls over disbursements were still weak

Finding

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- Lack of Supporting Documentation - Children's Services does not maintain copies of foster care and adoption assistance contracts in the central office. Instead, the central office relies on information in the Children's Plan Financial Information System (ChipFins) to generate foster care and adoption assistance payments to vendors. Through testwork performed for the SSBG and Title IV-E sections, it was determined that the information in ChipFins is not always reliable or accurate (See finding #98-DCS-02).

For SSBG, twelve of 40 expenditures tested (30%) were not allowable based on the actual foster care contract; however, the information in ChipFins showed the expenditure as being allowable. Five did not have valid foster care contracts, and for seven the foster care contract did not provide for therapeutic bonus fees paid by the department. These payments, totaling \$2,130.07, are included in the Schedule of Findings and Questioned Costs in the Single Audit Report for the year ended June 30, 1998. For the Title IV-E federal program, various problems were noted, such as:

- incorrect rates used to determine payment,
- payments not reimbursable under Title IV-E,
- incorrect number of days of service being paid to vendors, and
- payment not reasonable based on placement and goods or services received by the child.

These payments, totaling \$825.13, are included in the Schedule of Findings and Questioned Costs in the Single Audit Report for the year ended June 30, 1998.

- **Insufficient Approval** - Neither caseworker nor other knowledgeable party verified that goods or services had been provided to children before payments were made, and underlying records were not checked to ensure they reflect appropriate activities and allowable costs. This means that the department's central office paid vendor invoices with no knowledge that the invoices reflect actual expenditures. Because of the seriousness of this weakness in the department's internal controls, it will be reported as a material weakness in the 1998 Tennessee Single Audit report. For all 40 of the SSBG expenditures tested and 55 of 60 Title IV-E expenditures tested (91.6%), the receipt of goods or services was not verified, and underlying records were not checked to ensure they reflect allowable costs.

Effective internal controls are essential to account for government resources and to ensure that payments are appropriate. Management has the responsibility to institute control procedures that will ensure all transactions are properly authorized and supported. Management's responsibility for establishing effective internal controls includes effective supervisory review procedures to provide reasonable assurance that errors and irregularities will be detected timely. When there are no controls, payments may be made for goods or services that were not received.

Recommendation

The Commissioner should immediately determine why the Assistant Commissioner of Fiscal and Information Services and the Director of Fiscal Services did not take appropriate measures to strengthen the controls over the processing of all disbursements as assured in the department's responses to the last audit. If the department intends to rely on ChipFins to process foster care and adoption assistance payments, procedures should be in place to ensure ChipFins information is reliable and accurate. The Director of Fiscal Services should also ensure that proper supervisory approvals are obtained to minimize the likelihood of mistakes in processing transactions. The internal audit unit should continue to review the department's payment process to determine what changes need to be made to ensure that proper documentation exists for every payment.

Management's Comment

We concur. Program staff have been instructed and are cooperating in a review of all foster care contracts to make sure they are a valid and appropriate foster care contract based on current requirements. This corrective process began in early 1999 and will be completed by the end of this fiscal year for the foster care contracts funded with SSBG. As those foster care contracts are modified, fiscal staff are working to ensure they are correctly funded. A departmental policy has been developed for the review of all foster care contracts within a 12 month period which will also help facilitate the determination of contractual problems. This latter process will be occurring in conjunction with the SSBG process.

The Internal Audit Division, in conjunction with the Planning and Research Division have developed an authorization and approver process for a significant number of non-residential service contracts that are or will be part of the new network system. These controls were to have been implemented April 1999. The goal of the department is to have all claims go through an authorization and approval process before coming to fiscal for payment. After the April 1999 date, the Director of Fiscal Services is to be notified by payables staff of any claims for payment without a signed approval. Information concerning the lack of the required designated approvers signature will be accumulated and reported to management for appropriate corrective action.

Use of a standard claim process to insure that the rates paid agree with the rates contained in the designated contract was started in May of 1997 with improvements being made as determined necessary. We will continue to develop more adequate methods of controls for other contract payments.

In addition, please see the response to finding 98-DCS-02 for additional controls put in place for foster care contracts.

Finding Number	98-DCS-03
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
Pass Through Agency	Department of Health
State Agency	Department of Children's Services
Grant/Contract No.	Various
Finding Type	Reportable Condition, Allowable Costs/Cost Principles
Questioned Costs	\$18,072.76

Failure to resolve disciplinary issues in a timely manner resulted in the inappropriate use of state and federal funds for administrative leave with pay

Finding

The Department of Children's Services did not resolve disciplinary issues within a timely manner. In three instances, employees of the department were put on administrative leave with pay while investigations into alleged wrongdoing were being conducted. These employees remained on administrative leave with pay for 1,247 hours, 1,316 hours, and 1,285 hours, for an average of eight and a half months each. Review of the investigation files and the employees' personnel files, revealed that in all three cases, sufficient evidence existed early in the investigation either to remove the employee from administrative leave with pay or to dismiss the employee. There were many consecutive months during each investigation when no action was taken to resolve the matter. Therefore, the employees were not reporting to work, but were being paid even after there appeared to be sufficient evidence at least to put the employees on administrative leave without pay until resolution of the disciplinary issues. Two of the employees were eventually terminated and the other employee was reassigned to different job duties.

One of the employees was investigated for not performing her job duties adequately. It was found that the employee had not performed her job duties satisfactorily and the employee was reassigned to different job duties. Another employee was investigated for falsifying her employment application by not including a previous employer on her application. The employee had been criminally charged with grand larceny from this previous non-state government employer. In addition, the employee took sick leave when she was arrested on these charges. This employee was eventually terminated. The third employee was investigated for misappropriation of state funds and misuse of state property; this employee was eventually terminated for gross misconduct.

Two of the employees' salaries were paid with federal program funds. Since these employees were not benefiting the program during the investigation, it does not seem reasonable that the department continued to use federal funds to pay their salaries. The programs charged are Title IV-E Adoption Assistance (\$487.98), Title IV-E Foster Care (\$10,163.16), Title IV-B (\$776.33), Social Services Block Grant (\$8,313.29), and Title XIX (TennCare) (\$18,072.76). These payments are included in the Schedule of Findings and Questioned Costs in the Single Audit Report for the year ended June 30, 1998.

According to management, the disciplinary process was not handled timely because there were problems scheduling due process hearings and because of the number of investigations occurring at the same time. By not acting in a timely manner to resolve the disciplinary issues, the department misused federal and state funds.

Recommendation

The Commissioner should take appropriate steps to ensure that investigations and due process hearings are held in a timely manner. Employees under investigation should be taken off of administrative leave with pay as soon as there is sufficient evidence. In addition, the Assistant Commissioner of Fiscal and Information Services should be instructed not to use federal funds to pay salaries while an employee is on extended administrative leave with pay.

Management's Comment

We concur. Efforts are being made to ensure that investigations and due process hearings are held in a timely manner for a department with over 3,000 employees. A departmental policy will be developed so the Director of Fiscal Services will be notified when staff are on administrative leave with pay. Steps will then be taken to ensure that federal funds are not used to pay salaries while an employee is on administrative leave with pay status. The Commissioner has encouraged staff to proceed with appropriate action based on the testimony of investigators rather than wait for the release of written investigative reports.

In at least 50% of the cases handled by the department a grievant doesn't obtain an attorney or other representative in a timely manner to allow the hearing to go forward at the time and date set. This results in numerous delays and continuances in an attempt to coordinate all individual's (the grievant, the grievant's attorney, and the department's representative) schedules and that of the hearing officer's docket. During this time placing an employee on leave without pay could be considered as "taking action" which the department feels in most cases would be improper until the culmination of the investigation. The department will, however, make every effort to complete all investigations in a timely manner.

Finding Number 98-DCS-12
CFDA Number 93.778
Program Name Medical Assistance Program
Federal Agency Department of Health and Human Services
Pass Through Agency Department of Health
State Agency Department of Children's Services
Grant/Contract No. Various
Finding Type Reportable Condition
Questioned Costs None

The department did not approve invoices of major medical vendors before payment was made, resulting in a voluntary \$281,145.47 refund from a major medical vendor

Finding

As noted in four previous audits, from July 1, 1993, to June 30, 1997, Children's Services did not adequately review the four major medical vendors' invoices for appropriateness, and these payments were not appropriately authorized by a state official. The only signature on an invoice was generally that of the physician, counselor, or nurse providing the service. Management concurred with the prior audit finding and stated that these four contracts ended on December 31, 1997. The vendor submitted invoices for services rendered prior to December 31, 1997, and the department paid these invoices with no approval or authorization by a state employee.

The purpose of the contracts with the four vendors was to provide services for medically fragile children who were not in state custody and who were not case-managed by departmental staff. The department did not require the vendors to prove denial of payment from any other source, such as a managed care organization (MCO) or a parent's private insurance, prior to payment. This control weakness resulted in one of the vendors receiving payments totaling \$281,145.47 from the department and from a MCO for the same services. This vendor discovered the duplicate payment and voluntarily refunded the money to the department. There were no controls in place at Children's Services to detect that the vendor had been paid by another source for the same services.

The initial payments to the vendor were at least partially funded with TennCare dollars. Therefore, TennCare paid for the same services twice, once through the MCO and then through Children's Services. As of December 1998, Children's Services had not performed the necessary research to determine the amount that should be reimbursed to TennCare. Consequently, Children's Services has held money that is rightfully due to TennCare for 12 to 18 months without making any effort to determine the amount reimbursable to TennCare.

Recommendation

The Assistant Commissioner of Fiscal and Information Services and the Director of Fiscal Services should ensure that the necessary research is immediately performed to determine the amount of the refund which is due to TennCare. Future contracts should include language requiring proper documentation for verification and approval purposes. Future refunds should be researched and disposed of in a more timely manner. Any additional billings made by these vendors should be thoroughly researched and approved before payment is made.

Management's Comment

We concur. Research has been ongoing to determine the amounts to be refunded to TennCare concerning this vendor. Twenty-four refund checks represented in the finding (13 refunds returned to TennCare as of April 1999 and 11 remaining to be processed) have been received from this medical vendor. As of April 1999, the 13 refunds totaling \$45,334.76 have been returned to TennCare. As stated in the finding, the medical contract for this particular vendor ended on December 31, 1997. TennCare and the department's receivables staff are working to reconcile the processing of these 13 refunds. At this time, it is not known how long it will take to complete the reconciliation of these 13 refunds. There are 11 refunds remaining to be researched and sent to TennCare for processing. The department is dedicated to processing these remaining 11 refunds as timely as possible. There will also be a reconciliation process for those refunds. The department is currently developing approval processes for all contracts issued through DCS and will complete this process as timely as regular work schedules allow.

Finding Number	98-DCS-13
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
Pass Through Agency	Department of Health
State Agency	Department of Children's Services
Grant/Contract No.	Various
Finding Type	Reportable Condition
Questioned Costs	None

The department did not process journal vouchers promptly, which resulted in approximately \$419,000 in lost interest income

Finding

As noted in the prior two audits, journal vouchers (used to record expenditure and revenue transactions between state departments) were not always processed promptly. Management concurred with the prior findings and stated that procedures would be developed to ensure that journal vouchers are processed in accordance with the time requirements of the Department of Finance and Administration's Policy 18, "Journal Voucher - Type J." According to management, procedures were developed and implemented after the prior audit period. Management also stated in their prior year comments that the department's internal audit staff would be monitoring for compliance with Policy 18, but this monitoring has not been performed.

In spite of management's assertions during the prior audit, the department did not bill TennCare for targeted case management and administration costs in accordance with Policy 18 during the current audit period. The department did not bill TennCare for services rendered by Children's Services, totaling \$22,982,172.06, from July 1, 1997, through December 31, 1997, until March 3, 1998, as much as nine months after the initial expenditure was incurred. Because TennCare bills the federal government for approximately 50% (federal share) of these expenditures, the state lost approximately \$419,000 in interest on these funds. In addition, the state lost the use of these funds for up to twelve months. Also, 14 of 60 other revenue and expenditure journal vouchers tested (23.3%) were not processed promptly in accordance with Policy 18.

According to Policy 18, expenditure (paying) journal vouchers which total \$2,500.01 to \$350,000.00 should be processed within five working days of the receipt of the journal voucher. Revenue (billing) journal vouchers totaling \$2,500.01 to \$350,000.00 should be processed at least monthly, and those over \$350,000.00, within five working days after the expense/ expenditure is incurred.

Errors of this nature and magnitude could jeopardize the state's cash position. If journal vouchers are not processed promptly, the accounting records for the affected departments could be misstated. Also, failure to process journal vouchers in compliance with Policy 18 could affect the state's compliance with the federal Cash Management Improvement Act of 1990.

Recommendation

The Commissioner should determine why the Assistant Commissioner for Fiscal and Information Services and the Director of Fiscal Services did not establish procedures to ensure that journal vouchers

were processed in accordance with the time requirements of the Department of Finance and Administration's Policy 18 as promised at the conclusion of the prior audit. Procedures should be established immediately to provide for regular monitoring of journal voucher processing to prevent mismanagement of this significance from occurring in the future. The internal audit division should review for compliance with these procedures and corrective action should be taken whenever the time requirements are not met.

