Performance Audit Report

Department of Health

September 2022

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Comptroller of the Treasury

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September 26, 2022

The Honorable Randy McNally  
Speaker of the Senate  
The Honorable Cameron Sexton  
Speaker of the House of Representatives  
The Honorable Kerry Roberts, Chair  
Senate Committee on Government Operations  
The Honorable John D. Ragan, Chair  
House Committee on Government Operations  

and

Members of the General Assembly  
State Capitol  
Nashville, Tennessee 37243  

and

Dr. Morgan McDonald, MD, FACP, FAAP, Interim Commissioner  
Department of Health  
710 James Robertson Parkway  
Nashville, Tennessee 37243  

Ladies and Gentlemen:

We have conducted a performance audit of selected programs and activities of the Department of Health for the period October 1, 2018, through June 30, 2022. This audit was conducted pursuant to the requirements of the Tennessee Governmental Entity Review Law, Section 4-29-111, Tennessee Code Annotated.

Our audit disclosed findings, conclusions, and recommendations in this report. Management of the Department of Health has responded to the audit findings, conclusions, and recommendations, and we have included the responses in the respective sections. We will follow up the audit to examine management’s corrective actions instituted because of the audit findings.

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

Sincerely,

Katherine J. Stickel, CPA, CGFM, Director  
Division of State Audit

KJS/mc/jw  
22/031
We have audited the Department of Health for the period October 1, 2018, through June 30, 2022. Our audit scope included assessments of program effectiveness, efficiency, internal controls, prospective analysis, and compliance with laws, regulations, policies, procedures, and provisions of contracts or grant agreements in the following areas:

- management’s Healthcare Safety Net initiative to improve the availability of primary healthcare services to Tennessee’s uninsured adults;
- management’s process to ensure performance of routine food inspections intended to minimize the public’s health risks when consuming food from local food service establishments;
- management’s responsibilities to verify hospitals’ self-reported Joint Annual Report data used to identify gaps in healthcare across the state;
- management’s plan for monitoring approximately $400 million in federal and state grant funds used to support various health programs at the local level to ensure these programs have achieved the goals to protect, promote, and improve the health of Tennesseans;
- management’s process to comply with the state’s procurement policy for awarding grants and contracts as well as procuring goods and services; and
- management’s responsibility to protect vulnerable Tennesseans through prompt updates to the state’s abuse registry.
Findings

- Administering the Healthcare Safety Net Program should include ensuring that program dollars are optimized to support the health of uninsured Tennesseans (page 12).
- As noted in the prior audit, the Healthcare Safety Net Program’s annual report to decision makers contains unsupported data to validate program results (page 15).
- Inspection system functionality should include reporting capabilities for management to quickly and easily identify missing or late food inspections to minimize the health risk to the public; additionally, establishing a robust quality assurance process promotes uniformity among inspectors and can help reduce the risk of falsified inspections (page 21).
- As noted in the prior audit, the information used for identifying gaps in healthcare needs across the state is not reliable, in part, due to the lack of internal processes to validate the self-reported data (page 28).
- Monitoring for the state and federal dollars awarded should align with the state’s uniform monitoring policy to ensure grant awards were used for their intended purposes to achieve the department’s healthcare mission (page 38).

Communication of Audit Recommendations for the State’s Abuse Registry

We reviewed the Department of Health’s administration and operation of the state’s abuse registry. Effective July 1, 2022, the department’s Office of Health Care Facilities, including the abuse registry functions, transferred to the Health Facilities Commission. We make the following recommendations for the commission:

- Recommendation 1: Commission management should seek revisions to the applicable rules governing their responsibilities (page 54).
- Recommendation 2: Commission management should establish sufficient internal controls to accurately and timely place individuals on the abuse registry (page 55).
- Recommendation 3: Commission management should work with state agencies and county court clerks regarding the statutory requirements of the respective parties to ensure timely reporting of abuse registry placements (page 56).
- Recommendation 4: Commission management should ensure that the language on the “Notice of Intent to Place” matches the language approved in the rules (page 58).
Recommendation 5: Commission management should assess whether they need a records disposition authorization for abuse registry files (page 59).

Recommendation 6: Commission management should prioritize efforts to comply with healthcare facilities’ survey timeframes given the Centers for Medicare and Medicaid Services has established January 9, 2023, as the goal for compliance (page 60).

**Matters for Legislative Consideration**

- The Department of Health should seek counsel from the General Assembly regarding Section 68-11-310(a)(2), *Tennessee Code Annotated*, which requires the hospital owners to file (with the Department of Health) a Joint Annual Report within 105 days of the hospital’s closure (page 33).

- The General Assembly may wish to amend Section 39-15-506, *Tennessee Code Annotated*, to include a required timeframe for courts to submit abuse registry referrals to the commission (page 57).
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**Finding 4** – As noted in the prior audit, the information used for identifying gaps in healthcare needs across the state is not reliable, in part, due to the lack of internal processes to validate the self-reported data

**Matter for Legislative Consideration**

Grant Contract Monitoring

**Finding 5** – Monitoring for the state and federal dollars awarded should align with the state’s uniform monitoring policy to ensure grant awards were used for their intended purposes to achieve the department’s healthcare mission

**Contract Procurement**

**State Abuse Registry**

- Communication of Audit Recommendations for the State’s Abuse Registry
- **Matter for Legislative Consideration**

**APPENDICES**

- **Appendix 1** – Objectives, Conclusions, and Methodologies
- **Appendix 2** – Internal Control Significant to the Audit Objectives
- **Appendix 3** – Department of Health Operations
- **Appendix 4** – Organizational Chart
- **Appendix 5** – Financial Information
- **Appendix 6** – Regional Offices and County Health Departments
- **Appendix 7** – Healthcare Safety Net Provider Locations
- **Appendix 8** – Counties That Have Referred Individuals for Placement on the Abuse Registry
Audit Authority

We conducted this performance audit of the Department of Health, pursuant to the Tennessee Governmental Entity Review Law, Title 4, Chapter 29, *Tennessee Code Annotated*. Under Section 4-29-244, the department is scheduled to terminate June 30, 2023. Section 4-29-111 authorizes the Comptroller of the Treasury to conduct a limited program review audit of the agency and to report to the Joint Government Operations Committee of the General Assembly. This audit is intended to aid the committee in determining whether the Department of Health should be continued, restructured, or terminated.

Background

Although the Tennessee General Assembly established the Department of Health in 1923 under Title 68, *Tennessee Code Annotated*, Chapter 1, Part 1, the state’s efforts involving public health date back to 1778. The department’s mission is to

*Protect, promote and improve the health and prosperity of people in Tennessee.*

The Commissioner oversees a staff of approximately 3,100 state employees.¹ See *Appendix 3* for a description of the department’s operations. The department also provides public health services for 89 of the 95 county health departments² across the state; these services include primary care and preventive services with an emphasis on health promotion, disease prevention, and healthcare access. The department’s eight regional offices are responsible for overseeing the services provided at the 89 county health departments. See *Appendix 6* for a map of each region.

County Health Departments

General Background

The 89 primarily rural county health departments operate under the direct supervision of the Tennessee Department of Health, headquartered in Nashville, while the six larger, urban counties–Madison,

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¹ Source: 2021-2022 state budget.
² Six county governments independently operate their own larger, urban health departments, except during a pandemic. For more information about the department’s oversight responsibilities of the rural and urban county health departments, see pages 3 and 4.
Shelby, Knox, Davidson, Hamilton, and Sullivan—have health departments that operate under local governance but work closely with the Tennessee Department of Health.³

Directors of the 89 rural county health departments are appointed by the Commissioner of the Tennessee Department of Health. Directors of the six larger, urban county health departments are appointed by their county leadership. In some instances, a health board appointed by the mayor will provide recommendations regarding these appointments.

The county health departments serve local communities by providing health-related services to children and adults, such as

- primary medical and dental care;
- family planning;
- immunizations; and
- nutritional assistance.

They also assist with carrying out federal programs and other state services at the local level, such as

- issuing Women, Infants, and Children (WIC) vouchers;⁴
- performing presumptive eligibility screenings and enrollment for TennCare, the state’s Medicaid program;⁵
- collecting birth and death information and issuing certificates for the department’s Office of Vital Records; and
- inspecting food service establishments, public swimming pools, hotels and motels, and other establishments to ensure they are complying with the state’s health and safety requirements when serving the public.

³ Source: Department of Health’s website.
⁴ According to the U.S. Department of Agriculture, WIC provides “supplemental foods, healthcare referrals, and nutritional education to low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age 5 who are found to be at nutritional risk.” https://www.fns.usda.gov/wic
⁵ Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states, according to federal requirements. States and the federal government jointly fund the program. Prenatal presumptive eligibility grants pregnant women short-term Medicaid eligibility to cover early prenatal costs while they undergo the full Medicaid eligibility determination process.
Rural County Health Departments

The rural county health directors are responsible for the daily operations of rural health departments. The rural county health directors report to the department’s regional offices based on location.

Between 2018 and 2021, rural county health departments served between no fewer than 322,313 and as many as 432,152 patients and received approximately $200 million in funding annually. See Chart 1 for the number of patients served and Table 1 for funding received. In addition to providing core public health and medical services, the county health departments provided COVID-19 testing and vaccinations since 2020.

Chart 1
Rural County Health Departments
Number of Patients Served for Medical and Core Public Health Services
Fiscal Years 2018 Through 2021

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>432,152</td>
</tr>
<tr>
<td>2019</td>
<td>422,386</td>
</tr>
<tr>
<td>2020</td>
<td>401,635</td>
</tr>
<tr>
<td>2021</td>
<td>322,313</td>
</tr>
</tbody>
</table>

Source: Department management.
Table 1
Rural County Health Department Funding Sources for Medical and Core Public Health Services
Fiscal Years 2018 Through 2021

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Federal Funding</th>
<th>State Funding</th>
<th>Local Funding</th>
<th>Service Revenue</th>
<th>Inter-Departmental Funding</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$84,607,734</td>
<td>$80,119,056</td>
<td>$3,329,052</td>
<td>$20,759,522</td>
<td>$46,069,520</td>
<td>$234,884,884</td>
</tr>
<tr>
<td>2019</td>
<td>$70,616,821</td>
<td>$93,089,115</td>
<td>$3,010,273</td>
<td>$19,641,815</td>
<td>$45,755,623</td>
<td>$232,113,647</td>
</tr>
<tr>
<td>2020</td>
<td>$80,790,236</td>
<td>$75,197,039</td>
<td>$3,008,608</td>
<td>$16,465,106</td>
<td>$42,482,803</td>
<td>$217,943,792</td>
</tr>
<tr>
<td>2021</td>
<td>$92,155,506</td>
<td>$78,126,685</td>
<td>$2,780,351</td>
<td>$11,463,555</td>
<td>$21,708,200</td>
<td>$206,234,297</td>
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</tbody>
</table>

* The rural county health departments received revenue from services billed to individuals, private insurance, and TennCare.
† The health departments received other inter-departmental funding from the Division of TennCare and the Department of Human Services.
Source: Department management.

Urban County Health Departments

The department shares information with urban county health departments related to statewide healthcare initiatives they develop for the rural county health departments, such as plans for combatting communicable diseases or the state’s opioid epidemic. The department also awards grants to urban county health departments for public health programs or projects to serve citizens within the county. Some examples of these programs and projects include

- adolescent pregnancy prevention,
- breast and cervical cancer screenings, and
- child health and development.

See Table 2 for the total grants the department awarded to each urban county health department from fiscal years 2019 through 2022.
Table 2
Department of Health Grants Awarded to Urban County Health Departments
State Fiscal Years 2019 Through 2022

<table>
<thead>
<tr>
<th>Urban County Health Department</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jackson-Madison County Regional Health Department</td>
<td>$355,644</td>
<td>$355,644</td>
<td>$355,644</td>
<td>$355,644</td>
</tr>
<tr>
<td>Shelby County Government</td>
<td>$917,800</td>
<td>$917,800</td>
<td>$917,800</td>
<td>$917,800</td>
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<tr>
<td>The Government of Knox County</td>
<td>$156,900</td>
<td>$156,900</td>
<td>$156,900</td>
<td>$156,900</td>
</tr>
<tr>
<td>Metropolitan Government of Nashville Davidson County</td>
<td>$725,200</td>
<td>$725,200</td>
<td>$725,200</td>
<td>$725,200</td>
</tr>
<tr>
<td>Sullivan County Regional Health Department</td>
<td>$458,906</td>
<td>$458,906</td>
<td>$458,906</td>
<td>$458,906</td>
</tr>
<tr>
<td>Chattanooga-Hamilton Health Department</td>
<td>$351,494</td>
<td>$593,928</td>
<td>$593,928</td>
<td>$593,928</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>$2,965,944</strong></td>
<td><strong>$3,208,378</strong></td>
<td><strong>$3,208,378</strong></td>
<td><strong>$3,208,378</strong></td>
</tr>
</tbody>
</table>

Source: Department management.

In Appendix 6, see a map of county health departments and their assigned regions.

AUDIT SCOPE

We have audited the Department of Health for the period October 1, 2018, through June 30, 2022. Our audit scope included assessments of program effectiveness, efficiency, internal controls, prospective analysis, and compliance with laws, regulations, policies, procedures, and provisions of contracts or grant agreements in the following areas:

- management’s Healthcare Safety Net initiative to improve the availability of primary healthcare services to Tennessee’s uninsured adults;
- management’s process to ensure performance of routine food inspections intended to minimize the public’s health risks when consuming food from local food service establishments;
- management’s responsibilities to verify hospitals’ self-reported Joint Annual Report data used to identify gaps in healthcare across the state;
- management’s plan for monitoring approximately $400 million in federal and state grant funds used to support various health programs at the local level to ensure these programs have achieved the goals to protect, promote, and improve the health of Tennesseans;
management’s process to comply with the state’s procurement policy for awarding grants and contracts as well procuring goods and services; and

management’s responsibility to protect vulnerable Tennesseans through prompt updates to the state’s abuse registry.

We present more detailed information about our audit objectives, conclusions, and methodologies in Appendix 1 of this report.

We provide further information on internal control significant to our audit objectives in Appendix 2. In compliance with generally accepted government auditing standards, when internal control is significant within the context of our audit objectives, we include in the audit report (1) the scope of our work on internal control and (2) any deficiencies in internal control that are significant within the context of our audit objectives and based upon the audit work we performed.

For our sample design, we used nonstatistical audit sampling, which was the most appropriate and cost-effective method for concluding on our audit objectives. Based on our professional judgment, review of authoritative sampling guidance, and careful consideration of underlying statistical concepts, we believe that nonstatistical sampling provides sufficient appropriate audit evidence to support the conclusions in our report. Although our sample results provide reasonable bases for drawing conclusions, the errors identified in these samples cannot be used to make statistically valid projections to the original populations.

We conducted our audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings, recommendations, and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings, conclusions, and recommendations based on our audit objectives.

Department of Health management is responsible for establishing and maintaining effective internal controls and for complying with applicable laws, regulations, policies, procedures, and provisions of contracts and grant agreements.
Report of Actions Taken on Prior Audit Findings

Section 8-4-109(c), *Tennessee Code Annotated*, requires that each state department, agency, or institution report to the Comptroller of the Treasury the action taken to implement the recommendations in the prior audit report. The prior audit report was dated October 2018 and contained three findings. According to our records, the Department of Health filed its report with the Comptroller of the Treasury on April 18, 2019. We conducted a follow-up of the prior audit findings as part of the current audit.

Partially Resolved Audit Finding

The current audit disclosed that the Department of Health partially resolved one previous audit finding. This finding concerned

- the department and the Central Procurement Office not ensuring that the Healthcare Safety Net (safety net) provider contracts were proper and in accordance with state procurement policies;
- the department not ensuring safety net provider contracts were classified as grant contracts, subjecting them to department monitoring; and
- the department not ensuring that adequate procedures were in place for reviewing contract payments for safety net providers.

The current audit disclosed that management ensured that the safety net contracts were proper, in accordance with state procurement policies, and classified as grant contracts; however, we identified issues with management’s procedures to review contract payments to safety net providers. See the Uninsured Adult Healthcare Safety Net Program section for further information.
Repeated Audit Findings

The prior audit report also contained findings stating that the department

- was unable to provide verifiable supporting documentation for *HealthCare Safety Net Update* reports and did not include pertinent information related to the use of program funds; and
- should improve controls over the review process of Joint Annual Reports submitted by hospitals, including issuing deficiencies to hospitals as required by statute, to ensure reports are accurate.

The current audit disclosed that management did not verify data in the 2021 *Uninsured Adult Healthcare Safety Net Annual Report* prior to publication and has neither complied with statute nor established the necessary controls for the Joint Annual Report data, including issuing deficiencies to hospitals. See applicable section under Audit Findings, Conclusions, and Recommendations for further information.

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AUDIT FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

Uninsured Adult Healthcare Safety Net Program

We reviewed the Healthcare Safety Net Program, which is intended to improve the availability of primary healthcare services to Tennessee’s uninsured adults. Our specific goal was to review management’s funding strategy, including the provider payment methodology, and management’s responsibility to report related healthcare statistics.

General Background

The Department of Health (the department) administers the **Healthcare Safety Net Program**, as enacted by Section 71-5-148, *Tennessee Code Annotated*, as part of meeting its mission to “protect, promote, and improve the health and prosperity of people in Tennessee.” Specifically, the program provides uninsured Tennesseans with primary healthcare, as well as mental, dental, and specialty services.

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6 The department works with the Tennessee Department of Mental Health and Substance Abuse Services to provide mental health services.
healthcare services. Eligible state residents must be between the ages of 19 and 64 and must not have access to health insurance elsewhere.

According to *The Impact of TennCare: A Survey of Recipients, 2021*, prepared by the University of Tennessee, Boyd Center for Business and Economic Research, there were approximately 527,000 adult Tennesseans without insurance in 2021.7

The department’s Office of Rural Health is responsible for the daily administration of the Healthcare Safety Net Program, which currently provides services to uninsured adults in need of healthcare services through two grant contracts:

- **Primary Care Plus**8 provides primary, dental, and/or mental healthcare services across the state.

- **Project Access Care Coordination** was implemented in fiscal year 2021 to deliver specialized care, such as cardiology, to uninsured adults, and is available in Nashville, Chattanooga, Knoxville, and Johnson City.

In addition, the soon-to-be-implemented **Safety Net Quality Improvement Incentive Program** (anticipated for 2023) will measure the impact of the Healthcare Safety Net Program by location and by the populations that providers serve, such as women who need prenatal healthcare and people without housing. The Healthcare Safety Net Program is 100% state funded through annual appropriations. See Table 3 for the Healthcare Safety Net Program’s budget and expenditures per year for fiscal years 2018 through 2022. Unless otherwise noted, the department uses the funds to pay safety net service providers.

### Table 3

**Healthcare Safety Net Program Budget and Expenditures**  
Fiscal Years 2018 Through 2022

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Budgeted Amount</th>
<th>Total Paid to Providers</th>
<th>Carryover</th>
<th>Number of Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$10,900,000</td>
<td>$10,900,000</td>
<td>–</td>
<td>606,621</td>
</tr>
<tr>
<td>2019</td>
<td>$9,400,000</td>
<td>$9,400,000</td>
<td>–</td>
<td>609,902</td>
</tr>
<tr>
<td>2020</td>
<td>$12,900,000</td>
<td>$12,900,000</td>
<td>–</td>
<td>578,149</td>
</tr>
<tr>
<td>2021</td>
<td>$30,400,000</td>
<td>$19,200,000</td>
<td>$11,200,000†</td>
<td>598,616</td>
</tr>
<tr>
<td>2022</td>
<td>$24,900,000</td>
<td>Not available*</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

* In addition to the $9 million set aside for the Safety Net Quality Improvement Incentive Program, the Governor also allocated an additional $2.2 million to expand the state’s safety net provider network in the state.
† Total expenditures for fiscal year ended June 30, 2022, will be determined after the fiscal year ends.
Source: Department management.

8 During fiscal year 2022, the department contracted with 108 Primary Care Plus providers.
Primary Care Plus Background

For this audit, we focused our audit work on how the department’s Office of Rural Health has structured the Primary Care Plus portion of the Healthcare Safety Net Program so that uninsured Tennesseans can benefit from primary care services. The Office of Rural Health utilizes the county health departments and contracts with external entities to deliver Primary Care Plus services across the state. The contracted service providers include

- Federally Qualified Health Centers,\(^9\) and
- community and faith-based centers.

A **Federally Qualified Health Center** provides primary medical care to an underserved area or population based on a sliding-fee scale, provides comprehensive services such as an ongoing quality assurance program,\(^{10}\) and is overseen by a governing board of directors. **Community and Faith-Based Organizations**\(^{11}\) are charitable clinics and not-for-profit entities that provide healthcare services by using volunteer licensed health professionals and/or non-clinical support personnel to deliver services to low-income, uninsured individuals for free, or at discounted or sliding-scale rates.

See Appendix 7 for the locations and types of safety net providers statewide.

Payments to Primary Care Plus Providers

Department and office management developed the *Tennessee’s Health Care Safety Net for Uninsured Adults Program Guidelines* (safety net guidelines) and provides the guidelines to all service providers (internal and external entities) that are responsible for delivering the services to ensure all parties comply with program requirements for proper provider reimbursement. Once service providers begin seeing patients, the guidelines require the service providers to submit a list of patient encounters\(^{12}\) each quarter using the prescribed departmental template. This information includes each patient’s unique patient ID number, the patient’s date of birth, and the date of the medical service. According to management, Office of Rural Health staff are responsible for reviewing each provider entity’s

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\(^9\) County health departments can also be Federally Qualified Health Centers.

\(^{10}\) A quality assurance program is designed to determine if goals and requirements related to products or services are met.

\(^{11}\) The community and faith-based organizations may also be called community health centers.

\(^{12}\) According to management, an encounter is defined as a medical provider seeing a patient for the purpose of diagnosing and treating an illness or injury.
quarterly list of encounters to ensure the patients served met the eligibility age requirements (to be eligible, patients must be between the ages of 19 and 64) and that no duplicate services were provided, meaning that the service providers did not seek reimbursement for patients who were seen for the same ailment during a 24-hour period.

Provider Reimbursement Rate Calculation

According to department management, to establish the service provider reimbursement rates, management divides the safety net program budget between Primary Care Plus and Project Access Care Coordination, and develops spending plans for each. For the Primary Care Plus spending plan, management further allocates the budget into quarterly amounts and develops the service provider rates based on encounter data for the quarter. According to safety net management, given the nature of the program, the department may adjust the reimbursement rates from quarter to quarter; however, within a quarter, the department reimburses all service providers based on the same rate.

Safety Net Program’s Annual Report

Section 68-1-123, Tennessee Code Annotated, requires the department to submit an annual report, the Uninsured Adult Healthcare Safety Net Annual Report, on the program to the Tennessee General Assembly by January 15 each year. This annual report provides the General Assembly with pertinent healthcare statistics regarding the program, including data related to access to care, issues with access to care, and the variety of program services. State law also requires that the annual report include information regarding the allocation of resources when developing a healthcare system without duplicating services, especially in rural and underserved areas.

Results of the Prior Audit

In the department’s October 2018 performance audit report, we noted two findings related to the Healthcare Safety Net Program. For one finding, we found that management did not require service providers to submit documentation to support provider reimbursements. In management’s six-month follow-up report, management stated that they developed and implemented standardized tools and procedures to ensure all budgeted funds are spent quarterly based on documentation of total encounters for that quarter. Management also indicated that they implemented a process to review encounter data before approving payments to providers.

We also noted a prior finding related to the Uninsured Adult Healthcare Safety Net Annual Report. Specifically, department management did not have formal written policies and procedures that outline the duties and responsibilities for preparing the report. They were also unable to provide

13 According to management, they designate 82.5% of the Healthcare Safety Net Program’s budget to Primary Care Plus and 17.5% to Project Access Care Coordination. For example, of the $24.9 million program budget for fiscal year 2022, management allocated approximately $20.5 million to Primary Care Plus, which was divided into approximately $5.1 million for each quarter.
verifiable supporting documentation for the annual reports. Additionally, we reported that the 2015 report was not published on the department’s website by January 15 as required by statute. Department management concurred with the finding and stated they had posted the 2015 report to the department’s website. Furthermore, in their 2018 six-month follow-up, management stated that they implemented a template for the program’s annual report in October 2018 to address missing data.

Current Audit

In the current audit, we expanded our work to follow up on the prior audit finding to include a review of management’s encounter data review process implemented since the prior audit. The encounter data serves as the source documentation for the program’s healthcare statistics presented in the Uninsured Adult Healthcare Safety Net Annual Report.

Finding 1

Administering the Healthcare Safety Net Program should include ensuring that program dollars are optimized to support the health of uninsured Tennesseans

Criteria, Condition, and Cause

Management is responsible for establishing the necessary operational processes and related controls to reasonably ensure both management and staff can effectively carry out the department’s mission, functions, objectives, and goals and can consistently comply with state statute. Since the last audit, management implemented new tools and procedures; based on our review of the tools and procedures, we found the following new problems.

Imperfect Payments to Providers

Duplicate Services

According to Section 68-1-123, Tennessee Code Annotated, the department must address the “allocation of scarce health care resources in the safety net, with attention to developing a rational health care system that does not duplicate services” [emphasis added] as part of its annual reporting. Based on our discussions with management, they define duplicate services as when a provider sees a patient for the same ailment within a 24-hour period. Management stated they strive to prevent duplicate services via the providers and departmental staff’s compliance/adherence to the safety net guidelines and provider contracts. As part of the office’s provider reimbursement process, the office’s guidance, and the service providers’ contracts require that the providers must submit the total number of unduplicated patients who received services by health service type for that quarter. According to
management, the staff manually evaluate each provider’s data submission to search for duplicate encounters (made more difficult when there are hundreds of encounters) before making the provider payments.

We tested a sample of 60 quarterly provider payments that were made during fiscal years 2021 and 2022 (through December 2021) and found that for 20 of 60 provider payments, the department paid for at least 1 duplicated service in which the provider served the patient for the same ailment within a 24-hour period. The 20 providers submitted approximately 24,000 total encounters; out of those, we identified 388 duplicate encounters.