Management's Comment

We concur, however, the department actually billed TennCare. TennCare entered batches in STARS for these journal vouchers in August 1998 after the required final approval was received on the interdepartmental agreement between the Department of Health and the Department of Children's Services in August. The following events delayed the processing of these journal vouchers until March. A major rewrite of the Department of Children's Services cost allocation plan for 1997-98 was undertaken at the request of management which included rebuilding over 33 cost allocation tables. The combination of cost allocation plan revisions, rebuilding the 33 tables and the development of a process to record federal administrative revenues in the appropriate cost centers were the major reasons for the delay. During discussions with TennCare about the billing process, it was determined a state plan amendment for the Department of Health would need to be sent to HCFA by TennCare. The state plan amendment dated June 30, 1998 was approved retroactive to April 1, 1998. All required approvals on the interdepartmental agreement were in place on August 14, 1998. The journal vouchers were processed by the Department of Finance and Administration's Division of Accounts on August 20, 1998. Fiscal staff are exploring ways to improve this process in the future.

The finding states that 14 of 60 expenditure journal vouchers were not processed promptly in accordance with Policy 18. Thirteen of those journal vouchers relate to billings by the Department of Education for the School Food and Nutrition program. A request has been sent to the Director of Accounts requesting ten days to process these type of journal vouchers due to the number of staff and the number of steps involved in the verification process, which is required for adequate support for the expenditure. The other journal voucher was submitted late by one of the Youth Developmental Centers due to ACA accreditation deadlines. Accounting staff at that Youth Development Center will be informed about the importance of adhering to the requirements of Policy 18.

In addition, the fiscal division of DCS is in the process of developing policies and procedures to address the Policy 18 compliance issue.

Finding Number	98-TDH-02
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	05-9705TN5028, 05-9805TN5028
Finding Type	Material Weakness
Questioned Costs	None

TennCare eligibility verification procedures are not adequate

Finding

The three prior audits of the Bureau of TennCare noted that in many cases, the eligibility of TennCare participants who are classified as uninsured or uninsurable had not been verified. Management concurred with the prior finding, stating that face-to-face enrollment and reverification projects would confirm eligibility information onsite. However, based on this audit, verification procedures did not adequately ensure all TennCare participants were eligible. Additionally, TennCare does not have an effective method to monitor the eligibility of TennCare/Medicaid recipients who are eligible because they receive Supplemental Security Income (SSI). See 98-TDH-17 for more information on the ineffective monitoring of SSI eligibility.

TennCare's reverification project began in June 1998, the last month in the fiscal year, and established face-to-face interviews for eligibility updates. This project was intended to reverify the eligibility of one-twelfth (1/12) of the entire uninsured and uninsurable population each month. TennCare also relied heavily on updates to the TennCare Management Information System (TCMIS) for reverifying eligibility through data matches and information received from various sources. These verification procedures, however, did not adequately ensure all TennCare participants were eligible.

Testwork revealed that 42 of 245 (17%) uninsured and uninsurable participants had not had their eligibility information updated in the last year. For 21 of the 42 found without updates, eligibility information had not been verified since initial enrollment in 1994.

Furthermore, using computer-assisted audit techniques to search the TennCare Management Information System (TCMIS), auditors found several TennCare participants had "pseudo social security numbers," e.g., numbers that began with 8 or had all zeros in one field. According to TennCare personnel, some applicants who do not have their social security cards and/or newborn children who have not yet been issued social security numbers are assigned these "pseudo" numbers. Management concurred with the prior finding stating that the reverification project described above would help ensure that valid numbers are obtained for enrollees when available.

Testwork revealed that 84 of 140 (60%) individuals found with "pseudo" social security numbers had not had a correct social security number entered on TCMIS, although the enrollment dates exceeded almost a year. Some of the TennCare participants found had been enrolled as early as 1983. Also, while it is not always possible to obtain social security information for newborns (0-3 months), auditors noted that several individuals with pseudo social security numbers were over a year old. As noted in the prior audit, management stated that TennCare strives to provide needed care to children as soon as possible and that the reverification project would help ensure that valid numbers can be obtained after enrollment.

According to the *Code of Federal Regulations*, Title 42, Section 435.910, the state agency must require, as a condition of eligibility, that those requesting services (including children) provide social security numbers. Additionally, Section 3(g) of the Code states that the agency “must verify the social security number of each applicant and recipient with the Social Security Administration, as prescribed by the Commissioner, to insure that each social security number furnished was issued to that individual, and to determine whether any others were issued.”

Adequate verification procedures are needed to ensure that only those eligible are enrolled in TennCare. According to Office of Management and Budget Circular A-133, payments are only allowed for individuals who are eligible for the TennCare/Medicaid program. The average amount paid per month to a managed care organization and to a behavioral health organization is \$104 and \$22, respectively. In fiscal year 1998, the Bureau paid \$1,744,414,397 to MCOs and \$325,590,444 to BHOs for TennCare enrollees.

Annual reverification is also necessary to obtain current, accurate information about family size, income, Tennessee residency, and access to other insurance. This information is also needed to determine whether participants previously considered eligible have become ineligible because of changes in their family or personal circumstances. Also, this information is used to determine the correct premium and deductible amounts paid by participants. TennCare's inadequate verification procedures will be reported as a repeated material internal control weakness in the 1998 Tennessee Single Audit Report.

Recommendation

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

Management's Comment

We concur that a formal face-to-face reverification process for the uninsured/uninsurable was not in place during the audit review period. As stated by TennCare to previous audit findings, even though a formal reverification process was not in place during the audit period, attempts were made to update enrollee information based on data obtained through various sources.

In April 1997, the TennCare Section of Information Services and the Facilities Manager (EDS) designed and implemented a new application processing subsystem. In conjunction with the new system, an on-line edit was created that would flag enrollees with duplicate applications. The edit reported any new application for an enrollee that had existing TennCare eligibility under another uninsured/uninsurable application. This edit condition created a reporting mechanism that allowed TennCare to identify applications for enrollees with existing eligibility after the records had updated the TCMIS database. A process was implemented to compare the information reported on the new application against the information provided on the older application. Since the new application contains the more current information, the older case is closed. This review includes comparison of family members, income and other pertinent information. While this process depends on the submission of a new application and has not occurred on all cases, we consider updated information on the uninsured/uninsurable cases meeting this condition to be part of reverifying their eligibility.

TennCare officially implemented a face-to-face Reverification System in June 1998. The design, development, testing and implementation occurred during this audit review period. TennCare initiated various reverification projects during the past three years. It is important to note that the new application processing system implemented in April 1997 became the foundation of the current production Reverification System. The enhancements of the current application subsystem eliminated many of the obstacles that prevented previous reverification implementations.

Information Services conducted numerous meetings with Health Department and TennCare Policy staff on the overall design and development of the Reverification project. The meetings were critical to evaluate staffing needs and system load/processing capabilities for 95 county Health Departments who would be responsible for conducting reverification interviews.

Reverification application data entry screens were constructed with on-line connectivity for all county Health Departments to the TennCare Management Information System (TCMIS). The screens would allow the Health Departments to enter new case information and edit the data for approval /denial results. Edit logic was implemented that provided Health Department staff with a screen that detailed whether the enrollee would remain eligible for TennCare. The screen would provide the detailed reason why an enrollee would no longer be eligible. Training regions were established within the OIR CICS on-line system for use by Health Department staff for Reverification training. In addition, a training packet that detailed reverification information was prepared to assist in the training process.

The Health Departments included information in their training that addressed validation of Social Security Numbers and obtaining a valid number for enrollees with pseudo numbers. As stated in this audit finding, pseudo Social Security number assignments will continue to occur for newborns because TennCare does not want to delay a child's access to health care because they haven't received an official Social Security number.

Notices are generated to cases that have been reverified. Each notice details family members approved for continued eligibility. Notices are also generated to enrollees losing TennCare eligibility, which informs them of their appeal rights.

The Bureau of TennCare worked with key Health Department staff in the determination on the number of cases to select for reverification each month. Staffing and other Health Department required activities were considered in the number of monthly cases selected for reverification.

The initial uninsured/uninsurable population targeted for Reverification included all cases added 1994 through 1996. The following describes the status of the project through June 1, 1999. These numbers represent approximately 80% of the original projected number of cases for this time period. These numbers have not been reviewed by the auditors.

- 81,871 Reverification Initial Selection notices mailed (Cases)
- 41,495 Reverification Cases completed by Health Departments
- 37,643 Reverification Cases Approved for continuing eligibility
- 3,021 Enrollees terminated through Reverification process
- 5,967 Cases have members who have been terminated for undeliverable mail or no response to initial Reverification notice

The Reverification system produces numerous outputs that are used to monitor reverification activities. These reports are shared with key TennCare staff and other departments who are involved in Reverification monitoring.

Finding Number	98-TDH-03
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	05-9705TN5028, 05-9805TN5028
Finding Type	Material Weakness, Subrecipient Monitoring
Questioned Costs	\$3,523.66

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

Finding

As noted in the previous audit and despite management's concurrence with the finding, TennCare has not monitored the Department of Children's Services (Children's Services) to ensure the accuracy and allowability of billings from that department. During the year ended June 30, 1998, TennCare paid approximately \$101 million in fee-for-service reimbursement claims to Children's Services. TennCare's failure to ensure Children's Services complied with all federal laws, regulations, and guidelines will be reported as a material internal control weakness in the 1998 Tennessee Single Audit report for the second year.

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

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

- Only services allowable under the grant are billed.
- The amounts billed are correct and allowable.
- The expenditures are valid and properly supported.
- Only eligible, licensed, or certified providers are providing the services.

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

This reliance includes not establishing predetermined, preapproved payment rates in the TennCare Management Information System (TCMIS), TennCare's claims processing and payment system, for all of the claims billed by Children's Services. When no rate is established in TCMIS, the system is programmed to pay any amount billed by Children's Services, without limit. TennCare has also relied on Children's Services to determine the treatment rates paid to the service providers for children in the state's custody. Children's Services pays the service providers for all services (treatment, room and board, and education) directly, then is permitted to bill TennCare only for the treatment portion. Based on testwork performed and numerous discussions with Children's Services management, management could not provide information as to how the treatment portion was determined. Without a methodology to determine the true treatment costs incurred by the service providers, Children's Services may be over- or underbilling TennCare for costs associated with medically necessary treatment. Because actual treatment

costs could not be determined, auditors could not determine the amounts of possible overbillings to the federal government.

Testwork on Children's Services claims also revealed the following:

- No supporting documentation (e.g., no case files and related details) for 4 of 60 claims tested. The amount questioned will be \$1,616.50.
- Children's Services billed TennCare for days when a child was on runaway status and no treatment costs were incurred by the service provider. The amount questioned is \$1,364.94.
- Children's Services is paying service providers directly for children in custody who are classified as Seriously Emotionally Disturbed (SED). TennCare has also paid the enhanced BHO capitation rate for these children. The amount questioned will be \$2,555.28.

Similarly, Children's Services claims are not reviewed or tested by TennCare's internal auditors, other bureau personnel, or the Department of Finance and Administration's Division of Research and Support. Although this problem was identified in the prior year's report, the TennCare bureau, again, has not monitored Children's Services' practices and ultimately was unaware that Children's Services billed for the health care costs of incarcerated children who were not eligible for Medicaid (TennCare). See 98-TDH-10 for more details.

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

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

Recommendation

The Commissioner should determine why Bureau staff failed to ensure that the Department of Children's Services properly administered its responsibilities under the TennCare program. All necessary steps should be taken to ensure that Bureau staff monitor Children's Services regularly for fiscal and programmatic compliance. The Commissioner and Assistant Commissioner should work with Children's Services to establish treatment costs for children in state custody.

Management's Comment

We concur. The Department of Health has entered into an agreement with the Department of Finance and Administration to monitor several aspects of the Department of Children's Services including internal controls. We have also met with the Department of Children's Services to review deficiencies noted by the fiscal year 1997 Comptroller audit of DCS, and the agreement with the Department of Finance and Administration will be used to follow-up on the corrective actions proposed by DCS. A task force headed by the Department's Director of Budget and Finance is working to establish a new rate setting methodology for children in state custody.

Finding Number	98-TDH-04
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	05-9705TN5028, 05-9805TN5028
Finding Type	Reportable Condition
Questioned Costs	None

**TennCare Management Information System
lacks the necessary flexibility and internal controls**

Finding

Management of the Bureau of TennCare has failed to address critical information system internal control issues. In addition, the TennCare Management Information System (TCMIS) lacks the flexibility it needs to ensure that the Department of Health and ultimately the State of Tennessee can continue to run the state's \$3.6 billion federal/state health care reform program effectively and efficiently.

Because of the system's complexity, frequent modifications of the system, and because this system was developed in the 1970s for processing Medicaid claims, TennCare staff and Electronic Data Services (EDS) (the contractor hired to operate and maintain the TCMIS) primarily focus on the critical demands of processing payments to the managed care organizations, behavioral health organizations and the state's nursing homes rather than developing and enhancing internal controls of the system.

According to Bureau personnel, the Director of Information Services alone prioritizes any system change requests, work requests, or any special requests for system information. If such a request does not involve the payment function to the external contractors, it is unlikely to be viewed as a priority according to bureau staff. Furthermore, the Director of Information Services does not penalize EDS when the contractor fails to perform under its contract.

As evidenced by the number of new and repeat findings, management of the department has not made internal control a priority. The TennCare bureau

- has not strengthened system security controls related to access (98-TDH-05), which resulted in a material weakness in internal control;
- currently utilizes two systems to prepare the required federal reports (98-TDH-06);
- has not made payments to certain providers in accordance with the rules (98-TDH-07);
- has not strengthened system controls for Medicare professional cross-over claims (98-TDH-08);
- made capitation payments for individuals who were not eligible for TennCare (98-TDH-09 and 98-TDH-10);
- failed to promptly update the system to process \$59 million of mental health waiver claims and reimburse the Department of Mental Health and Mental Retardation timely which resulted in lost interest income on the \$59 million of state funds used to pay that department's providers (98-TDH-11);

- did not provide information necessary to conduct audits of TennCare timely (98-TDH-12).