**Ineligible Recipients**

Pursuant to Section 71-5-148, *Tennessee Code Annotated*, the Healthcare Safety Net Program was established for uninsured adults between the ages of 19 and 64 to seek health services that they might not otherwise afford. For fiscal year 2021, program management failed to require providers to submit patients’ dates of birth on the departmental template so that program staff could verify age eligibility requirements. In fiscal year 2022 program management began requiring providers to include the patients’ birthdates as part of the steps for eligibility verification. Based on our testwork, we found no issues involving the 21 fiscal year 2022 quarterly provider payments we tested (our sample included items selected through December 2021); however, we could not test the 39 quarterly provider payments related to fiscal year 2021 because, given the lack of pertinent birthdate information, we could not quantify the total provider payments in dollars related to age ineligibility.

Based on our discussion with program management and our review of the program guidelines, we found that the guidelines were not comprehensive enough to direct staff concerning how to verify provider encounter data; therefore, we had to rely on program management’s explanation of the payment process to providers. Furthermore, we found that program management had not established the necessary controls, such as supervisory review of staff’s work, to ensure the process was working as intended.

Although management has taken some steps to correct the conditions noted above, management has not yet established the necessary internal controls to ensure the newly established provider processes and annual report processes are designed and implemented to ensure that management and staff consistently and reasonably comply with state statute. We will follow up on management’s new processes, including any new controls, during the next audit.

**Department’s Risk Assessment**

Management identifies risks throughout the entity to provide a basis for analyzing risks. Risk assessment is the identification and analysis of risks related to achieving the defined objectives to form a basis for designing risk responses.

We reviewed the department’s December 2021 Financial Integrity Act Risk Assessment and determined that management did not assess the provider payment process for any potential risks of errors, fraud, waste, abuse, fiscal and operational risks, and noncompliance with state statute and also did not establish controls to mitigate risks.

**Effect**

The Healthcare Safety Net Program is funded by the state for the purpose of serving individuals who otherwise might not receive health services elsewhere. To ensure the department is able to optimize the state-funded Healthcare Safety Net Program and provide needed healthcare to eligible uninsured Tennesseans, the department must establish proper controls to avoid improper spending of state funds due to eligibility errors or duplication of services. Furthermore, by not verifying safety net program data, management increases the risk that the General Assembly will make a program or funding decision with inaccurate information. See Finding 2.

**Recommendation**

The Commissioner should ensure management continues to develop the new processes related to the Healthcare Safety Net Program, including updating the existing guidelines to include more comprehensive instructions for staff to ensure compliance with the state statute. Program management should conduct a risk assessment of the program and design and implement effective controls to mitigate the identified risks, including those identified in this report’s audit findings. To ensure controls are operating effectively, the Commissioner should ensure management properly monitors control activities and timely corrects deficiencies when they occur.

**Management’s Comment**

We concur.

New leadership, including a Director for the Safety Net and senior leadership, performed an internal review prior to the COT sunset audit. During that process, the program identified problems and immediately put a corrective action plan in place for the remainder of the fiscal year. During the COT sunset audit, the program noted existing errors and reported them to the audit team.
errors were found from previous years that are part of this sunset audit period, corrective measures were already in place when the audit began.

A new reporting template has been created with formulas to automatically monitor ineligible encounters and unduplicated patients. The quarterly site visit template is sent out each quarter and is uploaded in REDCap. These changes ensure the program no longer validates encounter data manually, thereby reducing errors. As stated in the COT sunset audit, program management had already discovered the errors and implemented procedures to automatically verify data in quarterly reporting.

Finding 2

As noted in the prior audit, the Healthcare Safety Net Program’s annual report to decision makers contains unsupported data to validate program results.

Condition and Effect

We found that management did not implement the necessary controls to ensure the information presented in the 2021 Uninsured Adult Healthcare Safety Net Annual Report was accurate. Management told us they did not verify the data in the report and did not maintain supporting documentation. As noted in the prior audit, the Department of Health still has no formal written policies and procedures that outline the duties and responsibilities for preparing the report. Management stated that they only reviewed the report for grammatical errors. Because management has not ensured accurate program reporting, such as the number of individuals served and the number of patient encounters as reported in Finding 1, the General Assembly may lack accurate information about the Healthcare Safety Net Program for future decision-making.

Criteria and Cause

Regarding providing quality information to external users, Green Book Principle 3.03, “Organizational Structure,” requires the following:

3.03 Management develops an organizational structure with an understanding of the overall responsibilities and assigns these responsibilities to discrete units to enable the organization to operate in an efficient and effective manner, comply with applicable laws and regulations, and reliably report quality information.
According to current management, they did not verify the data in the report due to time constraints and former management’s failure to maintain documentation.

**Recommendation**

The Commissioner should ensure that management designs and implements the necessary controls so that the information in the department’s *Uninsured Adult Healthcare Safety Net Annual Report* has been verified against the source documentation prior to publication. To ensure controls are operating effectively, the Commissioner should ensure management properly monitors control activities and timely corrects deficiencies when they occur.

**Management’s Comment**

We concur.

As mentioned in Finding 1, in response to our internal review, the Safety Net program put a corrective action plan in place. This plan includes implementing Standard Operating Procedures effective July 2022. In addition, REDCap patient encounters submitted with each quarterly report will be verified and signed off by a program team member and the Safety Net Director. During the COVID-19 pandemic, site visits were temporarily paused. We have resumed performing periodic visits to participating Safety Net locations. These visits include both physical and electronic verification reviews.

**Food Service Establishment Inspections**

Our goal was to review the inspection system, its functionality, and how it assists management with food inspection compliance. Additionally, we reviewed management’s quality assurance process used to validate, in part, that food inspections were performed.

**General Background**

As part of its mission to protect the public’s health, the Department of Health’s Division of Environmental Health is responsible for protecting the public safety for risks related to the state’s food
establishments, public swimming pools, childcare facilities, and other facilities. The division regulates businesses by ensuring they follow federal and state law, state rules, and regulations. While the department is responsible for performing over 94,000 inspections of various facility types across the state each year, the Division of Environmental Health’s inspectors\textsuperscript{14} are responsible for performing over 48,000 of the 94,000 total. See Table 4. The remaining inspections are performed by local governments under contract with the department\textsuperscript{15} to conduct inspections at food service establishments in their counties.

Table 4
Annual Facility Inspections Conducted by the Division of Environmental Health Staff

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>No. of Establishments</th>
<th>Inspection Frequency</th>
<th>No. of Inspections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Service Establishments</td>
<td>15,438</td>
<td>1-4 per year</td>
<td>26,875</td>
</tr>
<tr>
<td>Public Swimming Pools</td>
<td>2,700</td>
<td>1 per month while in operation</td>
<td>14,350</td>
</tr>
<tr>
<td>Hotels and Motels</td>
<td>978</td>
<td>2 per year</td>
<td>1,957</td>
</tr>
<tr>
<td>Childcare Facilities</td>
<td>1,357</td>
<td>1 per year</td>
<td>1,357</td>
</tr>
<tr>
<td>Tattoo Studios</td>
<td>362</td>
<td>4 per year</td>
<td>1,448</td>
</tr>
<tr>
<td>School Buildings</td>
<td>1,255</td>
<td>1 per year</td>
<td>1,255</td>
</tr>
<tr>
<td>Organized Camps</td>
<td>528</td>
<td>2 per year</td>
<td>1,056</td>
</tr>
<tr>
<td>Body Piercing Studios</td>
<td>125</td>
<td>1 per year</td>
<td>125</td>
</tr>
<tr>
<td>Bed and Breakfasts</td>
<td>47</td>
<td>2 per year</td>
<td>94</td>
</tr>
<tr>
<td>Correctional Facilities</td>
<td>18</td>
<td>1 per year</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22,808</strong></td>
<td></td>
<td><strong>48,535</strong></td>
</tr>
</tbody>
</table>

Source: HealthSpace, the department’s inspection system, as of March 15, 2022.

Food service establishments—which include restaurants, hotel kitchens, food trucks, childcare facility kitchens, and school cafeterias—account for 55% of total inspections performed by the division; therefore, we focused our audit on the department’s process for inspecting food service establishments.

Department’s Responsibilities

The Tennessee Food Safety Act (the Act), codified in Section 68-14-701 et seq., *Tennessee Code Annotated*, established the Commissioner of the Department of Health (the department) as the regulatory authority for food service establishments within Tennessee to ensure that these businesses safely prepare, serve, and deliver food for public consumption. The Act allows the Commissioner, using the rulemaking process, to adopt all or part of the U.S. Department of Health and Human Services, Food and Drug Administration’s Food Code.\textsuperscript{16} Chapter 1200-23-01, “Food Service

\textsuperscript{14} As of April 2022, the division had 69 environmental inspection positions.

\textsuperscript{15} Davidson County, Hamilton County, Knox County, Madison County, and Shelby County.

\textsuperscript{16} The Food Code serves as a model for state and local governments to ensure food safety within their jurisdictions.
Establishment,” in the department’s rules states that “a person may not operate a food establishment without a valid permit issued by the department.” All new establishments must request a permit through the department and obtain the required inspection prior to the business opening and another inspection within 30 days after the business opens. The rule establishes an ongoing inspection process based on a performance and risk-based approach, and also requires more frequent inspections for establishments that have a history of noncompliance that could pose a greater risk to the public. The department’s policy for Inspection Frequency creates the risk-based inspection schedule, including how often and when inspections are conducted based on the risk category assigned. See Table 5.

### Table 5
**Food Service Establishment Inspection Frequency**

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Number of Inspections per Calendar Year</th>
<th>Risk Category Description</th>
<th>Minimum Time Between Inspections</th>
<th>Maximum Time Between Inspections</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Very limited food preparation</td>
<td>3 months</td>
<td>18 months</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Complex food preparation</td>
<td>3 months</td>
<td>9 months</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>Repeated priority item violations</td>
<td>1 month</td>
<td>5 months</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Confirmed foodborne outbreak; specialized processing methods</td>
<td>1 month</td>
<td>4 months</td>
</tr>
</tbody>
</table>

Source: Department of Health’s Inspection Frequency Policy, “Risk Categorization.”

**Food Service Establishment Inspection Process**

The Division of Environmental Health performs food service establishment inspections for 90 of the 95 counties in the state and contracts with the remaining 5 local governments to conduct food service establishment inspections. Local governments are required by their contracts to conduct inspections in accordance with the department’s rules and policy and are responsible for 50% of the state’s food establishment inspections.
Alternative Work Plan

If management in a region\textsuperscript{17} or contracted county determine they will not meet annual inspection requirements, the department’s regional (field) office manager or the local government must submit an alternative work plan to the division’s director for approval. An alternative work plan establishes that food establishments categorized as level 1s and 2s will be inspected in the applicable calendar year. Inspectors will then give precedence to those establishments not inspected in the previous year or that serve high-risk populations, such as senior care centers, or have a potential for foodborne outbreaks. For calendar year 2021, three regions operated under an approved alternative work plan; none of the five contracted counties requested an alternative work plan.

Routine Inspection Process

All food establishments for which the department issued permits are listed in HealthSpace, the department’s online inspection system.\textsuperscript{18} During our audit period, the Division of Environmental Health had 69 inspector positions, 18 supervisors, and 8 field office managers. Supervisors are responsible for assigning inspections to inspectors. Supervisors report to field office managers in one of the eight regions of the state.

Inspectors perform unannounced inspections to observe the establishment’s operations for proper food storage, food handling, food temperature, and other food safety requirements. Inspectors document their inspections on department-issued iPads using the HealthSpace system. At the conclusion of the inspection, the establishment’s representative electronically signs the inspection, which is then considered complete. Completed inspections are automatically uploaded to the department’s public website,\textsuperscript{19} where all health inspections are available for review and where an establishment can print its inspection report for posting in the business as is statutorily required.

Supervisors and field office managers are responsible for ensuring that establishments in their region are inspected as required. Each supervisor develops a weekly productivity report for each inspector in their region to accomplish these tasks. The productivity report is an Excel spreadsheet template that supervisors use to examine and report on data extracted from HealthSpace. Field office managers examine inspection information via the HealthSpace dashboards by filtering and sorting data to review inspections completed by individual inspectors. To illustrate, the division’s 8 field office managers ensure that the 18 supervisors review 3,588 productivity reports (for the 69 inspectors x 52 weeks) to ensure inspections are conducted and performed timely.

\textsuperscript{17} The division’s inspectors are responsible for conducting inspections in 90 counties, which are grouped into the following eight regions: Northeast, East, Southeast, Upper Cumberland, Mid Cumberland, South Central, Northwest, and Southwest.
\textsuperscript{18} The department implemented the system in May 2018 and includes inspection-related data such as permit number, risk category, most recent inspection date, inspection score, violations, and follow-up inspections.
\textsuperscript{19} Go to \url{https://inspections.myhealthdepartment.com/tennessee}.
For contracted counties, the division director holds monthly meetings with the local governments’ environmental health program directors to provide guidance, such as technical assistance, to ensure the contracted inspectors have achieved compliance with the department’s inspection process rules and policy. The department’s contract with the county governments requires the county governments to “conduct regular or complete inspections of food service establishments at intervals prescribed in [the department’s] Rule 1200-23-01-.08(4)(a).”

Quality Assurance of Inspections

To ensure that quality inspections are performed and that training needs are assessed for inspectors, a supervisor is required to perform at least three joint inspections each month with each inspector.

Field office managers are required to perform quality assurance consultations at each food service establishment that was recently inspected (within two weeks) to ensure inspections were performed. The managers compare their own inspection results to those results from the most recent inspection. Managers also speak to the establishment’s representative and ask how the inspection went to verbally validate that an inspection was performed.

Results From the Prior Audit

In the Department of Health’s 2018 performance audit report, we reported an observation stating that because the Division of Environmental Health’s methods for overseeing, tracking, and managing inspection data were decentralized and manual, the division had limited ability to provide department leadership with real-time statewide inspection data. We recommended that management improve its technology and review its organizational structure and staffing levels to produce more efficient, effective, and timely inspections considering the large volume of inspections the division was required to complete. For most of the audit period, the division’s inspection process was manual; however, in May 2018, HealthSpace implementation was initiated with full implementation completed in September 2018, close to the end of that audit period. We did not audit the division’s inspection process in the prior audit, given that HealthSpace was in the testing and implementation phase.

Management agreed with the observation and stated that HealthSpace would provide supervisory and management staff daily updates of completed and timely inspection records. Management also noted that the central office would have the ability to monitor and verify the inspection staff’s time accountability and monitor inspection quality and frequency to ensure compliance with laws, rules, and program policies. Management stated that inspector position vacancies should be filled as soon as possible and in those regions with vacancies, the regions would develop alternative work plans.

20 Paragraph A.2a(1) in the contract’s scope of services.
Finding 3

Inspection system functionality should include reporting capabilities for management to quickly and easily identify missing or late food inspections to minimize the health risk to the public; additionally, establishing a robust quality assurance process promotes uniformity among inspectors and can help reduce the risk of falsified inspections.

Condition, Cause, and Effect

Deficiencies in the Process for Inspecting Food Service Establishments

Inefficient Inspection Tracking

In the prior audit observation, before the division implemented HealthSpace, we noted that the Division of Environmental Health’s inspections were paper-based, and management used manual inspection tracking processes. We requested that management provide us a listing from HealthSpace of all food service establishment inspections that the department did not conduct during 2021; however, according to the director, she had not requested that the HealthSpace vendor establish reporting capabilities so that management could identify missing inspections. Instead, supervisors and field office managers must still perform additional spreadsheet tasks outside the new HealthSpace system to track inspections through to completion. Additionally, management does not have reports to provide notifications in advance of upcoming inspections to help the department facilitate completion of all required inspections.

Given these workarounds, department management does not have the ability to analyze inspection data quickly for both the department’s inspections as well as inspections performed by contracted counties. Furthermore, these manual tasks mask risks and proliferate inefficiencies that build up over time. See testwork results below.

Testwork Results

According to department policy, higher-risk food service establishments which pose potential risk to public health and safety require inspections based on the department’s assignment of the establishment’s risk category (see Table 5). We performed testwork on a sample of 85 food service establishments statewide (60 inspections performed by the division and 25 inspections performed by contracted counties). For calendar year 2021, while we did not find issues with the division’s inspectors performing the required number of inspections, we found that the contracted inspectors did not perform the required number of inspections for 9 of 25 food service establishments (36%). Five of the 9 errors involved higher-risk food service establishments. See Table 6. According to the division director, Shelby County, which had most of the errors noted, had issues completing their inspections.
She also stated that the category 4 establishment was miscategorized and should have been a category 2; however, even if the establishment was a category 2, the contracted county still failed to perform the required inspection.

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Number of Establishments</th>
<th>Total Missed Inspections</th>
</tr>
</thead>
<tbody>
<tr>
<td>4*</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

* In 2021, the department classified this establishment as a category 4, requiring 4 inspections during the year. On April 7, 2022, management changed the category to 2.

Source: HealthSpace inspection information.

Lack of Formal Policies and Procedures for Quality Assurance

Not only has the department not ensured all required inspections were performed, but we also found that the department does not have a quality assurance process to ensure that its inspectors are performing consistent and uniform quality inspections to ensure the best outcomes for public health and safety. Having a quality assurance process for inspections can promote uniformity among food inspectors based on proper interpretation and application of regulations, policies, and procedures and attainment of the required inspection frequencies and timeframes.

In 2020, a food establishment owner reached out to the department to let them know that they had not received an actual inspection report. Management determined that the inspection was not actually performed because the inspector falsified the inspection report. Management subsequently terminated the employee.

Management took action in 2021 to partially address the risk of falsified inspections by adding a work outcome for quality control in regional managers’ performance plans; however, management did not address the risk through a formalized change in the division’s policy and procedures. As such, based on our discussions with two regional managers, the managers stated they were not performing quality assurance consultations with inspectors. Furthermore, the division director acknowledged that she could have done a better job following up with regional managers to ensure they implemented the quality assurance consultations. We also noted that supervisors’ quality control expectations were only included in their performance plans. By not updating the policy including controls (in this case, the quality assurance consultations) to mitigate the identified risk of falsified inspections, the department has failed to adequately communicate job expectations and the intended controls to prevent fraud or abuse in the inspection process.

21 Performance plans serve as a basis for evaluating employees.
Department’s Risk Assessment

We reviewed the department’s December 2021 Financial Integrity Act Risk Assessment and determined that management did not assess the inspection process for food service establishments for any potential risks of errors, fraud, waste, and abuse; for fiscal and operational risks; or for risks of noncompliance with state statute. Without risk identification, management cannot effectively develop the proper mitigating controls.

Criteria

The Department of Health’s Inspection Frequency Policy requires food service establishment inspections to be based on the public health risk of the operation. Management is responsible for designing, implementing, and monitoring internal controls in accordance with *Standards for Internal Control in the Federal Government* (Green Book), Overview, Section 3, OV3.07, which states,

A deficiency in internal control exists when the design, implementation, or operation of a control does not allow management or personnel, in the normal course of performing their assigned functions, to achieve control objectives and address related risks.

Principle 16.05 states,

Management performs ongoing monitoring of the design and operating effectiveness of the internal control system as part of the normal course of operations. Ongoing monitoring includes regular management and supervisory activities, comparisons, reconciliations, and other routine actions.

According to Green Book Principle 7.02, “Identification of Risks,”

Management identifies risks throughout the entity to provide a basis for analyzing risks. Risk assessment is the identification and analysis of risks related to achieving the defined objectives to form a basis for designing risk responses.

Paragraph A.2 of the department’s contract with county governments to conduct inspections states that the counties agree to “conduct regular or complete inspections of food service establishments at intervals prescribed in Rule 1200-23-01-.08(4)(a).”

Recommendation

The Director of the Division of Environmental Health should work with its vendor, HealthSpace, to improve the system’s reporting capabilities for monitoring and tracking food inspections. Management should ensure that inspections are performed by
contracted inspectors and, when necessary, take corrective action to ensure any missed food establishments are inspected as required. The director should also ensure that the quality assurance process is functioning to achieve high-quality consistent and uniform inspections and that the full process is included in their formal written policies and procedures and implemented across all regions.

Additionally, department management should evaluate their risks related to the process for inspecting food service establishments noted in this finding and implement effective controls to address the risks. Management should update the risk assessment as necessary, assign staff to be responsible for ongoing monitoring of the risks and mitigating controls, and take action if deficiencies occur.

Management’s Comment

We concur.

By January 1, 2023, the EH [Environmental Health] Program Director will take the following corrective actions:

Inefficient Inspection Tracking:

A request was made to our software vendor on August 24, 2022, to create a report that will provide a list of establishments that have missed or late inspections. Additionally, the EH Program has already implemented an inspection program review process that Field Office Managers and Contract County Directors use to analyze completion of inspections according to applicable laws and to communicate compliance or potential issues with program leadership. This inspection review process was implemented in July with the contract county directors and will also be used by the regions. The objective of the monthly inspection review process is to prevent missed and late inspections. Of note, beginning July 1, 2022, the General Assembly funded four additional food service inspector positions to aid in the inspection review process.

Lack of Formal Policies and Procedures for Quality Assurance:

Quality Control tasks to prevent potential fraud in the inspection process were added to the Field Office Manager IPPs [individual performance plans] in 2021 but formal Policy & Procedures were not developed. Quality Control Policy and Procedures will be developed and implemented statewide by January 1, 2023.
Department’s Risk Assessment:

The inspection process for food service establishments will be added to the next Financial Integrity Act Risk Assessment to control for potential risks of errors, fraud, waste, abuse; for fiscal and operational risks; or for risks of noncompliance with state statute.

Joint Annual Report

Our goal was to review management’s responsibilities to verify hospitals’ self-reported Joint Annual Report data used to identify gaps in healthcare across the state.

General Background

The Joint Annual Report (JAR) consists of self-reported health facility data related to a particular facility type and operation for a particular time period. The department requires eight healthcare facility types to submit JARs. Data collected includes facility locations, services provided, patient origin by county, and financial indicators. The Division of Health Planning is responsible for collecting the JARs, and division management has assigned one employee responsible for all hospital JARs. For the purposes of our audit, we focused on JARs submitted by hospitals.

Hospital Joint Annual Reports

Section 68-11-310, Tennessee Code Annotated, requires all hospitals licensed by the Department of Health (the department) or by the Department of Mental Health and Substance Abuse Services to submit a Joint Annual Report that includes hospital statistics and financial information. The department obtains and reviews the JARs to identify gaps in healthcare across the state and evaluates the causes for the gaps so that management can develop strategies to address healthcare shortages. Additionally, the Division of Health Planning uses a health

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22 Effective July 1, 2022, the Health Facilities Commission is responsible for licensing hospitals.
23 If a hospital licensed by the Department of Mental Health and Substance Abuse Services (DMHSAS) does not submit a JAR timely and department staff cannot get in contact with the hospital, department staff will contact DMHSAS for assistance.
facility’s JAR data to validate the healthcare facility’s Certificate of Need application\textsuperscript{24} to expand operations within a specific location in the state. Other entities, such as research entities, also use the health facilities’ self-reported data for other purposes and, as such, expect the data to be complete and accurate.

**JAR Reporting System**

To prepare the JAR for submission, hospital staff, including those licensed by the Department of Mental Health and Substance Abuse Services, self-report hospital data by completing numerous data fields in the department’s JAR Reporting System, a web application located on the department’s website. The JAR for hospitals contains 17 schedules that cover the following six areas:

- hospital information, including ownership and accreditation;
- financial data, such as revenue and expenses, including sources;
- patient statistics, such as use of hospital beds, admissions or discharges, medical diagnoses, and childbirth/deliveries;
- hospital staff statistics;
- health plans accepted; and
- uninsured patients served.

Section 68-11-310(a), *Tennessee Code Annotated*, requires each hospital licensed in Tennessee to submit a JAR within 150 days of the hospital’s fiscal year end, or 105 days after its closure. The hospital’s submission includes a notarized statement signed by the Chief Financial Officer and Chief Executive Officer, attesting that the hospital’s financial data in the JAR is consistent with the hospital’s audited financial statement for the respective fiscal year.

\textsuperscript{24} Healthcare facilities submit a certificate of need (CON) application to the state to obtain approval to open a new or modify an existing healthcare facility, institution, or service at a designated location for the purpose of delivering improvements in access, quality, and cost savings by managing the growth of the state’s healthcare system. For our audit period, the Health Services and Development Agency is responsible for reviewing and approving CON permit applications. On July 1, 2022, the Health Services and Development Agency was renamed the Health Facilities Commission.
Process for Verification and Independent Review

Section 68-11-1615, *Tennessee Code Annotated*, requires the department’s Commissioner to “establish policies and procedures to ensure independent review and verification of information submitted by healthcare providers for inclusion in the joint annual report.” The department’s Division of Health Planning’s supervisor, who reports to the division’s director, is solely responsible for the entire hospital JAR process. Specifically for hospital JARs, according to the supervisor, after hospitals submit the JAR through the JAR Reporting System, the system performs automated cross-checks of the data by comparing the data (for example, patient statistics) to the hospital’s previously submitted annual JAR. When the cross-checks identify an anomaly, such as a significant change (decrease or increase) in patient county of origin, the system highlights the data field in red. For the highlighted data, the supervisor contacts the hospital administrator via telephone to verify whether that hospital’s data was correct. If the hospital confirms that data is incorrect, the supervisor “unsubmits” the original JAR in the JAR Reporting System and asks the hospital to resubmit a corrected JAR. Once this correction process is completed, the supervisor approves the JAR and posts it to the department’s website.

Upon approval, division management uses the JARs to compile the annual *Hospital Summary Report*. This report contains combined hospital statistics from across the state, such as

- the number of active licensed hospitals in the state;
- a list of hospitals that did not submit a JAR;
- patient hospital admissions by county; and
- hospital financial data, such as revenues and expenses per hospital, including revenues received from Medicaid and Medicare and the cost of care provided to the uninsured.

This *Hospital Summary Report* is published around November 1 of each year.