In its three-year information system plan dated July 1, 1998, TennCare submitted a proposal to study the replacement of TCMIS. According to Bureau personnel some progress has been made; however, due to concern about year 2000 issues, progress has been slow.

Recommendation

The Commissioner and the Assistant Commissioner for TennCare should consider the seriousness of the findings contained in this report and the nature and broad extent of repeat findings and make a commitment to regain control of the program. The Assistant Commissioner should assist the Director of Information Services in setting priorities for system changes and updates. Internal control responsibilities should be taken more seriously and given a higher priority. Penalties should be enforced as allowed by the contract when EDS fails to perform as required. In addition, the department should pursue the acquisition of a system designed for the managed care environment. The Commissioner and the internal audit unit should frequently monitor the activities of the responsible individuals correcting the problems and determine whether progress is being made. The Commissioner should take appropriate action if the problems are not corrected in accordance with the plans of action.

Management's Comment

We concur in part with the finding that the current TennCare Management Information System (TCMIS) should be analyzed to ensure that the TCMIS will continue to support the overall mission and goal of the TennCare program.

Prior to the inception of the TennCare program, the Information Systems in place were stable. The implementation of the TennCare program resulted in substantial new business and programming requirements. Furthermore, changes in business requirements and their relative priorities continue to drive new requirements and priorities for information systems support. These stages can be expected to continue until the program becomes more mature and predictable.

The overall information systems design does currently supply functional capability to address many of the critical TennCare business needs. However, the information systems in several areas of the TCMIS does not support the requirements adequately.

The current TCMIS uses a single-tier technical architecture consisting of the host computer (IBM compatible legacy mainframe), MVS/ESA as its operating system, TSO/CICS/-Cobol II as the development environment and VSAM as the vital structure. The TCMIS contains well over 200 gigabytes of data and is accessed by numerous TennCare users. This technical architecture is adequate in areas such as the maintenance of a large enrollee eligibility database and the processing of capitation payments to MCOs and BHOs. However, certain areas of the TCMIS do not adequately support the business environment. Data is maintained on separate large files and critical information within each file is not consolidated within a single database. Access to and quick retrieval of information contained within the TCMIS is cumbersome. Ad hoc reports are slow to execute because they run against large databases which were originally designed for data entry and transaction processing and not originally designed for data access and retrieval.

TennCare was able to provide significant improvement in the area of data analysis through the acquisition and implementation of the decision support system which utilizes the PANDORA software in

which data storage is highly structured and uses an operational database geared for data access and retrieval. This decision support system is utilized to analyze encounter data reported by the MCOs and BHOs to TennCare.

Because of the integrated nature of a managed care information system, there is little opportunity to replace one module of the TCMIS with the "Best in Class Module from any commercially available managed care information systems." We believe that opportunities exist to replace and/or layer additional subsystems on top of the TCMIS base in order to supply flexible functionality more rapidly. The Department currently has a project proposal to study replacing or adding layers to the existing TCMIS with newer technology. The Commissioner has been meeting with key TennCare staff within the Department and the Bureau of TennCare and with key staff from the Department of Finance and Administration to review the overall business goal and objectives of this proposal.

We do not concur with the finding that the Director of Information Services alone prioritizes any system change requests. The priorities for the TennCare program are set by the Assistant Commissioner. These priorities are influenced by: the program needs, needs of our Federal partner, input from other State officials, and input from provider and consumer groups. It is the Director of Information Services responsibility to prioritize the information system work in order to address the program priorities set by the Assistant Commissioner. A formal process for managing the deployment of information systems resources to support program priorities exists. Ensuring that program priorities are being addressed is a major goal of the TennCare Information Services Director and his staff. Their daily activities include formal meetings with TennCare Facilities Manager Contractor, EDS. Every effort is taken to formally identify resources available for systems development and system change requests and to produce reports to meet information requests. With the immense demands placed on the old system, pressures can increase for immediate needs. The TennCare Information Services Director is dedicated and committed to rapid response in spite of system limitations.

The facility's manager contractor has experienced difficulties in retaining staff with TCMIS experience. This impacts TennCare's ability to respond to request for information requiring ad hoc reports. However, every effort continues to occur in ensuring that priority requests are responded to timely and that all requests are responded to in a responsible manner. The TennCare Information Services Director is working with current EDS TennCare account management to identify and implement options for responding to the increasing demands on the system. It should be noted that the current year 2000 project has had and is having an impact on the availability of resources. The Information Services Director will work with the Assistant Commissioner when applicable to enforce penalties when the contractor fails to perform adequately. The contractor recently was placed on liquidated damages penalty for failure to complete specified contract requirements by the designated due date.

Internal control will be focused on as a high priority. A plan of action will be developed to address weaknesses. The Internal Audit unit will monitor the progress of the individuals implementing the plan of action to assure appropriate action in accordance with the plan.

Auditor's Comment

Based on interviews with bureau staff, the auditors' understanding was that the Director of Information Services prioritizes the deployment of information resources. The process of deployment was not fully described until "Management's Comments" were received on June 7, 1999.

Finding Number	98-TDH-05
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	05-9705TN5028, 05-9805TN5028
Finding Type	Material Weakness
Questioned Costs	None

Controls over access to the TennCare Management Information System are weak and inadequately documented

Finding

One of the most important responsibilities, if not the most important, for the official in charge of an information system is security. The Director of Information Services and the Security Administrator have held these positions at TennCare for five and four years respectively. The Director of Information Services is responsible for but has not implemented adequate TennCare Management Information System (TCMIS) access controls. As a result, numerous deficiencies in controls were noted during system security testwork. In addition, existing controls are not adequately documented. These weaknesses will be reported as a material internal control weakness in the 1998 Tennessee Single Audit report.

The TCMIS contains extensive recipient, provider, and payment data files; processes a high volume of transactions; and generates numerous types of reports. Who has access, and the type of access permitted, is critical to the integrity and performance of the TennCare program. Good security controls provide that access to data and transaction screens be limited to a "need-to-know, need-to-do" basis. When system access is not properly controlled, there is a greater risk that individuals may make unauthorized changes to the TCMIS or inappropriately obtain confidential information, such as recipient social security and Medicaid identification numbers, income, and medical information.

Current and complete documentation is necessary to adequately administer and monitor user access and system security and to increase accountability to management and internal and/or external auditors. Audit testwork revealed the following discrepancies.

No Security Authorization Forms

Access to TCMIS is controlled by Resource Access Control Facility (RACF) software. The purpose of RACF is to prohibit unauthorized access to confidential information and system transactions. The TennCare Security Administrator in the Division of Information Services is responsible for implementing RACF, as well as other, system security procedures.

The Security Administrator assigns a "username" ("RACF User ID") and establishes at least one "user group" for all TennCare Bureau and TCMIS contractor users. User groups are a primary method by which RACF controls access. Each member of a user group can access a set of TCMIS transaction screens.

The Security Administrator assigns every user to the "default group." To determine which other user groups, if any, an individual should be placed into, the Security Administrator determines the type of access other employees in the new employee's work area have and assigns him or her the same type of access. Therefore, access may not be assigned based on true needs because there is no signed and

approved security authorization form or documentation explaining the type and level (inquiry or update) of access required, except for programmers.

Failure to require signed security authorization forms with proper supervisory approval makes it more difficult to monitor user access. For example, it is not possible to compare the type and level of access needed and requested with the type and level of access given.

Unnecessary Access to TCMIS

User access testwork revealed that all users in the default group have access to at least 44 TCMIS transaction screens, some of which are not necessary for the performance of each user's job duties. Because of the lack of documentation, we were not able to determine the exact number of transaction screens available to the users in the default group or the nature and purpose of each transaction available. More generally, the Director of Information Services did not provide a comprehensive list and detailed descriptions of all TCMIS transaction screens, i.e., the transactions available to users in the default group and transactions available to users assigned to additional groups, as well.

Transaction Screens Not Protected

As discussed earlier in this finding, typically users must have a RACF user ID to sign on to TCMIS and access TennCare transaction screens. The auditors discovered that many transaction screens, including but not limited to recipient inquiry, eligibility history inquiry, Medicare history inquiry, long-term history inquiry, and liability history inquiry could be accessed without a user ID. This could occur if a user pressed a particular function key during the sign on process. The function key enabled the user to bypass the sign-on process and go directly to the transaction command screen. At that point, the user could enter one of the transaction screen commands and obtain unauthorized access.

This condition apparently existed because security levels for many screens were set to minimal values to facilitate a quick switchover when the old Medicaid system was modified for TennCare purposes. This occurred five years ago, but apparently no correction of the security weakness had been considered. Based on discussion with management during fieldwork, auditors recommended TennCare management review security settings for all screens and set the appropriate security parameter tables and security keys as deemed necessary.

More Lack of Documentation

TennCare personnel did not provide the following basic and essential information:

- documentation describing the purpose and proper composition, by job function, of the various TennCare user groups;
- a complete list and descriptions of all "external" TCMIS users, and explanations why the access is needed (external users were defined as users who are not employees of TennCare or the TCMIS contractor);
- the access to individual transaction screens available to all TennCare, TCMIS contractor, and external TennCare users;
- an overall diagram of the TCMIS that shows all of the various subsystems and modules;
- a list and description of the TCMIS-related functions performed by the Office for Information Resources (OIR), Department of Finance and Administration; and
- a list of policy and procedure manuals concerning the use and control over the TCMIS (both user and technical manuals).

It is difficult to understand how the individuals responsible for this system *could perform* their duties without having this information readily available. When this type of fundamental information is not available and organized it calls into question how the system can be effectively managed at all.

Security Administration Not Centralized

Testwork also revealed that the Security Administrator for the Department of Health, who is separate from TennCare's Security Administrator, gives users access to TCMIS. The department's Security Administrator is not required to notify the TennCare Security Administrator when users are given access to TCMIS. Furthermore, if users' RACF user names expire, the TennCare Security Administrator can reinstate the access of users given by the department's Security Administrator, and vice versa. When access to TCMIS is decentralized it is more difficult to monitor and control.

The TennCare Security Administrator relies on security administrators in other departments when a user in another department wants access to TCMIS. Although other departments' security administrators contact the TennCare Security Administrator to obtain the access, no explanation of why access is needed is required before access is given.

Lack of Monitoring

According to TCMIS system security personnel, users' type and level of access is not reviewed periodically. In general, management relies on individual supervisors to contact the Security Administrator if changes are needed. The Security Administrator stated, however, that often he was not informed. Although one would expect that if more access were needed users would contact the Security Administrator promptly, however users may not be as concerned about reporting the need for less access, as a result of changes in job responsibilities.

TennCare Application Data Entry Weakness

A report issued by the department's Office of Audit and Investigations in April 1998 noted that because TCMIS is "routinely down" employees at the Lakeshore Mental Health Institute leave "the system 'open' with their password allowing other employees to access the system." In addition, the report stated that adequate controls did not exist to prevent employees who enter TennCare application information into TCMIS from also approving the applications on-line. Good segregation of duties dictates that the data entry function should be separate from the approval function so that the same person cannot enter and approve a transaction. The auditor contacted the Director of Information Services to determine whether the concerns raised by the internal auditors had been addressed; however, no information was provided.

Employee Termination Procedures

According to the Security Administrator, TennCare has no procedures to ensure that user access is promptly canceled when employees are terminated from the department or the TCMIS contractor. The Security Administrator stated that supervisors for the contractor sometimes call him with the names of persons hired to replace terminated employees; however, he believed that improvement in this area was needed.

New TCMIS Transactions

As noted above, the auditor asked for a listing, with detailed descriptions, of all TCMIS transaction screens. Related to this, the auditors asked the Security Administrator if there were procedures in place to ensure that he was informed, on a timely basis, of new TCMIS transaction screens.

The Security Administrator stated that the TCMIS contractor sends a form to the Office for Information Resources (OIR) in the Department of Finance and Administration when a new transaction screen is ready to be placed into production. The Security Administrator, however, does not receive a copy of the form and typically is not informed about new transactions in a timely manner. In addition, the Security Administrator stated that at times he had to guess which users needed access to new transaction screens.

Recommendation

The Director of Information Services should set a tone for serious commitment to internal controls and recognize the obligation to protect confidential client information against unauthorized access. Specifically, the Director of Information Services should require employees to complete and sign request forms that document their specific system access needs. A supervisor should approve the request forms, and the Director should review the forms to determine if the requests appear appropriate. The same or a similar form should be obtained from all external users before access to TCMIS is provided. The forms should include the user's name, position, and division.

The Director should redefine user groups to strengthen access controls. The Director also should ensure that adequate system security records and documentation are maintained. Also, all transaction screens should be properly secured and all documentation should be provided to the auditors, as soon as possible, upon request.

Responsibility for TCMIS security should be centralized under the TennCare Security Administrator. The Director should ensure that system security monitoring procedures are developed, written, and implemented. A record of the procedures performed, and the results, should be maintained. The Director needs to make internal control a priority and should ensure the Security Administrator promptly addresses system security and concerns raised by the internal auditors.

Management should ensure that procedures are developed and implemented to promptly cancel access of terminated employees. Periodic tests should be performed to determine that terminated employees are promptly removed from the system. The Director should take the necessary measures to ensure that adequate information about new TCMIS transactions is provided to the Security Administrator. The Security Administrator should not guess, but be informed, in writing, who should be given access to new transactions and the type of access (inquiry or update) required. Finally, supervisors should notify upper management when security breaches occur.