Hospital Reporting Deficiencies

Section 68-11-310(c), *Tennessee Code Annotated*, requires the department to issue deficiency notices to hospitals for not submitting their JAR timely, not submitting it at all, or submitting data that does not pass the department’s edit process. Once the department’s Division of Health Care Facilities’ Licensing Unit issues a deficiency, the hospital has 15 days to submit a corrective action plan to the division. When a hospital fails to submit a corrective action plan, or when the department determines the plan is unacceptable, the hospital is subject to disciplinary action, which may ultimately impact the hospital’s license to provide services.
Results of the Prior Audit

In the department’s October 2018 performance audit report, we reported the department’s Hospital Summary Report contained anomalies related to rural county hospital patient counts, and we found one hospital that failed to submit a JAR; however, the department did not issue a deficiency as required by statute. Management concurred with the finding and stated that the Hospital Summary Report errors resulted from data entry errors by the hospitals and the Department of Finance and Administration’s Strategic Technology Solutions’ (STS) programming errors related to hospital patient counts for certain counties; therefore, department staff created a checks-and-balances tool to help verify hospitals’ reporting accuracy. Management also stated that not issuing deficiencies to hospitals was an oversight and they would begin preparing Notice of Deficiency forms.

In management’s six-month follow-up to the 2018 performance audit report, management stated that an automated validation tool was put in place to help verify hospitals’ reporting accuracy. Also, the department’s Public Health Program Director worked with STS’s Information Systems Director to update software to correct data errors impacting the summary report. The Public Health Program Director also developed a Notice of Deficiency form and placed a notice on the department’s Joint Annual Report webpage with a statement that failure to provide accurate and complete information by a healthcare facility would result in the filing of a Notice of Deficiency with the department’s Division of Healthcare Facilities’ Licensing Unit.

Finding 4

As noted in the prior audit, the information used for identifying gaps in healthcare needs across the state is not reliable, in part, due to the lack of internal processes to validate the self-reported data.

Effect

The department obtains and reviews the Joint Annual Reports (JARs) to identify gaps in healthcare across the state and evaluates the causes for the gaps so that management can develop strategies to address healthcare shortages. Other entities, including state agencies, research institutions, and health facilities, also rely on the JARs self-reported data to make their own healthcare-related decisions. Given the relevance and significance of data used to make these decisions, all users expect that the data is independently reviewed and verified as statute requires.

While the department functions as an independent reviewer, we found that the department’s internal processes, as described, are insufficient to validate the JAR data. When management does not validate the hospital’s self-reported data in the JARs as statute requires, both the department and other
report users are at risk of making inaccurate, incomplete, and/or unsupported decisions which may impact both public and private businesses or other stakeholders, including Tennesseans.

**Condition, Criteria, and Cause**

We learned that although management includes the following message to users of the *Hospital Summary Report*, the department has not established sufficient controls and processes to validate the hospitals’ self-reported data submitted in the JARs. The disclaimer states:

While an extensive effort has been made to ensure that the data reported on the Joint Annual Reports and the resultant reports are complete and accurate, please consider the limitations of the data as this is self-reported by each facility. We subject each [Joint Annual Report of Hospitals] to standard editing procedures. Detected errors are corrected with information supplied by the hospital; nevertheless, other, less apparent errors may go undetected.

Specifically, we found the following issues.

**No Written Policies and Procedures to Verify Data or to Maintain Documentation of Process Results**

Section 68-11-1615, *Tennessee Code Annotated*, requires the department to develop policies and procedures for the verification and independent review of JAR data. When we asked management for their policies and procedures, they provided internal documents, such as presentations and flowcharts, but none of these documents describe management’s process to document how they verify data. Furthermore, one employee, a supervisor, is solely responsible for the entirety of the hospital JAR process. The supervisor’s director does not perform any review of the supervisor’s work. The supervisor told us he believes the current JARs validation process as described is sufficient; however, based on our interpretation of state law and without sufficient documentation of the current process, neither management nor we can determine that management’s actions achieve compliance with statute.

Management is responsible for designing, implementing, and monitoring internal controls in accordance with *Standards for Internal Control in the Federal Government* (Green Book), Overview, Section 3, OV3.07, which states,

A deficiency in internal control exists when the design, implementation, or operation of a control does not allow management or personnel, in the normal course of performing their assigned functions, to achieve control objectives and address related risks.
Principle 16.05 states,

Management performs ongoing monitoring of the design and operating effectiveness of the internal control system as part of the normal course of operations. Ongoing monitoring includes regular management and supervisory activities, comparisons, reconciliations, and other routine actions.

Insufficient Validation Process of Submitted Data

The Division of Health Planning’s supervisor stated that he does not believe he has the authority to request supportive documentation from hospitals to verify JAR data. Instead, the division’s standard editing procedures for the JAR Reporting System are automated cross-checks to identify data anomalies by comparing data elements to JARs submitted in prior years. When the system identifies an anomaly, meaning the entered field data has exceeded a predetermined threshold established by the division, the system highlights these numbers. We asked the supervisor for documentation for developing the anomaly threshold amounts; however, he told us this was an internal department decision, and no further documentation was available.

When the system identifies an anomaly, the supervisor calls the hospital administrator to verify whether the reported data is correct. If a hospital has to resubmit a JAR to correct data, the corrected JAR when submitted completely overwrites the original JAR. As a result, because the system is not designed to keep all iterations of the JARs, the department does not have the historical records within the system, nor does the supervisor maintain an external record of the anomaly and subsequent corrective action by the hospital. We also confirmed that the supervisor does not document the details of the phone calls with the hospitals when the cross-check edits identify anomalies in the data. He also does not obtain documentation from the hospital to verify the data the hospital changed and resubmitted.

Public officials are legally responsible for creating and maintaining records that document the transactions of government business. These records provide evidence of government operations and accountability to citizens. As a result, the department is still relying on the hospital’s self-reported data without validation. Without adequate records, department management cannot ensure compliance with state law, which requires the department to either document the validity of the data or to issue Notices of Deficiency when the hospitals fail to submit accurate data that successfully passes the department’s edit process.

Did Not Issue Deficiencies to Hospitals

We also found that the department still did not issue deficiencies despite their concurrence in the prior audit to begin issuing deficiencies to hospitals that do not comply with statute.
not comply with statute. The supervisor stated that he would rather work with hospitals than penalize them if they have issues with JAR data they submit. While collaboration toward corrective action could be a viable alternative to issuing deficiency notices, we could not evaluate, nor can management provide evidence that this alternative has been effective to ensure hospitals submit accurate data. Additionally, we spoke with the Director of Licensure for the Board for Licensing Health Care Facilities, who has been in her position since 2006. She is responsible for handling all deficiencies, and to her knowledge, the department has issued no deficiencies to hospitals during her tenure. Section 68-11-310(c)(1), *Tennessee Code Annotated*, states,

Hospitals that fail to file their joint annual report in a timely manner . . . or that file a joint annual report that does not include all of the required data elements or includes data that does not pass the department’s editing shall receive a deficiency from the department.

Section 68-11-310(a)(2), *Tennessee Code Annotated*, states that,

If a hospital closes during the fiscal year, the owner of the hospital at the beginning of the fiscal year shall file a joint annual report with the department of health for the period of time that the hospital was owned or operated. The joint annual report shall be submitted within one hundred five (105) days after closure.

The department reported in their 2019 and 2020 *Hospital Summary Reports* a list of hospitals that did not submit a JAR because they were closed (see Table 7).

### Table 7
**Hospitals That Were Closed for JAR Reporting Periods 2019 and 2020**

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>Lakeway Regional Hospital</td>
</tr>
<tr>
<td></td>
<td>Copper Basin Medical Center</td>
</tr>
<tr>
<td>2020</td>
<td>Jellico Community Hospital</td>
</tr>
<tr>
<td></td>
<td>Curahelth</td>
</tr>
<tr>
<td></td>
<td>Decatur County General Hospital</td>
</tr>
<tr>
<td></td>
<td>Perry Community Hospital</td>
</tr>
</tbody>
</table>


The department did not issue deficiencies to hospitals that closed. The supervisor believes this statute, as written, is not practical since they cannot request JARs from closed hospitals because there is no staff. See the *Matter for Legislative Consideration* following this finding.
Department’s Risk Assessment

We reviewed the department’s December 2021 Financial Integrity Act Risk Assessment and determined that management did not assess the JAR process for any potential risks of errors, fraud, waste, abuse, fiscal and operational risks, and noncompliance with state statute and also did not establish controls to mitigate risks.

According to Green Book Principle 7.02, “Identification of Risks,”

Management identifies risks throughout the entity to provide a basis for analyzing risks. Risk assessment is the identification and analysis of risks related to achieving the defined objectives to form a basis for designing risk responses.

**Recommendation**

The Commissioner should ensure management designs and implements the necessary controls, including comprehensive written policies and procedures, to ensure the department complies with the required state statutes. Management should conduct a risk assessment of the Joint Annual Report process and design and implement effective controls to mitigate the identified risks, including those identified in this report’s audit finding. To ensure controls are operating effectively, the Commissioner should ensure management properly monitors control activities and timely corrects deficiencies when they occur.

If management believes that statute does not give them authority to obtain supporting documentation to verify the data or if they believe the statute’s intent is unclear, they should seek legislative changes.

**Management’s Comment**

We concur in part.

In response to the prior audit, the department created a platform that both serves the customers and improves the reliability of the hospital JAR data. This includes a web application for error validation, targeting areas of the report historically difficult for hospitals. It also includes four staff members who conduct reviews of the reports for completeness as much as possible. However, division staff does not have access to a hospital’s internal data.
A hurdle that TDH [the department] faces with validating the data within the JARs is that hospital data systems often include confidential and proprietary information. A legislative change may need to be considered to take into account the nature of self-reported, manually-entered data, and the lack of legal authority and capacity of department staff to directly access and audit private hospital data for point-by-point verification purposes.

It should be noted that the department’s strategic planning to address healthcare gaps and needs in the state is derived from multiple state and federal sources of data.

The Division Director will assess the JAR process for risks of errors, fraud, waste, abuse, fiscal and operational risks, and noncompliance with state statute. This will be completed by December 31, 2022, in alignment with the Financial Integrity Act Risk Assessment timeline. In addition, written policies to guide staff regarding data inconsistencies and other errors will be developed by June 30, 2023.

**Auditor’s Comment**

Section 68-11-1615, *Tennessee Code Annotated*, requires the department to establish policies and procedures to independently verify the information submitted by healthcare providers in their Joint Annual Reports. If management believes that statute does not give them authority to obtain supporting documentation to verify the data or if they believe the statute’s intent is unclear, they should seek legislative changes.

**Matter for Legislative Consideration**

The Department of Health should seek counsel from the General Assembly regarding Section 68-11-310(a)(2), *Tennessee Code Annotated*, which requires the hospital owners to file (with the Department of Health) a Joint Annual Report within 105 days of the hospital’s closure.

According to Section 68-11-310(a)(2), *Tennessee Code Annotated*,

If a hospital closes during the fiscal year, the owner of the hospital at the beginning of the fiscal year shall file a joint annual report with the department of health for the period of time that the hospital was owned or operated. The joint annual report shall be submitted within one hundred five (105) days after closure.

The current law does not provide any enforcement action to the department to address noncompliant hospital owners who fail to file their JAR (with the department) within 105 days of the hospital closure. As noted in our finding, department management further explained the difficulty the department has in contacting any former hospital management after the hospital has closed or after the owner has failed to submit the JAR by the 105th day of the hospital closure date. Given the
department’s explanation, we recommend that the department work with the General Assembly to discuss possible legislative changes to bring owners of closed hospitals into compliance with statute.

**Management’s Comment**

We concur.

No actively licensed hospitals were deficient in the years 2019, 2020, and 2021. The only hospitals to which a deficiency could have been issued were closed. Statute states that closed hospitals are required to file a JAR within 105 days after closure. However, hospitals do not report to the Division of Health Planning their intent to close or that they have, in fact, closed. Historically, by the time Division staff is notified, the hospital staff responsible for reporting JAR data are no longer employed by the hospital, which resulted in no JAR for that hospital. At this time there is no longer an existing (licensed, active) hospital to which a deficiency can be issued. In the future, the Division will report to the Health Facilities Commission the need to issue a deficiency.

Due to these realities, statutory change may be the best course of action to remedy this situation. While it would be beneficial to the Department to collect this data, it may not be feasible. Either a hospital must notify Health Planning of its closure early enough to still complete the JAR for the year-to-date or be issued a deficiency, or it should no longer be a requirement for the Division to issue these specific deficiencies.

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**Grant Contract Monitoring**

Our goal was to review management’s annual plan for monitoring grant contracts based on assessed risks to ensure program funds are used for their intended purposes.

**General Background**

The Department of Health administers federal and state grants and distributes funding to county health departments, hospitals, colleges and universities, nonprofits, and local governments through grant contracts to provide health-related resources to communities across the state in
alignment with the department’s mission. See Table 8 for the department’s total disbursements to grant recipients and subrecipients by federal fiscal year.

<table>
<thead>
<tr>
<th>Federal Fiscal Year</th>
<th>Total Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>$234,014,194</td>
</tr>
<tr>
<td>2020</td>
<td>$330,712,818</td>
</tr>
<tr>
<td>2021</td>
<td>$425,716,956</td>
</tr>
</tbody>
</table>

Source: Edison, the state’s accounting system.