Management's Comments

We concur that there should be internal security controls for the TennCare Management Information System (TCMIS). The TennCare Director of Information Services and his staff are committed to protecting confidential client information. While we agree that all procedures may not be documented, there are procedures in place to control unauthorized manipulation of files.

During the review period, a formal procedure manual did not exist. Since then, the TennCare Information Services Security Administrator has begun the task of documenting the procedures that are in place in addition to those that are being implemented.

We are currently reviewing all processes that are in place to ensure that there are sufficient security measures in place, as well as adding procedures/policies where they are lacking. A new security

authorization form is being developed and should document each employee's specific system access needs. External users will also be required to use the security authorization form.

No Security Authorization Forms

The Security Administrator conducts ongoing reviews to determine if there are users who do not have a security agreement on file. The security agreement forms are sent to the appropriate personnel to have signed and returned for filing. The current procedures in place require that the signed Security Agreement form be received before any ID is activated. Users and their managers that are identified without the proper security agreements on file receive notification that their RACF ID's will be revoked until the proper paperwork has been submitted. When the new security authorization form is implemented, periodic reviews will be conducted to assure their completeness and ongoing accuracy.

Unnecessary Access to TCMIS

While the default group has numerous transactions for inquiry and users in these groups may not have a need to use all transactions, they do perform functions that may require some or all types of inquiry, which are critical to TennCare business functions. The Director/Manager of each respective section or department is responsible for informing the TennCare Security Administrator which transactions are needed to perform their functions. The new security authorization form will contain information about each user to document particular need for access to various components of the system. A review is being done to the user groups to verify that the types of transactions for all groups are as they should be. Changes will be made as necessary.

Transaction Screens not Protected

This has been resolved. During the review, the audit team brought to our attention that a user could access inquiry to the system by pressing the F3 key to bypass the sign on screen. This was corrected immediately by the Information Services Section so that if an attempt was made to enter a transaction after the sign on screen was bypassed, an error message was returned.

More Lack of Documentation

The TennCare Information Services Director and his staff will review the items listed and assure that the necessary documentation is placed in the TennCare Security Administrator manual.

Security Administrator Not Centralized

We agree that it is necessary for the Security Administrator to be centralized. It is equally necessary for the Administrator to have sufficient backup. The Security Administrator for the Department of Health has served that purpose. TennCare was under the Department of Health at the time of the audit. The Bureau will explore naming a Bureau employee for backup. All security requests will be submitted to the TennCare Security Administrator and external users will be required to document why access is needed before access will be given.

Lack of Monitoring

Procedures are now in place to review all RACF ID security periodically.

TennCare Application Data Entry Weakness

The TennCare Security Administrator can not control whether a user leaves his/her ID signed on. Measures are in place and have been in place that systematically logs a user out of the system after a designated period of inactivity as defined by the Department of Finance and Administration, Office of

Information Resources. TennCare will ask the Internal Audit unit to review the current application processing function to assure appropriate segregation of duties.

Employee Termination Procedures

Procedures are in place to notify the TennCare Security Administrator when an employee terminates to revoke their ID. The TennCare Information Services Section is working with all TennCare Sections, departments, and users to ensure that the Security Administrator is notified timely when their employees are terminated. The Internal Audit unit will conduct periodic tests to assure that terminated employees are promptly removed from the system.

New TCMIS Transactions

As new TCMIS transactions are implemented, descriptions will be added to the TennCare Security Administrators procedure manual along with RACF Security designations submitted in writing with other information deemed necessary.

Auditor's Comment

Security Administration Not Centralized

We agree that the TennCare Security Administrator needs sufficient backup. During the audit period, however, the Security Administrator for the Department of Health acted in more than a "backup" capacity. Based on discussions with both the TennCare Security Administrator and Health's Security Administrator, Health's Security Administrator generally acted independently of the TennCare Security Administrator. Health's Security Administrator gave access to the TCMIS without consulting with or informing the TennCare Security Administrator. In fact, the TennCare Security Administrator was not aware of some of the transaction screens to which the Health Security Administrator was giving users access. Also, as stated in the finding, Health's Security Administrator was not required to notify the TennCare Security Administrator when access to the TCMIS was given.

Employee Termination Procedures

It is not clear from "Management's Comment" whether management disagrees with this section of the finding or if the procedures mentioned were implemented subsequent to the audit. During audit fieldwork the Security Administrator stated that he usually learned that an employee was leaving (or had already left) by word of mouth or, as stated in the finding, when supervisors with the TCMIS contractor sometimes called to notify him of personnel changes.

Also, the comment does not explain the nature of the procedures being used, e.g., an employee termination form or checklist. We strongly recommend that the Commissioner and the Director of TennCare ensure that formal procedures are developed and implemented to insure that the system access of terminated employees is canceled immediately.

During the next audit, the auditors will follow up on the finding to determine the existence and effectiveness of the procedures described by management.

Finding Number	98-TDH-06
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	05-9705TN5028, 05-9805TN5028
Finding Type	Reportable Condition
Questioned Costs	None

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

Finding

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

Although aware of the system's unreliability, TennCare still uses the system to determine the amount of overpayment adjustments (reductions in expenditures claimed because of overpayments) reported on quarterly federal expenditure reports to the Health Care Financing Administration (HCFA). However, management is concerned enough about the system's reliability to delay requests to Medicare to withhold provider payments until the cost settlement balances can be researched and confirmed using the provider account information in the TennCare Management Information System (TCMIS). (See 98-TDH-15 for more information about working with Medicare to collect provider cost settlements.) TennCare uses both systems because the TCMIS has not been modified to age receivables and does not provide the detail needed to easily track and analyze the receivable accounts.

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

When management reconciles the two systems, action can then be taken to collect the amounts due the state. However, it was determined that the on-site TCMIS contractor, Electronic Data Systems, takes two to three months to apply provider payments to the respective accounts receivable account. This delay creates large timing gaps between the two systems and adds confusion as to the correct amount of the receivable. In some instances, money was refunded to the provider when the provider actually had a zero balance or still owed TennCare.

Management concurred with the prior finding and hired an accountant to reconcile the systems. In addition, management stated that they were pursuing obtaining aged accounts receivable data through the TCMIS. Because this would require programming modifications to TCMIS, personnel in the Division of Budget and Finance submitted a "system change request" form to the Director of Information Services on April 3, 1997. As of November 1998, however, the requested system changes had not been made.

Accurate financial information is essential to effectively manage the fiscal operations of TennCare. When financial information and the systems used to compile the information are unreliable, management cannot make sound financial decisions, take appropriate action, and ensure the accuracy of federal financial reporting. In addition, it is time-consuming and costly to maintain and reconcile two computer systems.

Recommendation

To eliminate unnecessary or duplicate work and improve program financial management, including collection of accounts receivable, the Fiscal Director and his staff should perform a comprehensive review and assessment of their accounts receivable systems and procedures. The review should include the related procedures of the TCMIS contractor. Based on the results of the review, the Fiscal Director should take the appropriate steps to implement all needed changes, including system changes.

In the meantime, the Fiscal Director should ensure the provider balances on the TennCare Management Information System and the Medicaid Accounts Receivable Recoupment System are reconciled at least quarterly. Management should focus first on the most significant balances.

The Director of Information Services should ensure that the TCMIS is modified promptly to accommodate the financial management and reporting needs of the Division of Budget and Finance.

Management's Comment

We concur. The Bureau Fiscal Director and his staff will perform a comprehensive review and assessment of the accounts receivable systems and procedures. Staff will continue to take steps to identify and reconcile balances between TCMIS and the Recoupment system. The Director of Information Services will work with the Director of Budget and Finance to modify or convert the existing Recoupment system to eliminate the need to reconcile between the two systems.

Finding Number 98-TDH-07
CFDA Number 93.778
Program Name Medical Assistance Program
Federal Agency Department of Health and Human Services
State Agency Department of Health
Grant/Contract No. 05-9705TN5028, 05-9805TN5028
Finding Type Reportable Condition
Questioned Costs None

**As previously noted, since 1995 TennCare continues to not pay certain providers
in accordance with the departmental rules**

Finding

As noted in the prior two audits, covering the period July 1, 1995, through June 30, 1997, because TennCare has not complied with departmental rules, providers caring for enrollees who are both TennCare and Medicare recipients are sometimes overpaid. Management concurred with the prior findings and recommendations, and stated in fiscal year 1996 and again in fiscal year 1997, management would examine whether it is more appropriate to change the rules or their method of payment. However, no changes to the computer system or the rules have been made.

According to the Director of Fiscal Services, as of February 1999, TennCare is still researching the rules and has not determined whether it is more appropriate to change the rules or the computer system.

Medicare recipients are required to pay coinsurance and a deductible to the provider for services received. If the patient is also eligible for Medicaid, Medicare bills TennCare instead of the patient for the coinsurance and deductible. According to departmental rules, the total amount paid by all parties (Medicare, patient, and TennCare) cannot exceed the fee limitation set by TennCare. However, TennCare's computer system always pays the entire deductible billed for outpatient hospitalization services regardless of how much Medicare or the patient paid or any limitations set by the Medicaid fee schedule.

Recommendation

The Commissioner should determine why the staff has taken so long to research the rules and make a decision whether the method of payment or the rules should change. When a final decision is made, the Assistant Commissioner for TennCare should ensure that the Director of Information Services promptly makes the necessary changes to the TennCare Management Information System to bring the method of payment into compliance with departmental rules or have the rules amended.

Management's Comment

We concur. TennCare staff will be working with the Director of TennCare to bring payment methods into compliance with departmental rules. Additionally, the Bureau will examine its process for updating policies, procedures, and computer systems to reflect new developments and procedures for testing the claims pricing and payment subsystems.

Finding Number	98-TDH-08
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	05-9705TN5028, 05-9805TN5028
Finding Type	Reportable Condition, Allowable Costs/Cost Principles
Questioned Costs	\$9.10

TCMIS processing of Medicare professional cross-over claims still needs improvement

Finding

As noted in the prior audit, covering the period July 1, 1996, through June 30, 1997, there are several control weaknesses in the processing of Medicare professional cross-over claims (claims paid partially by both Medicare and Medicaid). The TennCare Management Information System (TCMIS) used to process these claims has not been modified and updated as needed to ensure claims are paid in compliance with state and federal laws. The amount of expenditures for professional cross-over claims during fiscal year 1998 was \$46,437,425.17. Management concurred with the prior finding and stated that policies, procedures, and computer systems would be reviewed in order to make necessary modifications. Also, management stated that the claims pricing and payment manual would be reviewed for any indicated revisions and would be updated to reflect changes in law and grant guidelines. However, TennCare management has failed to take these measures.

- Although professional cross-over claims have been Medicaid-eligible since the late 1980s, these claims are to be denied if the recipients have other insurance (third-party resources). However, TCMIS has not been updated to detect third-party resources on these cross-over claims. Testwork revealed that TCMIS failed to deny two cross-over claims even though the recipients had supplemental insurance information on the system. The questioned costs will be reported in the Tennessee Single Audit Report for 1998 because the error projects to approximately \$55,260. The total number of claims paid improperly and the actual total dollar amount paid in error for fiscal year 1998 was not determined.
- Despite the complex nature of the claims processing, bureau staff does not routinely perform manual pricing tests to determine if the system is paying claims properly.
- TennCare's fee-for-service claims pricing manual has not been updated.

Recommendation

The Commissioner should determine why TCMIS has not been updated to detect third-party resources on cross-over claims, and why the Director of the Policy Division has not revised and updated the claims pricing and payment manual to reflect changes in law and grant guidelines. Management and staff should keep abreast of new and changing program requirements and should ensure the bureau's policies, procedures, and computer systems are updated timely to reflect new developments. Also, the Commissioner and the Assistant Commissioner for TennCare should determine why the claims pricing and payment subsystem of TCMIS has not been tested routinely and take immediate action to implement testing.

Management's Comment

We concur. As stated in our response to 98-TDH-07, the Bureau will examine its process for updating policies, procedures, and computer systems for changes necessary to reflect new developments. Procedures will be implemented to assure that routine pricing tests are done to assure that claims are paying properly.

Finding Number	98-TDH-09
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	05-9705TN5028, 05-9805TN5028
Finding Type	Reportable Condition, Allowable Costs/Cost Principles
Questioned Costs	\$3,458,205.31

TennCare paid over \$6 million in capitation payments on behalf of deceased enrollees

Finding

Because TennCare failed to identify approximately 14,000 deceased enrollees, TennCare paid over \$6 million in capitation payments to the managed care organizations (MCOs) and behavioral health organizations (BHOs) on behalf of the deceased enrollees during the fiscal year ended June 30, 1998.

Using computer-assisted auditing techniques, we performed a data match comparing payment data from the Bureau of TennCare to death records from the Office of Vital Records (Vital Records). The results of the data match indicated that TennCare had improperly paid \$5,431,878 to the MCOs and \$827,185 to the BHOs.

Although management has procedures for identifying and disenrolling deceased recipients, including matching TennCare recipient files electronically with death record updates from Vital Records monthly, the procedures were not entirely effective. The Division of Information Services is responsible for performing all TennCare recipient eligibility data matches. According to the Director of Information Services, it appeared that the problem was caused by one or more of following:

- Only the most recent death record information from Vital Records was used for the data matches. The information did not include comprehensive death record information, or corrections.
- The criteria used by TennCare to detect actual and possible (“suspect”) matches was too restrictive. The program written by the auditor, which was less restrictive, detected more deceased enrollees.
- Suspect matches were not followed up adequately.

According to a manager in the Division of Information Services, a recipient is not removed from the program unless TennCare is certain that their information is correct (that the person has died). Despite this concern, however, TennCare does not send letters to recipients who are possible matches, based on the results of TennCare’s data matching procedures.

Also, each month TennCare receives doctor visit and medical procedure information (“encounter data”) from the MCOs and BHOs. Currently, this data is not being used to detect recipients

- who have not used their TennCare benefits for an extended period of time and, therefore, may have died, moved out of the state, or obtained other insurance, or
- who have been reported as deceased by their providers.

In a related matter, a report prepared by the internal auditors for the period October 1, 1997, through December 31, 1997, indicated that bureau staff were not using system-generated paid claims reports to ensure that Medicaid claims, such as nursing home claims, had not been paid improperly on behalf of deceased recipients.

Management stated that the payments to the MCOs probably can be recovered. It appears, however, that the payments to the BHOs cannot be recovered because their contracts state that they will receive a predetermined, total, annual amount. In addition, it is possible that the contract payments to the two BHOs were not allocated properly. Even if the improperly paid funds can be recovered, the costs to the state in the wasted actions of processing and paying the ineligible payments, and the costs of recovery cannot be recouped. Of the total expenditure, \$3,458,205 of federal funds will be a questioned cost on the Schedule of Findings and Questioned Costs in the 1998 Tennessee Single Audit Report.

Recommendation

Under the direction of the Commissioner, TennCare management should determine which capitation payments made on behalf of deceased recipients legally can be recovered and take the necessary steps to recover all such payments made since the inception of TennCare. Management also should consider whether any action is necessary regarding the monthly allocation of funds between the BHOs.

The Commissioner should ensure that the Director of Information Services considers the methodology used in detecting such payments and that the necessary changes are made to prevent future improper payments. The Director of Information Services should ensure that bureau staff effectively use the appropriate paid claims reports to determine if Medicaid claims have been paid improperly on behalf of deceased recipients, and prompt corrective action should be taken if improper payments are detected. Also, management should consider using the encounter data to detect changes in recipient eligibility.

Management's Comment

We concur. During the audit, TennCare staff met with the audit staff to discuss and validate methods used for the data match against the Vital Records files. The audit team shared their reports from the data match with TennCare.

As a result of the meeting with the audit team, Information Services staff met with Vital Records staff to discuss the date of death discrepancies identified by the auditors that existed between our databases. Prior to the meeting with Vital Records, Information Services researched existing data match processes to ensure the error was not occurring with the TennCare Management Information System (TCMIS). The meeting revealed that TennCare was not receiving corrected records. Vital Records agreed to start providing corrected records monthly.

In addition to the death data reported on the Vital Records file, TennCare also receives referrals from various sources (i.e. TennCare Information Line) and receives suspect match reports from the Vital Records match process. TennCare was granted approval to access the State On Line Query (SOLQ) into the Social Security Administration file, which contains date of death information. SOLQ access has provided TennCare with a valuable tool in the research and validation of death data that is not confirmed through the Vital Records validation/match process.

The audit group provided TennCare with a listing of 4,378 enrollees whose Social Security number matched exactly to TCMIS Social Security Number. As a result of the omission of corrected records from the Vital Records file, Information Services staff accessed the Social Security Administration file (SOLQ) to verify the date of death provided by the audit team. The TCMIS was updated for enrollee records validated through SOLQ. According to staff's evaluation, not the auditor's review, SOLQ did not contain death information on 22% of the enrollees listed on the audit report. The audit finding is correct in stating that match criteria used by the auditors was less restrictive than the criteria used by TennCare for date of death matching and subsequent TCMIS updates. TennCare is required to utilize more restrictive match criteria due to existing policy and court ordered requirements before termination of coverage. The percentage of non-matched records that occurred when the audit records were matched against the Social Security Administration database demonstrates why the more restrictive criteria should be used for automatic termination. The Director of TennCare Information Services has initiated discussions with appropriate TennCare Policy and Legal Staff to consider less restrictive data match criteria for the Vital Records matching process.

As a result of the TennCare Information Services manual efforts to react to the audit discovery, MCO capitation payments made from December 1997 through November 1998 for deceased enrollees were recovered in the December 1998 capitation check write representing approximately \$5,000,000.

We partially concur with the report prepared by Internal Audit indicating that TennCare staff were not using system generated paid claims reports made on behalf of deceased enrollees. These reports were not being worked timely and are now being worked by Information Services staff. Procedures have been implemented to ensure recoveries based on date of death information occur more timely. Each month after the Vital Records update, reports are produced that identify all claims paid that are beyond the enrollees' death date. The claims identified are voided or adjusted accordingly.

TennCare does load death dates based on data obtained from Medicaid claims, however, eligibility coverage is not closed until validation from Vital Records occurs. MCO capitation payments are recovered when date of death information is loaded to the TennCare database regardless of Vital Records matching.

We do not concur that the capitation payments made to the BHOs identified in this finding cannot be recovered due to contract language. As explained to the auditors, reconciliation of previous monthly capitation payments has not occurred since July 1997 because of changes to the reimbursement methodology. We do concur that it is possible payment allocations to the two BHOs could have been affected. We will perform a review to determine whether the allocations should be adjusted.

Auditor's Comment

Auditors were told by the TennCare Director of Budget and Finance and the Department of Health's Director of the Office of Budget and Finance that capitation payments made to the BHOs could not be recovered from the BHOs.

"Management's Comment" states that MCO capitation payments made from December 1997 through November 1998 had been recovered in response to the audit discovery. However the comment did not address the auditors' recommendation that management investigate whether improper capitation payments had been made on behalf of deceased enrollees since the inception of TennCare, in January 1994. If it is determined that erroneous payments were made, management should pursue recovery of the payments.

Also, management did not respond to the auditors' recommendation that management consider using the encounter data to detect changes in recipient eligibility.

Finding Number 98-TDH-10
CFDA Number 93.778
Program Name Medical Assistance Program
Federal Agency Department of Health and Human Services
State Agency Department of Health
Grant/Contract No. 05-9705TN5028, 05-9805TN5028
Finding Type Reportable Condition, Allowable Costs/Cost Principles
Questioned Costs \$302,134.32

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

Finding

As noted in the prior audit, because TennCare failed to identify incarcerated youth enrolled in the program, even though there are procedures to identify incarcerated adults, TennCare improperly paid for the health care costs of youth in the state's developmental centers. Under federal regulations (*Code of Federal Regulations*, Title 42, Section 435, Subsections 1008 and 1009), the state, not the federal government, is responsible for the health care costs of juvenile and adult inmates. Management concurred with the prior finding stating that they would work with the Department of Children's Services (Children's Services) to determine how they will ensure that procedures exist to prevent the billing of services provided to incarcerated youth. Although TennCare's management has met with Children's Services management, it appears that TennCare still has not taken sufficient action to implement effective procedures to prevent payments for incarcerated youth.

Using computer-assisted audit techniques, a search of TennCare's paid claims records revealed that TennCare made payments totaling at least \$571,880.03 from July 1, 1997, to June 30, 1998, for juveniles in the youth development centers. Of this amount, \$298,519.38 was paid to managed care organizations (MCOs); \$107,661.26 was paid to behavioral health organizations (BHOs); and \$165,699.39, to Children's Services. In addition, it was noted in the Children's Services audit that another \$10,400 was paid on behalf of children in detention centers. A total of \$474,618.77 is questioned.

The amount paid to the BHOs will not be questioned because they are paid based on a predetermined budget for mental health services approved by HCFA. Therefore, the total payments to the BHOs does not change regardless of the number of enrollees.

The payments to the MCOs were monthly capitation payments—payments to managed care organizations to cover TennCare enrollees in their plans. Since the bureau was not aware of the ineligible status of the children in the youth development centers, TennCare incorrectly made capitation payments to the MCOs on their behalf.

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

All known and estimated errors will be included on the Schedule of Findings and Questioned Costs in the Tennessee Single Audit report for the year ended June 30, 1998.

Recommendation

The Assistant Commissioner for TennCare should ensure the bureau develops and implements the procedures necessary to ensure federal funds are not used to pay for the health care costs of incarcerated juveniles. Management's top priority should be to pay only for eligible recipients. The Commissioner and the Assistant Commissioner for TennCare should ensure that the Director of Information Services designs and implements computer-assisted monitoring techniques to promptly detect ineligible enrollees. Amounts incorrectly paid should be recovered.

Management's Comment

We concur. TennCare staff have met with the Department of Children's Services on this subject and will be utilizing our monitoring agreement with the Department of Finance and Administration to examine internal controls over this area. In addition, we will pursue implementing computer-assisted monitoring techniques for detecting incarcerated youth.

Finding Number 98-TDH-11
CFDA Number 93.778
Program Name Medical Assistance Program
Federal Agency Department of Health and Human Services
State Agency Department of Health
Grant/Contract No. 05-9705TN5028, 05-9805TN5028
Finding Type Reportable Condition
Questioned Costs None

**The TennCare Management Information System was not updated timely to process
Department of Mental Health and Mental Retardation claims**

Finding

Claims from the Department of Mental Health and Mental Retardation (DMHMR) for services provided during the 1997 fiscal year (July 1, 1996, through June 30, 1997) were not paid until September 1997 because TennCare management failed to process the system change request to update the procedure codes and the payment rates in the TennCare Management Information System (TCMIS).

DMHMR annually contracts with providers to render services to recipients in the Home and Community Based Services–Mental Retardation (HCBS–MR) Waiver program administered by TennCare. After services are performed, the providers bill DMHMR, which then, under the HCBS–MR waiver, files claims with TennCare to be reimbursed for services paid to the providers.

Testwork revealed that TennCare failed to reimburse DMHMR for services paid to the providers because all of the procedure codes and reimbursement rates were not updated on the TCMIS, as stated in the system change request, until March 1997. Therefore, DMHMR was unable to bill TennCare for reimbursement of approximately \$59 million already paid to providers during the 1997 fiscal year, causing DMHMR to use state funds to reimburse providers. Apparently, poor communication between TennCare and DMHMR further delayed processing until the end of the 1998 fiscal year.

Recommendation

The Commissioner and the Assistant Commissioner for TennCare should ensure that the system change requests used to update the TennCare Management Information System are processed timely so as to avoid the unnecessary use of state funds when federal matching funds are available.

Management's Comment

We concur. TennCare will examine the procedures for implementing system change requests. One goal of the reorganization plan is to improve communication between the TennCare Bureau and other departments so situations like this will be less likely to occur.

Finding Number 98-TDH-12
CFDA Number 93.778
Program Name Medical Assistance Program
Federal Agency Department of Health and Human Services
State Agency Department of Health
Grant/Contract No. 05-9705TN5028, 05-9805TN5028
Finding Type Reportable Condition
Questioned Costs None

For the fourth straight audit, since July 1, 1994, the Director of Information Services did not provide information necessary to conduct audits of TennCare timely

Finding

During the prior three audits, covering the period July 1, 1994, through June 30, 1997, the Director of Information Services has not always provided the auditors with requested TennCare Management Information System (TCMIS) information timely. The Director also has not demonstrated a full understanding of and concern for the objectives of the audit and what is necessary for achievement of the objectives. Because the TCMIS is central to the function of the TennCare program, it is impossible to audit the TennCare program without obtaining critical information about the system and the data processed by the system. The Director is responsible for managing both the staff of the Division of Information Services and the contractor hired to maintain and operate the system. Therefore, the auditors must submit numerous requests for information to the Director.

As noted in the three prior audits, the auditors experienced significant delays (two months), or were not provided with critical TennCare recipient eligibility information. Because of these and other problems, at the start of this audit the auditors discussed their concerns about audit delays in the area of Information Services with the Commissioner at the field entrance conference. At the Commissioner's request, a planning meeting was held with the Director to communicate the audit needs and address and identify the audit timetable. To help facilitate audit information requests, the Commissioner also assigned the Assistant Commissioner of the Office of Budget and Finance, as the audit liaison. Despite these efforts, the situation did not improve.

Typically, a variety of information-gathering techniques are used during the audit process, including inquiry, observation, and inspection. On occasion unannounced visits are necessary to accurately evaluate actual processes and operational conditions. Because the Director asked that many requests be submitted in writing, and that contact with the employees of the data processing contractor be arranged in advance through their supervisors, at times it was difficult or impossible to employ these standard auditing techniques. This is a concern because the contractor's employees perform critical TennCare functions on a daily basis.

In several instances, information was not provided or was not timely. Often it appeared that the Director's primary objective was to control the flow of information to the auditors rather than provide a free flow of information. For example, the Director refused to provide the auditors with the telephone listing for the data processing contractor; and other information requested in September 1998, had not been received by January 6, 1999. In addition, it took several requests and discussions to obtain an organization chart for the data processing contractor, which is located on-site in the TennCare building.

The auditors encountered communication problems as well. The Director did not take reasonable measures to seek clarification when he was uncertain of the exact information requested in writing. As a

result, no information was received. Frequently telephone calls were not returned timely and/or they were returned after business hours. Delays also occurred on several occasions when employees in the Division of Information Services, who appeared apprehensive about answering the auditors' questions, declined to comment and referred the auditors to the Director.

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. The same section also states, "The comptroller of the treasury shall have the full cooperation of officials of the governmental entity in the performance of such audit or audits."

As discussed in the "Objectives, Methodologies, and Conclusions" section of the report, the audit of the Department of Health is part of the annual audit of the Comprehensive Annual Financial Report (CAFR) and the Tennessee Single Audit (Single Audit). The Single Audit is conducted in accordance with the Federal Single Audit Act, as amended in 1996. The Single Audit Act requires the auditors to determine compliance with rules and regulations, the existence and effectiveness of internal controls, and to report on these matters to the federal government. When information is not received timely, unnecessary delays in audit fieldwork and reporting can occur. Reporting delays can adversely affect management's ability to take prompt corrective action. In addition, unnecessary delays drive up audit costs, which are paid for with state (50%) and federal (50%) funds.