Federal Subrecipient Monitoring Requirements

When a federal grantor awards federal grants to the department and the department passes that funding to external entities to carry out the grant activities, those external entities are known as subrecipients. As a pass-through entity, the department is required by Title 2, Code of Federal Regulations, Chapter 200, Section 332 (commonly referred to as Uniform Guidance) to monitor subrecipients’ activities to provide reasonable assurance that the subrecipients administer these federal awards in compliance with federal requirements and guidelines. If the department determines that a subrecipient does not comply with federal requirements, the department is permitted to impose additional conditions on the subrecipient. According to 2 CFR 200.208(c), “Specific conditions,” these actions may include

- requiring reimbursement instead of advance payments;
- not allowing the agency to proceed to the next phase until it submits evidence of acceptable performance;
- requiring additional, more detailed financial reports or additional project monitoring;
- requiring the subrecipient to obtain technical or management assistance; or
- establishing other prior approvals.

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25 When the department awards a state grant (funded by state appropriations) to an entity, the entity is considered a recipient.
26 Central Procurement Office Policy 2013-007, “Grant Management and Subrecipient Monitoring Policy and Procedures,” defines a subrecipient as a non-federal entity receiving a grant from a pass-through entity, such as the State of Tennessee, to use as part of a federal program.
27 The department uses the federal fiscal year, October 1 through September 30, when preparing the annual monitoring plan, even though the plan includes state grants which are traditionally awarded on the state’s fiscal year.
If the department determines that the subrecipient cannot remedy its noncompliance through the above actions, the department can take further actions,\(^{28}\) such as

- temporarily withhold payments until the noncompliance is corrected,
- partially or fully suspend or terminate the grant contract,
- withhold additional grant contracts, and
- pursue other legal remedies.

State Monitoring Plan Requirements

To ensure state agencies comply with both state and federal subrecipient monitoring requirements, the state’s Central Procurement Office (CPO) issued CPO Policy 2013-007 “to establish guidelines for recipient and subrecipient monitoring by grantor state agencies.”\(^{29}\)

CPO Policy 2013-007 requires each state agency to submit to CPO an annual monitoring plan by October 1 each year. CPO is responsible for reviewing and approving state agencies’ monitoring plans, which must include all awards of state and federal funds or non-cash assistance. As the grantor agency, the Department of Health is responsible for complying with Section 9.2.1 of the policy, which describes all the details the monitoring plans must include.

Additionally, Policy 2013-007\(^{30}\) requires management to assess each recipient or subrecipient’s risk of noncompliance with federal and state program requirements for inclusion in the monitoring plan based on the following areas of risk:

- the recipient or subrecipient’s prior grant experience;
- the results of prior audits and federal monitoring, including single audits; and
- new personnel or new or significantly modified information systems.

CPO policy also requires departments to provide “the current list of all subrecipients that have completed a Federal Single Audit.” Pursuant to “Audit Requirements,” 2 CFR 200.501, a non-federal, not-for-profit entity (a subrecipient or direct recipient of grant funds) that spends $750,000 or more in federal funds during the entity’s fiscal year must receive a single audit. The purpose of the single audit is to provide assurance to the federal government that states, local governments, and nonprofit organizations are managing and using federal funds for their intended purposes.

\(^{28}\) As outlined in 2 CFR 200.339.

\(^{29}\) Federal regulations require the department to monitor recipients of federal funds; however, CPO policy requires the department to also monitor recipients of state grants.

\(^{30}\) Also required by 2 CFR 200.332(b).
Department’s Responsibilities for the Grant Monitoring Plan

Current Monitoring Plan Process

The department’s Office of Compliance and Ethics is responsible for creating the annual monitoring plan to monitor the recipients and subrecipients that receive funding directly from the state and/or that passes through the department from federal grant programs. The office’s Auditor 4, who is the lead monitor, relies on the department’s various program area management teams to compile a list of grant contracts each year, and she provides program management with an instruction guide to assist in the process. After the program areas return their completed spreadsheets to the Auditor 4, she compiles each list into an Excel spreadsheet that she uses to create the department’s official monitoring plan. To determine which grants to select for monitoring for the year, she told us she considers the following information:

- whether the grant contract is a one-year contract,
- if previous monitoring visits of the grant recipient/subrecipient resulted in high-risk findings, and
- whether the grant recipient was monitored in the prior three years.

Assessing Recipient or Subrecipient Risk

According to the instruction guide, when compiling their grant listing, program management must determine and indicate the recipient/subrecipient risk level by including an “H” for high-risk, “M” for medium-risk, or “L” for low-risk. Program management for each area evaluates risks based on their own protocols.

Single Audit Requirement

Grant contracts with subrecipients also contain a requirement that the subrecipient must provide a Notice of Audit Report form to the department acknowledging whether they are subject to a single audit. Upon receipt of this form, program management is responsible for informing the office’s administrative assistant when the Notice of Audit Report form indicates that the subrecipient is subject to a single audit. She maintains a log of those subrecipients.

Results of the Prior Audit

In the October 2018 Department of Health performance audit report, we reported a finding related to the department’s failure to monitor the Healthcare Safety Net providers because they were
improperly classified as vendors rather than as recipients of state grant awards (thus requiring management to perform monitoring). See the Contract Procurement section for more information about contract classification. We reported that the department did not perform subrecipient monitoring to ensure the subrecipients met contract terms and/or grant requirements. Part of the monitoring is to determine whether a contractor is a subrecipient or vendor, and once a contractor is determined to be a subrecipient, for staff to perform monitoring procedures, including site visits, for Healthcare Safety Net providers. Management concurred that monitoring site visits were not performed for all safety net providers and that program staff initiated and were expected to complete fiscal year 2019 monitoring site visits including review of programmatic and financial documentation for 5%, or 30, of the patient encounters. Also, management stated that a standardized checklist would be used to record and report results of site visit outcomes.

In management’s six-month follow-up to the 2018 performance audit report, management stated the steps outlined in their corrective action above were fully implemented.

Finding 5

Monitoring for the state and federal dollars awarded should align with the state’s uniform monitoring policy to ensure grant awards were used for their intended purposes to achieve the department’s healthcare mission

Condition, Cause, and Effect

We reviewed the department’s four annual monitoring plans submitted to the CPO during our audit period and found that management has not established the necessary internal control activities to ensure compliance with the federal and state monitoring requirements. Without accurate and complete monitoring plans, management increases the risk that subrecipients who are at a higher risk of not complying with state and federal compliance requirements are not monitored and that grant funds are not spent for their intended purposes.

Our review of the monitoring plans found the following noncompliance.

Risk Assessments Were Not Performed as Required by Policy

Management’s internal instruction guide, which assists the department’s program areas in assessing the risks associated with subrecipients, has not been updated to include CPO’s current criteria governing risk assessments of each recipient/subrecipient. These instructions do not describe what each program area should consider as they perform their risk assessment, which includes the risk of noncompliance with state and federal requirements as detailed in CPO policy. They only instruct
them to indicate the risk level for each grant contract on the listing. Management is responsible for instructing program staff on how to assess risk. From our discussions with various program area management and the Auditor 4, while some program areas document the risk assessment, others only verbally discuss the recipient/subrecipient risks and note the risk level on the Excel spreadsheet. We could not determine if program management used CPO policy criteria because management could not provide the supporting documentation. By not completing the risk assessment in writing and in accordance with the most current policy, top management does not know if each program area assessed the risks related to their respective recipients/subrecipients based on the CPO policy requirements.

Although all program area management teams provided input as to a risk level for each of their grant contracts, the Auditor 4 stated she did not consider the risk levels first when developing the monitoring plan. Instead, she selected grant contracts based on whether she monitored the grant contracts during any of the past three years, a requirement from the now-outdated 2015 CPO policy.31 The current policy requires risk assessments on each recipient or subrecipient, and if a recipient is considered high-risk or if previous monitoring revealed deficiencies, management and staff should monitor the recipient more frequently.

Noncompliance With Single Audit Requirements

We also found that management maintains a current list of all subrecipients that require a federal Single Audit, which is a requirement under the current CPO policy, but did not include such a list in the 2021 monitoring plan.32 Based on our discussions, she was not aware that she had to include the list in the monitoring plan.

Department’s Risk Assessment

We reviewed management’s December 2021 Financial Integrity Act Risk Assessment and determined that management did not assess the risks associated with not having a sufficient monitoring plan process. These potential risks include fiscal and operational risks and also risks from errors, fraud, waste, abuse, and noncompliance with state statute and federal regulations. In the absence of identified risks, management also did not establish controls to mitigate risks.

Criteria

To achieve the department’s mission, management is responsible for establishing the necessary operational processes to carry out the department’s functions, objectives, and goals. These key operational processes should include effective internal control activities, including management overseeing the processes that fulfill the department’s stated mission. According to the U.S. Government Accountability Office’s Standards for Internal Control in the Federal Government (Green

31 Management used the 2015 version of the CPO policy.
32 The current CPO policy became effective in February 2020.
Book), Principle 4.02, management should establish expectations for key roles to ensure staff have relevant knowledge, skills, and abilities to carry out their responsibilities. These responsibilities are further carried out through Principle 3.09, which states that management should design control activities in response to their objectives. Principle 3.10 explains that effective documentation helps management design internal controls by establishing and communicating internal control responsibilities. Principle 3.11 states that management should document internal controls to provide evidence that controls are identified, communicated to staff, and can be monitored and evaluated.

According to Section 9.2.1 of CPO Policy 2013-007, the monitoring plan shall include: the total Grant Contract Population . . . a description of each State and Federal program to be monitored and a risk assessment for each Recipient or Subrecipient and its related contracts . . . the most current list of all subrecipients that have completed a Federal Single Audit.

According to Green Book Principle 7.02, “Identification of Risks,”

Management identifies risks throughout the entity to provide a basis for analyzing risks. Risk assessment is the identification and analysis of risks related to achieving the defined objectives to form a basis for designing risk responses.

**Recommendation**

The Commissioner should ensure management designs and implements the necessary controls, including comprehensive written policies and procedures as needed, to ensure compliance with both state and federal monitoring requirements, including the development of management’s monitoring plan based on the risks assigned to each grant recipient and subrecipient.

Management should periodically evaluate (perform a risk assessment of) the department’s monitoring plan process and ensure that the design and implementation of effective controls achieve the goal to mitigate the identified risks, including those identified in this report’s audit finding. To ensure controls are operating effectively, the Commissioner should ensure management properly monitors control activities and corrects deficiencies timely when they occur.
Management’s Comment

We concur.

Management acknowledges that CPO policy changed to move toward a risk-based approach that includes a list of subrecipients requiring single audits as part of the department’s annual monitoring plan. For the past two monitoring cycles, the department inadvertently operated under the 2015 version of CPO Policy 2013-007 requiring that all subrecipient contracts must be monitored by the grantor state agency at least once every three years. By diligently following this standard, the department ensured and completed a 100% monitoring rate of subrecipient contracts.

Beginning in July of 2022, management created a comprehensive risk assessment tool assessing 14 relevant risk factors. This risk assessment tool was distributed to programs with subrecipient grantees, management trained the programs on its use, and included the completion of this risk assessment as part of the instruction for completing the list of grantees in preparation of the annual monitoring plan. The risk evaluation, performed by program management, will be used to plan the annual monitoring schedule. The final risk evaluation will be included in the annual monitoring plan, along with a list of all subrecipient grantees that require single audits, as noted in the 2020 version of the CPO policy. Prior to submission of this monitoring plan to the CPO, it will be reviewed by the Assistant Commissioner for Compliance and made available to the Commissioner for review.

Additionally, the Compliance Office will access risk by checking with the CPO to ensure that we have the most current version of Policy 2013-007 and by reviewing the monitoring planning process on an annual basis as part of the monitoring plan preparation.

Contract Procurement

Our goal was to review management’s process for compliance with the state’s procurement policy, including a review of purchases that occurred during the height of the COVID-19 pandemic. In our next audit of the Central Procurement Office, we plan to focus on lessons learned regarding the state’s use of emergency purchases. The department described its lessons learned on page 45 of this report.
General Background

The Department of Health must follow the state’s procurement process to purchase goods and services to aid in protecting the public health of citizens across the state. The state’s procurement process falls under the authority of the Central Procurement Office (CPO). The CPO’s personnel responsible for procurement include the Chief Procurement Officer and all persons acting on his behalf, whether located in the CPO or within a state agency. The Chief Procurement Officer has the authority to enter into contracts on behalf of other state executive agencies and to manage all procurement solicitation types. All procurement duties promulgated in state statute, including the central purchasing authority for goods, nonprofessional services, and professional services, as well as grants management for the State of Tennessee, are the responsibility of the CPO.

Department of Health Contracts

In the Department of Health, the Division of Administrative Services’ Procurement Management Office (PMO) assists the department’s programs, divisions, and offices in writing contracts for procuring goods and services, including grant contracts, and serves as the intermediary between the department and CPO. Primarily, the department enters into grant contracts with local health departments and other organizations to carry out federal and state grant programs at the local level, but also contracts with laboratory supply companies, colleges and universities, medical institutions, and technology companies for operational purposes.

Procurement Process

Department program staff initiate the procurement process by defining the scope of services or goods needed in an initial procurement request to the CPO and are responsible for classifying the contract relationship as a vendor, subrecipient, or recipient. According to Edison, as of January 20, 2022, the department had 1,186 contracts: 981 with subrecipients, 9 with recipients, and 196 with vendors. The PMO created internal checklists to aid department staff in meeting CPO requirements, which include ensuring that program staff correctly classify the contract relationship and adding the

33 Section 4-56-104, Tennessee Code Annotated, establishes the state procurement office and the state procurement officer, and grants the Procurement Commission power to adopt new rules and regulations and policies as necessary.