In addition, accountability to top management, the legislature, the federal community, and the public is avoided when information required for the audit is not forthcoming. When access to information is tightly controlled or cannot be obtained, additional concerns about management's integrity and performance of the program are heightened.

Recommendation

The Commissioner should clarify who the Director of Information Services reports to and should ensure that he cooperates fully with the Office of the Comptroller and provides the information necessary to conduct the audit in a timely manner. This cooperation should also extend to other areas of the department.

Management's Comment

We concur in part. There were instances where the requested information was not provided on a timely basis. After discussions with the Director of Information Services, the new TennCare Director does not believe there was a deliberate effort by the Director of Information Services to frustrate the audit. Having worked with and observed the Director of Information Services' efforts, the new TennCare Director believes the untimeliness of data responses were due more to extraordinary demands from numerous sources, e.g. daily operational requirements, HCFA, MCO monitoring, and an antiquated MMIS than to the Director of Information Services' willingness to comply.

The report states the Director of Information Services requested requests be submitted in writing and that intrusion on employees' time be arranged in advance. Again, the antiquated system, extraordinary requirements and time needs necessitate a management, a control of the work effort.

The Bureau is committed to assisting the audit function, and all efforts will be made to provide readily available information immediately and to prioritize the audit team's requests according to other requirements.

As to the Director of Information Services returning phone calls after hours, we are not surprised. The Director of Information Services' workload requires extraordinary hours, much more than many other employees in state government.

The Director of Information Services is aware and has always performed his duties in a manner that indicated his awareness of who his immediate supervisor is. The TennCare Director will work closely with the Director of Information Services along with other Bureau staff to ensure timely response to auditors' requests. We recognize the necessity for periodic audits and we will strive to make the data available to facilitate the audit in a timely manner. We appreciate the auditors' continued sensitivity to the incredible operational requirements of the TennCare Bureau.

Finding Number 98-TDH-13
CFDA Number 93.778
Program Name Medical Assistance Program
Federal Agency Department of Health and Human Services
State Agency Department of Health
Grant/Contract No. 05-9705TN5028, 05-9805TN5028
Finding Type Reportable Condition
Questioned Costs None

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

Finding

As noted in the prior audit, TennCare does not have a coordinated program for ADP (automated data processing) risk analysis and system security review of the TennCare Management Information System (TCMIS). Management concurred with the prior year finding and stated that the Bureau was seeking guidance from the Health Care Financing Administration (HCFA) regarding their expectations for this regulation and would take steps to comply. Although the bureau has relied on the Department of Finance and Administration's Office for Information Resources (OIR) for security of TCMIS and the system operations are being analyzed and reviewed for the Year 2000 project, the Bureau has failed to comply with Federal regulations by not establishing a program for ADP risk analysis and system security review.

According to Office of Management and Budget (OMB) Circular A-133 and the *Code of Federal Regulations*, Title 45, Subtitle A Section 95.621, such an analysis and a review must be performed on all projects under development and on all state operating systems involved in the administration of the Department of Health and Human Services' programs. TCMIS is such an operating system and is one of the largest in the state.

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

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

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

- Emergency preparedness
- Designation of an agency ADP security manager

Recommendation

The Commissioner and the Assistant Commissioner for TennCare should ensure the Director of Information Services promptly develops and implements procedures for ADP risk analysis and system security review. The Assistant Commissioner should look to staff to take the initiative in analyzing and reviewing these important areas and not accept the excuse that HCFA may not have specific guidelines to justify staff not taking the necessary steps. The Commissioner should monitor the procedures implemented and ensure the appropriate actions have been taken.

Management's Comment

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

Finding Number	98-TDH-14
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	05-9705TN5028, 05-9805TN5028
Finding Type	Reportable Condition
Questioned Costs	None

TennCare failed to identify ineligible incarcerated youth resulting in the loss of approximately \$55,000 in federal matching funds

Finding

TennCare incorrectly allocated behavioral health organization (BHO) contract payments because they failed to identify ineligible incarcerated youth. As a result, the state lost approximately \$55,000 in federal matching funds.

TennCare makes contract payments to BHOs for eligible individuals. The Health Care Financing Administration requires TennCare to allocate these contract payments between basic mental health services and enhanced services. If an individual needs enhanced services, he is classified as Severely and Persistently Mentally Ill (SPMI) (adults) or Seriously Emotionally Disturbed (SED) (children) and a higher fixed rate is allocated to the BHOs. The federal match is only available for the basic services and the enhanced services up to 60 days. After 60 days, the enhanced services must be funded with state dollars.

Because TennCare failed to appropriately identify ineligible incarcerated youth (see 98-TDH-10), some of whom were classified as SPMI/SED over 60 days, there were more SPMI/SED enrollees over 60 days not eligible for the federal match. Using computer-assisted audit techniques, it was determined that TennCare paid 269 of these payments for ineligible enrollees at the enhanced rate of \$319.41. Therefore, a total of \$85,921.29 was paid with state dollars only. If TennCare had not included these ineligible enrollees, the federal matching funds of approximately \$55,000 for the remaining eligible population would not have been lost.

Recommendation

The Commissioner should ensure that the Bureau identifies incarcerated youth in order to allocate contract payments properly and recoups the excess funds paid by the state, if possible. The Commissioner and the Assistant Commissioner for TennCare should ensure the Director of Information Services designs and implements computer-assisted monitoring techniques to promptly detect ineligible enrollees.

Management's Comment

We concur in part. As stated in our response to 98-TDH-10, we are coordinating with the Department of Children's Services to develop better controls over this area. With better controls in place at the Department of Children's Services and monitoring by TennCare, the risk of this occurring again will be reduced.

Finding Number 98-TDH-15
CFDA Number 93.778
Program Name Medical Assistance Program
Federal Agency Department of Health and Human Services
State Agency Department of Health
Grant/Contract No. 05-9705TN5028, 05-9805TN5028
Finding Type Reportable Condition
Questioned Costs None

Because of uncollected cost settlements, TennCare has remitted \$11.8 million in state dollars to the federal government

Finding

As noted in the past two audits covering July 1, 1995, through June 30, 1997, because TennCare has failed to collect Medicaid cost settlements from providers, state dollars have been used to pay the federal portion of the cost settlements. (A cost settlement due the state can occur if the annual review of a provider's cost report discloses that the cost of services or charges for services were less than the payments the provider received.) The federal grantor, the Health Care Financing Administration (HCFA), requires the state to remit the federal share (approximately two-thirds) within 60 days of settlement, whether or not the state has collected the amounts due from the providers.

TennCare pursues collection of the cost settlement receivables before and, if necessary, after the federal share of the cost settlement receivables has been remitted to HCFA. Management concurred with the prior findings and stated that staff "has aggressively pursued reducing the outstanding cost settlement balances." However, compared to the amount reported in the prior year, little improvement has been made. At June 30, 1998, the cost settlements over 60 days late were \$13,971,688.71. Furthermore, in November 1998, they had risen to \$17,798,717.60. Approximately two-thirds (\$11.8 million) of this amount has been returned to the grantor, using state funds.

According to TennCare's records, two hospitals had the largest overdue cost settlement balances at November 13, 1998—Regional Medical Center at Memphis (\$3,924,954.60) and George W. Hubbard Hospital of Meharry College in Nashville (\$2,916,487). Management is uncertain whether the Regional Medical Center at Memphis has the resources to pay its cost settlements and indicated that the hospital has questioned various aspects of its settlements.

According to bureau personnel, legal questions about Hubbard Hospital's current operating status have impeded collection. Also, the current audit revealed that Meharry Medical College has asserted that TennCare (Medicaid) owes the school approximately \$2.7 million for unreimbursed prior year costs at Hubbard Hospital.

Because of the difficulty collecting cost settlements directly from providers, in cooperation with the Medicare program administered by the federal government, TennCare initiated garnishment of providers' Medicare payments. However, TennCare has refrained from asking Medicare to garnish all of the outstanding cost settlement receivables until the two financial information systems containing provider balances—TennCare Management Information System(TCMIS) and the Medicaid Accounts Receivable Recoupment System—can be reconciled. (This matter is discussed further in 98-TDH-06.)

Although management has delayed requests to Medicare and the financial information from the Recoupment System is questionable, TennCare management has used this information to remit amounts and report quarterly to HCFA.

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

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

In fiscal year ending June 30, 1998, TennCare had requested that the Department of Finance and Administration withhold payments to only one provider, collecting \$6,409.39. Considering the approximately \$17.8 million owed, TennCare's failure to pursue this avenue more aggressively is incomprehensible and contrary to statute.

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

Recommendation

To recover the state funds that have been remitted to the federal grantor, the Assistant Commissioner and the Fiscal Director for the TennCare Bureau should ensure that all outstanding cost settlements are collected or written off in a timely manner. When accounts are written off, management should take the necessary steps to obtain a refund from the grantor for the amounts remitted using state funds.

Management should take immediate measures to resolve any questions concerning the amounts owed and each provider's ability to pay. If necessary, assistance from the Office of the Attorney General should be obtained. The Fiscal Director should continue to contact the Department of Finance and Administration about withholding additional payments through STARS.

Management's Comment

We concur. However, since the inception of TennCare, the TennCare staff has aggressively pursued reducing the outstanding cost settlement balances through additional billing correspondence, legal assistance, and other available offsets. After following the appropriate procedures, TennCare has written off those accounts determined uncollectible, including when a provider has filed bankruptcy and the court has upheld the bankruptcy. We have referred providers to Medicare when possible and will continue to do so. We are exploring options with the Department of Finance and Administration for alternate collection methods. We continue to reconcile balances and are working with the Director of Information Services to make system modifications to alleviate the reconciliation issues.

Finding Number 98-TDH-16
CFDA Number 93.778
Program Name Medical Assistance Program
Federal Agency Department of Health and Human Services
State Agency Department of Health
Grant/Contract No. 05-9705TN5028, 05-9805TN5028
Finding Type Reportable Condition
Questioned Costs None

**TennCare did not adequately verify enrollment application information
for cross-over and nursing home providers or monitor the enrollment of providers by the
Department of Children's Services**

Finding

As noted in the previous audit, professional cross-over and nursing home providers were not verified or updated in TennCare's enrollment process nor was the Bureau monitoring the enrollment of providers by the Department of Children's Services (Children's Services). Management concurred with the finding stating that greater verification of eligibility needs to occur for those providers that do not participate in the Medicare program. The bureau also indicated that the availability of licensure information on the Internet should provide for verification of provider eligibility for all future providers. TennCare personnel also agreed to review provider eligibility verification with Children's Services. While management established verification procedures for provider information, these procedures were not implemented timely. Therefore, the Bureau could not assure proper enrollment and adequate verification for all cross-over and nursing home providers.

New enrollment procedures were implemented in May 1998 that established verification procedures for cross-over and nursing home provider information. Cross-over providers are those physicians whose claims are partially paid by both Medicare and Medicaid. For participation in the TennCare/Medicaid program, providers must now submit, along with the appropriate application, a copy of their Tennessee license or a copy of the latest renewal and information on affiliations with medical groups. The Bureau's Provider Enrollment Unit must perform a verification of the application. While these procedures have significantly improved the enrollment process since implementation, a problem still exists because management did not execute these procedures until late in the fiscal year.

According to TennCare personnel, providers that were enrolled in TennCare prior to May 1998 are not updated systematically for current licensure and possible license suspensions, criminal convictions, etc. Any termination information received on these providers usually comes from Medicare, which TennCare does not automatically receive, and may not arrive in time to stop payments to the provider.

Testwork revealed that 15 of 60 (25%) providers were not accurately enrolled in the TennCare Management Information System (TCMIS). Ten of the 15 providers improperly enrolled did not have a license number recorded on TCMIS, four of the providers had license numbers on TCMIS that did not agree with Health Related Boards, and one provider was not enrolled in TCMIS, although the group to which he belonged was enrolled. Apparently, these providers were enrolled prior to the establishment of the new enrollment procedures.

TennCare has ultimately relied on Medicare for the verification of provider eligibility information for both cross-over and nursing home providers and on Children's Services' providers for children in state

custody. Medicare's application process is much more extensive than that of TennCare and, apparently, applications are thoroughly reviewed. TennCare personnel stated that since most providers are already participants of the Medicare program and Medicare's resources for verification are extensive, the bureau's reliance on Medicare for enrollment is sufficient for compliance with rules and regulations.

Additionally, TennCare has not monitored to ensure the service providers used by Children's Services are eligible to participate in the TennCare/Medicaid program. Children's Services contracts with these providers for therapeutic services for the children under its supervision, and ultimately bills TennCare for these services. See 98-TDH-03 for more information about Children's Services' service providers and billings to TennCare.

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

Recommendation

The Commissioner, the Assistant Commissioner for TennCare, and the Director of Operations should ensure that enrollment verification procedures are properly followed. Also, management should ensure update procedures for all provider information are established to assure that all providers remain eligible and assign the implementation of such procedures to the TennCare Provider Enrollment staff. The Commissioner and Assistant Commissioner should ensure that Children's Services is monitored to ensure all service providers are eligible to participate in the program. Management should ensure that the information is verified, updated, and maintained by either Children's Services or the TennCare Provider Enrollment staff.

Management's Comment

We concur. We will examine the procedures for enrollment verification and develop remedies for the deficiencies noted. An aggressive approach for verification and reverification is a key element of the Bureau's strategic plan. We have arranged for the Department of Finance and Administration to assist us in monitoring several aspects of the Department of Children's Services and will include provider enrollment in that review.

Finding Number	98-TDH-17
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	05-9705TN5028, 05-9805TN5028
Finding Type	Reportable Condition, Eligibility
Questioned Costs	\$630.88

**TennCare does not effectively monitor the eligibility
of Supplemental Security Income (SSI) recipients**

Finding

TennCare does not have an effective method to monitor the eligibility of TennCare/Medicaid recipients who are eligible because they receive Supplemental Security Income (SSI). The Rules for the Tennessee Department of Health, Bureau of TennCare, section 1200-13-12-.02 1(c) state, "the Social Security Administration (SSA) determines eligibility for the Supplemental Security Income (SSI) program. In Tennessee, SSI recipients are automatically eligible for Medicaid. All SSI recipients are therefore TennCare eligibles."

Testwork revealed that of nine SSI recipients, one recipient apparently became ineligible for TennCare and other state/federal benefits in December 1995 when she moved her residence out-of-state. However, the TennCare Bureau took 18 months (until June 1997) to identify this individual, detect ineligibility, and proceed with disenrollment. According to statements from TennCare personnel, the Bureau cannot disenroll an SSI individual and discontinue managed care organization and behavioral health organization capitation payments until adequate information indicates that eligibility is no longer met.

TennCare personnel stated that reports from SSA are manually worked to verify information such as out-of-state addresses. To verify addresses, TennCare personnel compare addresses on TCMIS against the Department of Human Services' and SSA's systems. Written notification from the enrollee is also accepted as verification. Although TennCare did not receive immediate notification of out-of-state residency for the above individual, the manual verification procedures that TennCare performs with the SSA should have provided for earlier detection of the ineligibility of the individual.

Because the individual was not disenrolled from TCMIS timely, TennCare paid excess capitation payments in the amount of \$968.29 to a managed care organization and \$249.40 to a behavioral health organization. According to Office of Management and Budget (OMB) Circular A-133, payments are only allowed for individuals who are eligible for the TennCare/Medicaid program. These costs will be questioned in the Schedule of Findings and Questioned Costs in the 1998 Tennessee Single Audit Report.

Recommendation

The Commissioner and the Assistant Commissioner for TennCare should ensure the Director of Information Services designs and implements computer-assisted monitoring techniques to promptly detect ineligible enrollees. Once ineligibility is established, management should make timely efforts for proper disenrollment.

Management's Comment

We concur in part.

The enrollee referenced in the audit finding was referred to the TennCare Information Services Section for termination by DHS. DHS had obtained information that the enrollee was no longer residing in Tennessee. During the review period, Information Services relied on DHS' verification of SSI enrollees receiving benefits in another state. TennCare did not have on line access into the Social Security Administration's State On Line Query (SOLQ) that houses SSA data until April 1998. This database is the source for verification of SSI benefits. The Director of TennCare Information Services and his staff worked with the Social Security Administration to obtain inquiry access to the State On line Query System. The SSA has very stringent RACF security procedures that must be adhered to for all SOLQ activities. TennCare received formal authorization from the Social Security Administration in March 1998 for access into SOLQ.

TennCare and DHS have strict rules regarding terminations of SSI enrollees which are stipulated as a result of the "Daniels" Court order decree. The rules allow termination of SSI enrollees only if the State verifies they are deceased or receiving benefits in another state. Access directly into SOLQ has eliminated TennCare's dependency on DHS for verification of benefit information, which now allows us to directly investigate and take termination action as needed. This will enable us to react more timely for disenrollment of SSI enrollees in accordance with TennCare Policy and Procedures. The Information Services Section continues to review system generated reports to identify SSI enrollees with out of state addresses.

Audit finding 98-TDH-09 detected a problem in the identification of deceased enrollees based on matches with Vital Records files. A procedure has been implemented to provide corrected death records each month.

Finding Number	98-TDH-18
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	05-9705TN5028, 05-9805TN5028
Finding Type	Reportable Condition
Questioned Costs	None

TennCare used memorandums of understanding to disburse payments to medical schools

Finding

As noted in the previous audit, TennCare did not use an appropriate type of agreement for graduate medical education (GME) payments. Instead of abiding by the Rules of the Department of Finance and Administration, Chapter 0620-3-3, "Personal Service, Professional Service, and Consultant Service Contracts," and establishing multi-year grant contracts, TennCare entered into memorandums of understanding (MOUs). Management concurred with the prior audit finding and stated that it was not in compliance with contract rules and state laws. They further stated that the current memorandums of understanding would expire in December 1998, and at that time the agreements would continue via state contracts. However, as of January 27, 1999, TennCare had not entered into the required state contracts.

In June 1996, the Health Care Financing Administration (HCFA) approved TennCare's five-year plan for determining and disbursing GME payments to the four medical schools in the state—East Tennessee State University, the University of Tennessee at Memphis, Meharry Medical College, and Vanderbilt University. The approved plan was for payments each fiscal year from July 1, 1995, through June 30, 2000. Subject to the availability of state and federal funding, total annual GME expenditures are expected to range from \$48 million for fiscal year June 30, 1998, to \$53,566,000 for fiscal year June 30, 2000.

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

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

Recommendation

The Assistant Commissioner should comply with all state laws and rules for contracts. Each school's memorandum of understanding should be replaced with a multi-year grant contract signed by all parties and approved by the Commissioner of Finance and Administration and the Comptroller of the Treasury. No payments should be made before these contracts are finalized.

Management's Comment

We concur. The Bureau has entered into grant contracts with GME fund recipients effective for the period January 1, 1999. These contracts have been executed and are loaded into the STARS system.

Finding Number 98-TDH-19
CFDA Number 93.778
Program Name Medical Assistance Program
Federal Agency Department of Health and Human Services
State Agency Department of Health
Grant/Contract No. 05-9705TN5028, 05-9805TN5028
Finding Type Reportable Condition
Questioned Costs None

TennCare has not monitored the graduate medical schools

Finding

TennCare has not monitored the graduate medical schools to ensure requirements related to graduate medical education (GME) payments are met, nor has TennCare advised the graduate medical schools of the audit requirements of subrecipients. GME payments are made to the state's four medical schools and consist of three components: a hospital pass-through component, a primary care allocation component, and a resident stipend component. The hospital pass-through funds are paid to the medical schools, which are required to allocate the funds to the hospitals designated in the GME plan. Under the primary care allocation, the GME dollars are to follow the residents to their sites of training. The amount of each school's primary care component is determined based on the lists of residents provided by the medical schools. The stipend component is awarded to a resident in family practice, internal medicine, pediatrics, or obstetrics during the years of residency for which the resident agrees to participate and to serve TennCare enrollees in a "Health Resource Shortage Area" of Tennessee. During the year ended June 30, 1998, GME expenditures were approximately \$48 million.

TennCare does not monitor the graduate medical schools to ensure the following:

- The hospital pass-through component dollars paid to the hospitals designated in the GME plan are properly allocated.
- The lists of residents used to determine the primary care component are valid.
- The graduate medical schools have taken appropriate action to correct federal compliance audit findings.

Although TennCare relies on the graduate medical schools to comply with the terms of their agreement, the bureau does not monitor the graduate medical schools to ensure requirements are met.

Office of Management and Budget (OMB) Circular A-133 requires the department to monitor subrecipients' activities to provide reasonable assurance that the subrecipients administer federal awards in compliance with federal requirements. OMB Circular A-133 also requires the department to ensure that required audits are performed and that subrecipients take prompt corrective action on any audit findings.

The department cannot determine subrecipients' compliance with applicable laws and regulations if appropriate monitoring procedures are not performed and required audits are not obtained. Furthermore, funds could be used for objectives not associated with the grant and subrecipient errors and irregularities could occur and not be detected.

Recommendation

TennCare should immediately advise the subrecipients of the audit requirements for subrecipients of federal funds. The Assistant Commissioner for TennCare should establish a monitoring program to ensure compliance with grant requirements. All monitoring should be sufficiently documented and deficiencies should be promptly reported to the graduate medical schools. TennCare should also require the schools to submit corrective action plans.

Management's Comment

We concur. The Bureau will advise the subrecipients of the audit requirements for subrecipients of federal funds. The medical schools have been included in the contract monitoring plan submitted to the Department of Finance and Administration in accordance with Policy 22.

Finding Number	98-TDH-20
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	05-9705TN5028, 05-9805TN5028
Finding Type	Reportable Condition
Questioned Costs	None

Policies and procedures for accounts receivable and accrued liabilities need improvement

Finding

TennCare's policies and procedures for accounts receivable and accrued liabilities are not adequate. Because of these inadequacies, numerous deficiencies in TennCare's accounts receivable and accrued liabilities records were noted.

As part of the state's year end financial closing procedures, management determines, and then records in the State of Tennessee Accounting and Reporting System (STARS), the accrued liabilities for the TennCare program. For the fiscal year ended June 30, 1998, the total amount of TennCare's accrued liabilities recorded in STARS was \$265,312,552.

Management obtained and recorded estimated accrued liability amounts from the Department of Children's Services (Children's Services), the Department of Mental Health and Mental Retardation (DMHMR), and the Medicaid/TennCare Section of the Comptroller's Office. However, management did not obtain and review sufficient supporting documentation for the amounts recorded, nor did they get assurance from these departments that the liability balances were accurate. With one exception, TennCare management could not provide worksheets or any other support for the amounts recorded.

Our audit of Children's Services determined that the \$42.4 million accrued liability for that department could not be supported and most likely was overstated. However, because of deficiencies in Children's Services' accounting records the correct amount of the liability could not be determined.

Because TennCare's Accounting Manager could not provide support for the TennCare-related accrued liabilities for DMHMR, the auditor was told to obtain the information from the Fiscal Director at DMHMR. As a result of the audit testwork, adjustments to the accrued liabilities for DMHMR were proposed. Without a clear delineation of the organizational structure of the Departments of Health and Mental Health and Mental Retardation, management cannot be assured of reliable financial reporting.

Testwork also revealed that Medicaid provider cost settlement receivables and payables were netted improperly. Cost settlement receivables and cost settlement payables were netted by category (e.g., hospitals, long term care facilities). For example, "hospital receivables" were netted with "hospital payables," instead of by individual hospital. In addition, all total net amounts, by category, also were netted together.

Medicaid provider cost settlement receivables were not treated consistently. Only some of the receivables were recorded in STARS—indirectly, when they were netted with cost settlement payables. Management did not record (i.e., include in the net amount) cost settlement receivables accounted for on the Medicaid Accounts Receivable Recoupment System. (The problems with this system are discussed in greater detail in 98-TDH-06.)

Furthermore, testwork revealed that TennCare's management has not developed written policies and procedures for recording accounts receivable in STARS or for monitoring, collecting, and writing off accounts receivable. Management considers many of the receivables uncollectible and, except for some of the cost settlement receivables discussed previously, does not record them in STARS. The types and amounts of receivables are as follows:

- TennCare enrollee premium receivables—The total outstanding balance at November 9, 1998, was \$18,878,463.
- Fraud and abuse receivables, which result from fraud and abuse investigations—At June 30, 1998, the total outstanding balance was \$3,176,884.
- Drug rebate program receivables that remain from the Medicaid program, prior to TennCare—The total outstanding balance at June 30, 1998, was \$2,534,190.
- Provider cost settlements receivables owed by Medicaid providers, such as hospitals and nursing homes—See 98-TDH-15 for more information about these receivables.
- "PA-68" receivables established in the names of recipients to collect payments to providers that should have been paid by recipients—At June 30, 1998, the total outstanding balance was \$51,730.

According to management, no effort has been made to collect the drug rebate program receivables since 1995, and no effort is made to collect enrollee premium receivables after a recipient is terminated from TennCare.

Proper accounting policies and procedures ensure that the financial information used for decision-making and state and federal reporting is accurate. In addition, good accounting policies and procedures result in audit resources being used more efficiently and effectively because of the reduced amount of time required to audit the financial records. Comprehensive written policies and procedures help staff carry out their job responsibilities and help ensure that accounting and reporting is consistent, which may result in improved management oversight and program financial performance.

Recommendation

The Commissioner should ensure the Fiscal Director obtains accurate and sufficiently detailed supporting documentation for amounts which will be recorded in STARS. In addition the Fiscal Director should ensure liabilities accrued by his office are carefully prepared and reviewed. This information should be provided to the auditors upon request.

The Fiscal Director also should ensure that receivables and payables (liabilities) are accounted for separately and consistently. Amounts should be netted on an individual provider or account basis only, if deemed necessary. The Fiscal Director should develop and implement written policies and procedures for monitoring, collecting, recording in STARS, and writing off TennCare's accounts receivable.

Management's Comment

We concur. We will begin the process of developing policies and procedures for monitoring, collecting, recording in STARS, and writing-off TennCare's accounts receivable. These policies and procedures will include obtaining and retaining accurate documentation of accrued liabilities.

Finding Number	98-TDH-21
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	05-9705TN5028, 05-9805TN5028
Finding Type	Reportable Condition
Questioned Costs	None

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

Finding

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

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

- Even though the bureau has contracted to make adverse selection payments to those managed care organizations with a disproportionate share of enrollees requiring extensive health services, and has made \$170 million in such payments, the bureau has not established rules concerning these types of payments. The contracts, which obligate the state to pay up to \$55 million annually, do not specifically describe how the payments will be calculated; they only state that the payments will be made using a formula developed by TennCare and approved by the Health Care Financing Administration.
- The bureau is paying some providers more than is allowed by departmental rules. The method used to calculate outpatient hospitalization payments to providers caring for enrollees who are both TennCare and Medicare recipients sometimes results in payments that exceed limits. (See 98-TDH-07 for more details.)
- The bureau has not revised its rules to include changes in the method it uses to determine payments to the state's medical schools for graduate medical education.
- The rules pertaining to the Home and Community Based Services waiver program have not been revised to reflect changes in the program. For example, TennCare no longer pays provider claims based on a per diem rate.