34 According to the CPO Glossary, a vendor is a “person or legal entity with the legal capacity to enter into contracts . . . who provides goods or services to the state through a contract or a purchase order.”
initial procurement request to the CASPIO\textsuperscript{35} system. To complete the internal processes, program staff submit the procurement request via Edison to the CPO for review and approval so that the department can move forward in the solicitation, negotiation, and finalization of the contract.

**Responsibilities for Managing the Department’s Contracts**

Program management for each program area assigns a manager or staff person to manage their contracts. These staff are responsible for ensuring the department received the contracted service or goods.

- For services received, program staff are responsible for notifying the Division of Administrative Services that the contractor met or did not meet the requirements of the contract. Program staff approve, and the division’s staff upload, contract invoices in CASPIO. The division’s staff match the approved invoice against the contract’s purchase order in Edison and process the payment.

- For goods obtained, the Division of Administrative Services staff upload vendor invoices into CASPIO, where program staff will approve or deny the invoices or notate changes to the invoices. If, for example, the department received incorrect or damaged items, then they work with the vendor until the problem is satisfactorily corrected. After program staff complete their review, they approve the invoice for payment in CASPIO. The Division of Administration’s staff upload the invoices into Edison and process the payment.

**Emergency Purchases in General**

According to Section 6.1.1., “Description of Emergency Purchases,” in the *Amended Procurement Procedures Manual of the Central Procurement Office* (CPO Manual), in effect during our audit period,

An Emergency Purchase may occur when there is a serious and unexpected situation that poses an immediate risk to health, life, property, or environment which calls an agency to action; such action entails the need to secure goods or services to carry out an emergency response. In such situations, competition should be engaged when practicable, but this policy recognizes that some emergencies are such that the exigencies of the situation may not allow for a competitive procurement.

\textsuperscript{35} CASPIO is the department’s internal document tracking system used to track procurements and manage contract payment approvals.
In general, when program management determine they need to make an emergency purchase, program personnel provide the PMO Director with the procurement request including a justification for the emergency purchase and documentation related to any bids obtained. When such circumstances arise, the CPO Manual requires the Chief Procurement Officer to approve all non-competitive emergency purchases. The director reviews the justification documentation for compliance with CPO policy, uploads the documentation into Edison, and immediately emails the emergency purchase details and dollar amount to the Chief Procurement Officer for his review and approval. Once the Chief Procurement Officer replies with an approval, the PMO uploads the approval email into Edison and proceeds with the procurement.

Emergency Purchase Challenges During COVID-19

The department made 44 emergency purchases from vendors between April 2020 through June 2021 to assist department staff, including county health departments, with COVID-19 related needs. According to the PMO Director, the department rarely used emergency purchases prior to the COVID-19 global pandemic. At the onset of the global pandemic, vendors in general struggled to meet global demand. To act quickly, the department used the state’s Central Procurement Office emergency purchase process to obtain equipment and testing supplies to aid those in the health industry and general population to prevent the spread of the disease. In addition, the state’s Unified Command Team36 could also use the Tennessee Emergency Management Agency’s (TEMA) emergency purchase authority to make COVID-19 related purchases for the department’s use.

In seeking transparency of purchases made during the COVID-19 emergency, the Tennessee General Assembly’s Fiscal Review Committee called the Department of Health, TEMA, and the Central Procurement Office to discuss a contract breach related to the state’s COVID-19 response. Based on the department’s testimonial evidence at the December 17, 2020, Fiscal Review Committee hearing, in the department’s pursuit to obtain much needed laboratory equipment, COVID-19 test kits, and personal protective equipment, the Unified Command Team secured a contract whereby the department received lab equipment that did not meet the state’s laboratory testing standards and was never used. According to management, the state canceled the contract due to a breach of terms and kept the supplies for possible future use.

36 The Unified Command Team consisted of the Governor, the Commissioners of the Departments of Health and Military, and the Director of the Tennessee Emergency Management Agency.
Lessons Learned as Represented by Management

We followed up with the PMO Director and the Deputy Commissioner for Operations to ask what lessons they had learned and what changes would they make when or if faced with the next health emergency that poses risks to health, life, property, or the environment. They both stated they would develop better communication—within the agency, between agencies, between the agency and the General Assembly—and be cognizant to maintain communication. For example, management stated that their communications with all parties at the beginning of the pandemic did not provide context or clarity as to how they pursued procurements (e.g., vendor selection) and/or the method of procurement (e.g., sole source procurement). Furthermore, management stated they did not do a good job explaining to key stakeholders why they made the decisions they did.

According to the PMO Director, the Central Procurement Office began to develop a more standardized emergency purchase process. We plan to audit the state’s procurement process, including emergency purchases, in the next audit of the Department of General Services and procurement-related entities, including the Central Procurement Office.

Results of the Prior Audit

In the October 2018 Department of Health performance audit report, we reported a finding related to the department’s procurement contracts with Healthcare Safety Net providers. Specifically, we stated that the department and the Central Procurement Office did not ensure that contracts with Healthcare Safety Net providers were properly classified and procured in accordance with state procurement policies, including making the initial determination of whether a contractor is a subrecipient or vendor.

In response to the finding, management did not concur with this portion of the finding, stating that they believe they executed provider contracts in accordance with state procurement policies; however, the Central Procurement Office concurred that the “Department of Health did not follow CPO’s rules, policies, and procedures when it submitted noncompliant documents for review.” CPO also stated that CPO staff erroneously approved the documents during their review.

In management’s six-month follow-up to the 2018 performance audit report, management stated that PMO

consistently maintained an ongoing relationship with CPO to determine the department’s expectations for contracts and provide reasonable assurance of fiscal responsibility, and to ensure future contracts are executed properly. Procurement management held meetings and communicated via email to program and divisional directors what the expectations are.

Based on our current audit, we identified no findings. See Appendix 1 for detailed audit objectives, methodologies, and conclusions.
State Abuse Registry

Our goal was to review the department’s responsibility for maintaining the state’s Abuse Registry.

General Background

The Department of Health’s mission includes protecting the health and prosperity of Tennesseans. The department accomplishes this in a variety of ways, one of which involves maintaining a statewide abuse registry that contains the names of individuals who have abused or neglected a vulnerable person or misappropriated or exploited their property.

State statute defines a vulnerable person as someone under 18, or someone over 18 and vulnerable to abuse, neglect, or misappropriation due to their advanced age or their physical or mental state. Section 1200-08-38 of the Rules of the Department of Health, Office of Health Care Facilities, states that the registry’s purpose is to make the public aware of individuals who have hurt or taken advantage of vulnerable persons to ensure they are not allowed to continue abusing others.

The state’s abuse registry was created in 1989 to comply with Title 42, Code of Federal Regulations, Part 483, Section 156, which required states to create a nurse aide registry to maintain the names of nurse aides who the state found committed abuse, neglect, or misappropriations against a vulnerable individual. Over time, state statute expanded the requirement for the abuse registry to include not just nurse aides but anyone, such as other healthcare professionals, family members, and caregivers who abused, neglected, or exploited a vulnerable individual.

The abuse registry is maintained by the department’s Office of Health Care Facilities and is housed in the department’s Licensure and Regulatory System (LARS). Abuse registry information is

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37 Along with housing the abuse registry, LARS is also the department’s licensure system for all of the state’s health professions.
uploaded daily from LARS to the department’s [website](https://apps.health.tn.gov/AbuseRegistry/default.aspx), where the public can search for individuals on the abuse registry using the individual’s name or Social Security number.

Individuals can be placed on the abuse registry in three ways:

- when another state agency refers a substantiated complaint to the department;
- when a criminal is convicted on a related charge; or
- when the department’s Abuse Panel recommends the individual be placed on the registry.

As of February 23, 2022, a total of **2,808 individuals** were listed on the abuse registry: 1,306 reported by state agency referrals, 525 as a result of criminal convictions, and 960 as a result of the Abuse Panel recommendations. From our review of the abuse registry data, we could not determine the reporting method for 17 individuals. See Chart 2. We further explain each of the different abuse registry reporting methods on the following pages.

Department of Children’s Services (DCS) referred one individual to the abuse registry; however, due to federal and state confidentiality laws, DCS is not required to report names to the abuse registry.

† Department of Mental Health and Substance Abuse Services.
‡ Department of Human Services.
§ Department of Intellectual and Developmental Disabilities.
ǁ Tennessee Bureau of Investigation.

Source: Department of Health’s Licensure and Regulatory System.

State Agency Referrals

As of February 23, 2022, 1,306 individuals were listed on the registry as a result of state agency referrals. See Chart 2.

After a state agency determines an individual has committed abuse, neglect, or misappropriation, Section 68-11-1003(a)(1), Tennessee Code Annotated, requires the agency to provide the individual’s name to the department for inclusion on the abuse registry. Section 1200-08-38 of the Rules of the Department of Health, Office of Health Care Facilities states that the referring agency has 180 days to send the referral to the department’s abuse registry program staff.
Criminal Convictions

Section 39-15-506, *Tennessee Code Annotated*, requires courts to notify the department of a conviction for any of the following offenses committed against an elderly or vulnerable person:

- financial exploitation,
- neglect,
- aggravated neglect,
- abuse,
- aggravated abuse, or
- sexual exploitation.

County court clerks document criminal convictions on judgment forms and send them to the department by email, fax, or mail. The form must include language specifying that the individual should be placed on the abuse registry. If a court clerk does not include the required language on the judgment form, the Tennessee Bureau of Investigation, a law enforcement agency, or a criminal justice agency may send the court judgment or other documentation to the department.38 The department’s Office of Health Care Facilities (OHCF) management uses the court judgment form and other documentation to substantiate that an individual committed an offense against a vulnerable person and should be placed on the registry. See Appendix 8 for counties that have referred individuals for placement on the abuse registry.

Department’s Abuse Panel

The department’s Abuse Panel receives and evaluates complaints from OHCF, and the Office of Investigations as follows.

*Complaints Handled by the Office of Health Care Facilities*

OHCF investigates allegations of abuse, neglect, misappropriation, or exploitation of vulnerable populations that have occurred at department-licensed healthcare facilities that receive Medicare and Medicaid funding. If the department receives a complaint about a facility that is not licensed by the department, the department refers the complaint to the appropriate state agency for investigation.39

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39 The agencies include, but are not limited to, the Department of Human Services, the Department of Intellectual and Developmental Disabilities, and the Department of Children’s Services.
Upon receiving a complaint, the OHCF complaint intake nurse determines if the complaint alleges abuse, neglect, or misappropriation; the nurse enters the incident into the Aspen Complaints/Incidents Tracking System, the federal information system owned by the Centers for Medicare and Medicaid Services (CMS). The complaint intake nurse determines the complaint’s priority level, which triggers the next steps, such as assigning the complaint to an OHCF health surveyor if the complaint’s priority level requires it. According to the CMS State Operations Manual, the priority level determines when the surveyor must begin an investigation into the complaint. For example, investigations involving immediate jeopardy complaints, which are those that have caused or are likely to cause serious harm or death, have to be initiated within two business days of receipt or approval from CMS. For less serious complaints, CMS has various timelines to initiate investigations, depending on the provider type.

The OHCF health surveyor is responsible for visiting the facility and conducting an investigation into the complaint. The surveyor documents the results of their investigation and submits the results to their supervisor for review. At that point, the surveyor and their supervisor determine if sufficient evidence exists to substantiate the allegation of abuse, neglect, or misappropriation; if so, the surveyor sends the complaint to the department’s Abuse Panel. Otherwise, the complaint is closed.

Complaints Handled by the Office of Investigations

The department’s Office of Investigations reviews complaints on behalf of the state’s health-related boards, except the Board of Pharmacy and the Board of Emergency Medical Services.40 Once the office receives a complaint, Investigations staff enter the complaint into LARS and log it on a complaint log, where it is tracked through completion. The board staff, Office of General Counsel staff, and a board consultant who is a licensed member of the related profession first review the complaint to determine if a state statute or board rule was violated. If they confirm a violation of abuse, neglect, or misappropriation, the complaint is assigned to an investigator.

Once the investigation is complete, investigation staff submit the evidence to the Office of General Counsel and the board consultant for a second review. During this review, the parties determine if the individual will be placed on the abuse registry. If the individual has a professional license and the evidence supports their placement on the abuse registry, the board consultant refers the individual for placement on the registry immediately. If the individual is unlicensed, the complaint is reviewed by the department’s Abuse Panel.

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40 The Board of Pharmacy and the Board of Emergency Medical Services have their own investigators.
Abuse Panel Determinations

Authorized by Section 68-11-1003(g)(B), *Tennessee Code Annotated*, the Abuse Panel serves as the department’s advisory group to determine if individuals whom the department investigated should be placed on the abuse registry. The panel meets monthly and consists of the Director of Health Care Facilities, the Public Health Nursing Consultant Manager, the Training Manager, and three Public Health Nurse Consultants. During meetings, panelists review and discuss the facts and circumstances of OHCF investigation files and then vote to either close the case or recommend the individual for placement on the abuse registry. The panel’s decision is documented on the Abuse Panel Form, and the form is signed and dated by the panelists and a member of the department’s Office of General Counsel.