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

Recommendation

The Assistant Commissioner for TennCare should exhibit a strong commitment to the importance of up-to-date rules and the necessity of complying with rules. TennCare management and staff should comply with the bureau's rules, and the Assistant Commissioner should take appropriate measures, including a system for monitoring relevant program changes, to ensure that the rules are revised to remain current. The Assistant Commissioner should recognize that when rules are out of date, the department has failed to stay abreast of changes and has failed to appropriately tie rules to the operational aspects of programs. The Assistant Commissioner should recognize that when rules are not feasible, the process of developing the rules and ensuring they compliment and facilitate operations has failed. These situations should be avoided when possible, and if they do arise, they should be corrected immediately.

Management's Comment

We concur. During 1997, the Bureau and the Office of General Counsel began an extensive review of the TennCare rules to identify rules that needed to be revised to reflect current policy. From January 1998 until the present, twenty-nine rules have either been adopted or set for hearing including three rules pertaining to home and community based services waivers. We will continue to review the departmental rules for areas that need revision including those areas noted in the finding.

Finding Number	98-TDH-22
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	05-9705TN5028, 05-9805TN5028
Finding Type	Reportable Condition, Allowable Costs/Cost Principles
Questioned Costs	\$11,628.00

For nine months TennCare inappropriately reimbursed the Department of Children's Services for employees on administrative leave with pay resulting from disciplinary actions

Finding

TennCare inappropriately reimbursed the Department of Children's Services (Children's Services) for two caseworkers' salaries for nine months while they were on administrative leave with pay resulting from disciplinary actions. Eventually one employee was placed in another position with Children's Services, and the other employee was terminated. A contract between TennCare and Children's Services allows TennCare to reimburse Children's Services for administration of health-related services to TennCare-eligible children served by Children's Services. These administrative services include caseworkers who will coordinate and provide for access to health-related services to TennCare-eligible children, including emergency assistance determinations.

In accordance with an administrative cost allocation plan approved by Children's Services and TennCare, Children's Services bills case management salaries to the Bureau of TennCare and these costs are charged to the TennCare program.

When Children's Services removed two caseworkers from normal duties and placed them on administrative leave with pay, they did not notify the Bureau of TennCare of the situation. In addition, Children's Services failed to promptly resolve the situation and return the employees to normal duties or terminate them. As a result, TennCare reimbursed Children's Services for \$18,072 of salaries for these two employees (approximately 9 months each). While on administrative leave with pay, the caseworkers were not providing any administrative services to the Bureau of TennCare or any other services to the state and, therefore, their salaries were inappropriately charged to the federal program. Of the total expenditure, \$11,628 of federal funds will be a questioned cost on the Schedule of Findings and Questioned Costs in the 1998 Tennessee Single Audit Report.

Because Children's Services did not act promptly to resolve the disciplinary issues, Children's Services and the Bureau of TennCare misused federal and state funds.

Recommendation

The Assistant Commissioner for TennCare should work with the Commissioner of the Department of Children's Services to ensure that staff bill only appropriate charges to the Bureau of TennCare. The Assistant Commissioner should require the Department of Children's Services to notify the Bureau when employees whose salaries are charged to TennCare are placed on administrative leave with pay. TennCare should monitor these situations to ensure they are resolved timely by the Department of Children's Services.

Management's Comment

We concur. The Department of Health has entered into an agreement with the Department of Finance and Administration for monitoring of TennCare related activities at the Department of Children's Services. The monitoring will include an examination of internal controls over billings to the TennCare program.

Finding Number 98-TDH-23
CFDA Number 93.778
Program Name Medical Assistance Program
Federal Agency Department of Health and Human Services
State Agency Department of Health
Grant/Contract No. 05-9705TN5028, 05-9805TN5028
Finding Type Reportable Condition
Questioned Costs None

TennCare should seek clarification of grant requirements

Finding

As noted in the prior two audits, modifications to TennCare's grant requirements are often necessary because TennCare is a relatively new approach to Medicaid for both the state and the Health Care Financing Administration (HCFA). However, the intent of some requirements becomes unclear with the changes. The payment rates for certain psychiatric services is one such case. Although, management concurred with the prior finding and stated they would contact the appropriate HCFA representative to obtain clarification, no evidence of this contact has been provided.

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

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

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

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

Although management agreed that all policies and programs and resulting payments should comply with grant requirements, management has not obtained documentation from HCFA regarding its position on the adjusted rates. During audit fieldwork, the Fiscal Director of TennCare stated that HCFA had verbally approved the adjusted rates. However, the Fiscal Director did not request formal written approval until December 1998, two years after the auditor's request. As of February 10, 1999, TennCare has not received the approval letter from HCFA.

Recommendation

The Assistant Commissioner for TennCare should immediately follow up with HCFA to obtain formal written approval for the adjusted rates. The Assistant Commissioner should also ensure that all policies or programs and resulting payments comply with grant requirements. If these requirements are unclear or if a substantial change is made, TennCare should seek guidance from the grantor before implementing the change.

Management's Comment

We concur. TennCare has contacted HCFA officials on this matter and is awaiting a response.

Finding Number	98-TDH-24
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	05-9705TN5028, 05-9805TN5028
Finding Type	Reportable Condition
Questioned Costs	None

Since fiscal year 1994, TennCare has not returned Medicaid refunds to the federal grantor promptly

Finding

For the past five years, from July 1, 1993, through June 30, 1998, TennCare has not promptly used the amounts recovered from third parties to reduce federal drawdowns. Management concurred with the prior audit findings and stated they would, “continue to work with the Department of Finance and Administration to further improve the timely processing of refund transactions that affect the federal draw of funds.” In addition, management of the Department of Finance and Administration concurred and has taken measures “to ensure that HCFA remittances are properly identified and prompt approval and processing occurs.” However, the timeliness of remittances to HCFA has not improved. Occasionally, refunds were delayed up to four weeks before remittance to HCFA. Based on reports provided by the department, refunds totaling \$12,527,527.97 were deposited in fiscal year 1998. Our review of \$5,193,005.23 of refund deposits disclosed that \$3,309,288.08 was not remitted to HCFA in a timely manner.

The timeliness of remittances to HCFA involves two components: TennCare’s prompt keying of information into STARS and the Division of Accounts’ (within the Department of Finance and Administration) prompt approval to process the transactions.

The Cash Management Improvement Act Agreement holds the state liable for interest on refunds from the date the refund is credited to a state account until the date the refund is subtracted from drawdowns. Both TennCare and Department of Finance and Administration personnel indicated that the interest is properly remitted.

Recommendation

Both TennCare and the Department of Finance and Administration should coordinate efforts to determine why remittances are not timely and take immediate action to correct the delays. The Assistant Commissioner for TennCare should ensure refund transactions are promptly entered into STARS and forwarded to the Department of Finance and Administration. TennCare staff should continue to communicate the priority of processing these refund transactions and monitor them until drawdowns are reduced.

Management’s Comments

Department of Health, Bureau of TennCare:

We do not concur. As stated in Finance and Administration Policy 20, all grant related revenue and expenditure transactions are coded to utilize the STARS grant module for draw-down purposes.

TennCare has taken steps to identify transactions that are related to the Cash Management Agreement in order to aid the Department of Finance and Administration in prioritizing processing. It should be noted that the Cash Management Agreement's interest assessment calculations are designed to keep transactions between the federal government and the state on an interest neutral basis. Any interest assessed is to compensate the federal government for interest the state earned on any funds not remitted to HCFA timely and therefore, interest that is assessed represents funds the state would not have had if the funds had been remitted timely.

Department of Finance and Administration:

We do not concur. TennCare is complying with the terms of the Treasury State Agreement using the Post Issuance Funding Technique. TennCare is also complying with Policy 20. In the event that transaction volume is high or processing is slow due to staff turnover, processes are in place to remit any interest liability owed to the federal government if transactions are not processed timely. The interest liability that was incurred was immaterial considering the size of the TennCare program.

Auditor's Comment

It is the auditors' understanding that Medicaid refunds should be returned promptly to the federal grantor by reducing federal drawdowns. Testwork revealed that 28 of 44 refunds (64%) were not keyed into STARS within one day by the TennCare Bureau and 42 of 48 of the refunds (88%) were not processed by the Department of Finance and Administration within four days of receipt from the Bureau.

Finding Number	98-TDH-25
CFDA Number	93.778
Program Name	Medical Assistance Program
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	05-9605TN5028, 05-9705TN5028, 05-9805TN5028
Finding Type	Reportable Condition
Questioned Costs	None

Controls over manual checks have been weak since 1994

Finding

As noted in the prior four years, July 1, 1994, through June 30, 1998, and despite management's concurrence with the findings, the TennCare Bureau needs to continue to improve controls over manually prepared checks. In fiscal year 1998, these checks totaled approximately \$315 million.

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

The only compensating control used was a reconciliation of checks issued and cleared each month. This reconciliation involves records from the Department of the Treasury (Treasury), the Department of Finance and Administration's Division of Accounts, and TennCare. This reconciliation ensures that TennCare's and Treasury's records of checks issued and cleared correspond to STARS. However, the reconciliations were not completed in a timely manner. As of June 1998, reconciliations had been performed only through April 1998.

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

Recommendation

The Assistant Commissioner for TennCare should ensure duties are adequately segregated. In addition, each month, the Department of the Treasury, the Division of Accounts, and TennCare should reconcile checks issued and cleared with Account Reconciliation Package (ARP), STARS, and TCMIS records.

Management's Comment

We concur. We will continue to improve controls over manual checks and the timeliness of the reconciliation of checks issued with ARP, STARS, and TCMIS.

Finding Number	98-TDH-01
CFDA Number	93.959
Program Name	Substance Abuse Prevention and Treatment Block Grant
Federal Agency	Department of Health and Human Services
State Agency	Department of Health
Grant/Contract No.	N/A
Finding Type	Reportable Condition
Questioned Costs	None

Monitoring of subgrantees is not adequate

Finding

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

- The Bureau of Alcohol and Drug Abuse Services does not conduct on-site fiscal monitoring reviews of subgrantees and does not have uniform written procedures for fiscal monitoring.
- The files of 80 subrecipients of grants administered by the Department of Health were reviewed for evidence of compliance and fiscal monitoring. The fiscal activities of 32 subrecipients had not been monitored. The programmatic goals and objectives of five subrecipients were not monitored.

Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, requires the department to “monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.”

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

- Three of the six audit reports reviewed contained questioned costs that were not resolved within six months of receipt of the reports. This resolution process was completed 23 to 122 days after the six-month period ended.
- The department’s review of the audit reports did not include following up other reported audit exceptions such as internal control weaknesses.
- Funds were not withheld consistently as follow-up action for subrecipients’ not obtaining an audit in accordance with OMB Circular A-133.

Circular A-133 states that it is the recipient’s (Department of Health’s) responsibility to “follow up and take corrective action on audit findings.” Furthermore, it states that “in cases of continued inability or unwillingness to have an audit conducted in accordance with this part, ... pass-through agencies [Department of Health] shall take appropriate action using sanctions such as... withholding a percentage of Federal awards until the audit is completed satisfactorily” or “suspending Federal awards until the audit is conducted.”

In addition, the department does not ensure subrecipient audit reports are obtained within six months of the subrecipient's fiscal year-end. The Department of Health's standard contract states:

The audit contract between the Grantee and the licensed independent public accountant shall be on a contract form prescribed by the Tennessee Comptroller of the Treasury.

The Contract to Audit Accounts states:

The auditor's report shall be filed prior to _____, but in no case, shall be filed later than six (6) months following the fiscal period to be audited, without prior written explanation to the Comptroller of the Treasury, State of Tennessee and the auditee. The auditor shall file one (1) copy of said report with the Comptroller of the Treasury, State of Tennessee, and with the appropriate officials of the granting agencies

Thirty-seven of 40 audit reports were not received within six months of the end of the subgrantee's fiscal year as required in the department's standard contract with subgrantees. Reports were received from 19 to 1,048 days after the six-month period. Also, 55 audit reports due as far back as 1994 had not been received as of June 30, 1998.

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

Recommendation

The Commissioner and related bureau directors should establish policies and procedures for annual fiscal monitoring of all subrecipients. Staff should sufficiently document all monitoring and promptly report deficiencies to subrecipients. Significant deficiencies should be reported to the department's Office of Audit and Investigation and to the Comptroller of the Treasury. Recommendations and deficiencies previously noted should be followed up, and this process should also be documented.

All audit exceptions should be followed up and resolved within six months of the receipt of the subrecipients' audit reports. Also, procedures should be developed to ensure subrecipient audit reports are received no later than six months following the subrecipient's year-end. The Commissioner should consider withholding funding from subrecipients when required audits are not conducted or when audit reports are not submitted to the department timely.

Management's Comment

We concur. The Department is in the process of developing a policies and procedures manual for Fiscal Monitoring which includes the annual independent audit and how to handle questioned and disallowed costs and audit findings. Further, the Department is working with the Department of Finance and Administration in the overall contract monitoring program that is being implemented by the Department of Finance and Administration and has submitted a plan for compliance with the program designed by Finance and Administration.