When the panel determines an individual should be placed on the abuse registry, OHCF staff send a “Notice of Intent to Place” letter to the individual within 10 working days of the decision. According to Section 1200-08-38-.05(2) of the *Rules of the Department of Health, Office of Health Care Facilities*, individuals have 30 days from the date of the notice to appeal the panel’s decision. If an individual’s appeal is unsuccessful or the 30-day timeframe expires without appeal, federal regulations require the department to place the individual on the registry within 10 days from the completion of due process.

Process for Adding an Individual to the Abuse Registry

To place an individual on the department’s abuse registry, OHCF staff first create a placement application in LARS. The application contains the individual’s basic information, such as their name, alias, Social Security number, date of birth, race, address, and phone number. The application also includes the offense(s) that resulted in the individual being placed on the registry. The offenses committed must match the definition of the offense as stated in Section 68-11-1002, *Tennessee Code Annotated*.

Staff attach any applicable documentation, such as the complaint investigation, the Abuse Panel documentation, and the state agency or court referral. OHCF staff also document in the application if the individual is a licensed healthcare professional and their license number. Any paper documentation received is also kept at OHCF and saved electronically in LARS. The OHCF supervisor stated that she reviews the application to ensure it is complete and accurate, and then she approves the application in LARS. After the application is approved, the individual’s information is uploaded, as part of a nightly process, to the public-facing abuse registry on the department’s website. OHCF staff notifies an individual of their placement on the abuse registry within two working days of placement, as required by department policy.
Maintenance of Abuse Registry Records

State law requires the Public Records Commission to determine and order the proper disposition of the state’s public records and to direct the Tennessee Department of State’s Records Management Division to initiate any action necessary to regulate any state agency’s record holding and management. Section 10-7-301(6), *Tennessee Code Annotated*, defines public records as

all documents, papers, letters, maps, books, photographs, microfilms, electronic data processing files and output, films, sound recordings, or other material, regardless of physical form or characteristics made or received pursuant to law or ordinance or in connection with the transaction of official business by any governmental agency.

Public officials are legally responsible for creating and maintaining records that document the transactions of government business. These records provide evidence of government operations and accountability to citizens. Public officials must maintain this information according to established records disposition authorizations (RDAs). According to Section 10-7-509, *Tennessee Code Annotated*,

The disposition of all state records shall occur only through the process of an approved records disposition authorization. Records authorized for destruction shall be disposed of according to the records disposition authorization and shall not be given to any unauthorized person, transferred to another agency, political subdivision, or private or semiprivate institution.

RDAs describe the public record, retention period, and destruction method for each record type under an agency’s authority. Upon destroying a public record, an agency must submit a certificate of destruction to the Records Management Division.

According to OHCF management, they store any paper files related to the abuse registry on-site for five years, then move them to storage. Management does not destroy the files.

Removing Individuals From the Abuse Registry Due to Death

Federal regulations\(^\text{41}\) authorize the department to remove deceased individuals from the abuse registry. According to OHCF management, the department’s Office of Vital Records and Statistics sends OHCF a quarterly report of deceased individuals. OHCF staff compare the death records to the abuse registry to confirm the individuals they should remove. To remove a deceased individual from the registry, OHCF staff create an “application for removal” in LARS; label the individual as deceased on the application; and, within LARS, submit the application for removal to be approved. Once it is approved, the individual is removed from the public-facing website overnight.

Entities Required to Search for Individuals on the Abuse Registry

Section 68-11-1004, *Tennessee Code Annotated*, requires state agencies that work with vulnerable populations, such as the Department of Mental Health and Substance Abuse Services (MHSAS), the Department of Intellectual and Developmental Disabilities (DIDD), the Department of Children’s Services, the Department of Health, and the Department of Human Services, to search for job candidates’ and volunteers’ names on the abuse registry. Additionally, Section 68-11-1004(a)(2) and (3), *Tennessee Code Annotated*, requires any entities licensed by or contracted with these agencies to check the abuse registry before permitting an individual to be employed or provide volunteer services at the entity. See Table 9.

Table 9
Licensed or Contracted Entities Required to Check the Abuse Registry for Potential Employees and Volunteers

<table>
<thead>
<tr>
<th>Entity Type</th>
<th>Statutory Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizations licensed by MHSAS or DIDD</td>
<td>Section 33-2-1202</td>
</tr>
<tr>
<td>Nursing homes and assisted-care facilities</td>
<td>Section 68-11-256</td>
</tr>
<tr>
<td>Health Related Boards and any entities created by the</td>
<td>Section 63-1-116</td>
</tr>
<tr>
<td>Department of Health</td>
<td></td>
</tr>
<tr>
<td>Adult day care centers</td>
<td>Section 71-2-403</td>
</tr>
<tr>
<td>Child care agencies</td>
<td>Section 37-5-511</td>
</tr>
<tr>
<td>Prescribed child care agencies*</td>
<td>Section 68-11-234</td>
</tr>
</tbody>
</table>

* According to Section 68-11-201, *Tennessee Code Annotated*, prescribed child care agencies are nonresidential child care, healthcare/child care centers that provide physician-prescribed services and appropriate developmental services for six or more children who are medically or technologically dependent and require continuous nursing intervention.

Source: *Tennessee Code Annotated.*
Communication of Audit Recommendations for the State’s Abuse Registry

Joint Government Operations Committee
Education, Health and General Welfare Joint Evaluation Committee
Management of the Health Facilities Commission

 Recommendation 1: Commission management should seek revisions to the applicable rules governing their responsibilities

We recommend that the Health Facilities Commission management review Department of Health rules relating to the responsibilities that transferred to the commission and initiate the rulemaking process to make all appropriate updates to the rules.

Managements’ Comments to Recommendation 1

Health Facilities Commission

We concur. Tenn. Comp. R. & Regs. 1200-08-38-.04(2) which states that any state government agency that finds that an individual has committed abuse, neglect, misappropriation, or exploitation of the property of a vulnerable person shall refer the individual to the Department for placement on the Registry within one hundred eighty (180) days of the completion of due process will be deleted. Further, we will reach out to our sister agencies to determine the requisite timeframes under which submissions of referrals shall occur.

Department of Health

We concur with this recommendation and would suggest the following. Review of Section 1200-08-38-.04(2) of the Rules of the Department of Health, Office of Health Care Facilities, and to gain an understanding of each individual agency’s required time frame to make referrals as technology and other resources may have changed, providing an opportunity for adjustments to the current 180 days allowed. Review of Section 1200-0-8-38-.05(2) of the Rules of the Department of Health, Office of Health Care Facilities, for clarity regarding interpretation of date of notice. Lastly, review Section 1200-08-38-.06(9) of the Rules of the Department of Health, Office of Health Care Facilities, to determine appropriateness and ensure structured decision making in the process of removal of CNAs from abuse registry.
**Recommendation 2: Commission management should establish sufficient internal controls to accurately and timely place individuals on the abuse registry**

We recommend that the Health Facilities Commission management review the statutory and regulatory requirements related to the abuse registry and develop comprehensive policies and procedures that instruct staff how to document and add individuals to the registry, as well as how to evaluate and remove individuals from the registry. The commission should ensure that the Licensure and Regulatory System (LARS) accurately captures all required registry information for the public’s use.

We performed a limited review of LARS and the abuse registry. Although this is not an exhaustive list, we recommend commission management perform its own review of the following items:

- ensure that an individual’s information on the abuse registry matches the file documentation, and ensure that the documentation includes the referring state agency or the local court placement orders;
- follow federal regulations for removing deceased individuals from the abuse registry;\(^{42}\)
- timely notify individuals of the intent to place them on the abuse registry;
- establish a timeframe for staff to place individuals on the registry once the commission receives a referral;
- design LARS to allow staff to select multiple types of abuses when an individual commits more than one type of abuse, as defined in statute;
- create edit checks to require nine digits for the Social Security number field in LARS; and
- perform and document supervisory reviews of individuals entered in LARS before submission onto the abuse registry website.

We also recommend that commission management conduct a complete risk analysis of management’s maintenance of the abuse registry and identify the controls to mitigate or avoid any identified risks. Commission management should document the risks and related controls in the formal annual risk assessment.

**Managements’ Comments to Recommendation 2**

**Health Facilities Commission**

We concur. HFC [Health Facilities Commission] management, in conjunction with the Office of Legal Services, have developed a log to ensure compliance and timely placement. Occasionally, referrals are made without the requisite information, such as a Social Security number.

\(^{42}\) 42 CFR 483.756(c)(1)(iv)(D) applies to nurse aides. If the commission wishes to consider removing all deceased individuals from the registry, the commission should seek a legislative change.
Department of Health

We concur in part with this recommendation. Additional and updated standard operating procedures regarding documentation and placement will enhance staff knowledge and consistency. However, the recommendations regarding social security number checks within LARS currently exist. Nine digits are required, and no letters or other characters can be entered. The only time this does not apply is when a staff member is intentionally making a change. If user permissions were removed, the staff would not be able to make any changes reducing their ability to perform operations within the Abuse Registry data. Lastly, the LARS team has determined securing vendor support would be required for multiple offense selections to be made available and displayed publicly as part of the Abuse Registry. Cost and priority are considerations for this change; however, the greatest value of the Abuse Registry is prevention of a reoccurrence by a known offender, regardless as to which or how many offenses are listed. If a person is listed, it is known it is not safe to employ them in a role supporting a vulnerable individual.

Auditor’s Comment

Based on our review of the Department of Health’s comments, we did not revise our recommendations related to the state’s abuse registry.

Recommendation 3: Commission management should work with state agencies and county court clerks regarding the statutory requirements of the respective parties to ensure timely reporting of abuse registry placements

State Agencies

Unless prohibited by state or federal law, all state agencies are required to refer the names of individuals who have abused or neglected a vulnerable person, or misappropriated or exploited their property, to the Department of Health, now the Health Facilities Commission, within 180 days for inclusion on the abuse registry.

According to the Department of Health, the immediate prior Commissioner requested that the departmental rule allow agencies 180 days after the completion of due process to give the agencies sufficient time to submit the referral to the department. However, given the risk to vulnerable persons

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43 Section 68-11-1003(a)(1), Tennessee Code Annotated, and Section 1200-08-38-.04(2) of the Rules of the Department of Health, Office of Health Care Facilities.
and current technology resources, agencies could provide referrals within days, if not hours, in order to immediately place potentially dangerous individuals on the abuse registry. We recommend commission management evaluate the timelines when seeking rule revisions.

County Court Clerks

Department of Health staff informed us that, on their judgment forms, county court clerks do not always specify that the individual should be placed on the abuse registry, as required by Section 68-11-1003(b)(3), *Tennessee Code Annotated*. We also found that only 42 of the state’s 95 counties have referred individuals to the abuse registry since its inception in 1989; specifically, larger-populated counties have low referral rates. See Appendix 8. When court clerks do not specify on the judgment form that an individual should be placed on the abuse registry, the commission may be required to spend additional resources investigating the court’s judgment to determine if the individual should be placed on the abuse registry, causing unnecessary delays in updates to the registry.

Furthermore, while the *Rules* require state agencies to send abuse registry referrals to the department [commission] within 180 days after the referring agency’s due process is completed, state statute does not have a timeframe for courts to submit referrals to the department. Section 68-11-1003(c), *Tennessee Code Annotated*, states that when the department [commission] receives an agency referral or a court judgment form, the individual listed on the referral or form is required to be placed on the registry upon receipt.

Without a specified timeframe to submit court referrals, individuals may not be placed on the abuse registry timely or at all, thereby placing vulnerable persons at risk of abuse or neglect, or misappropriation or exploitation of property. Therefore, the General Assembly may wish to amend the language in Section 39-15-506, *Tennessee Code Annotated*, to include a specific required timeframe for courts to submit abuse registry referrals to the commission.
Managements’ Comments to Recommendation 3

Health Facilities Commission

We concur. HFC will work on strengthening relationships with the Administrative Offices of the Courts, Clerks of Court, and the County Clerks Association to ensure clerks are aware of the Abuse Registry reporting and compliance requirements.

Department of Health

We concur with this recommendation and suggest the following in the above first recommendation response. Review of Section 1200-08-38-.04(2) of the Rules of the Department of Health, Office of Health Care Facilities, and to gain an understanding of each individual agency’s required time frame to make referrals as technology and other resources may have changed, providing an opportunity for adjustments to the current 180 days allowed.

We concur in part with the recommendation regarding a required timeframe for courts to submit referrals. While this recommendation would potentially increase accountability with timeliness, it only would do so with those 44.21% of counties that are making such referrals. Upon review of the General Manual for Clerks of Courts, a manual published and disseminated by the Administrative Office of the Tennessee Courts System, and the Tennessee Courts System website, there does not appear to be training or information relevant to obligations or procedures regarding court referrals to the Abuse Registry readily available. Ensuring that all courts have access to education and information related to the courts obligation and the procedures to make such referrals may assist as part of a comprehensive approach to achieving accurate and timely placement of individuals on the registry.

Auditor’s Comment

Based on our review of the Department of Health’s comments, we did not revise our recommendations related to the state’s abuse registry.

Recommendation 4: Commission management should ensure that the language on the “Notice of Intent to Place” matches the language approved in the rules

When the Department of Health staff determined an individual was to be placed on the abuse registry, department staff sent the individual a “Notice of Intent to Place” letter to inform them of their pending placement, their right to appeal, and the timeframe allotted for requesting an appeal. During our review, we found that both the letter and the department’s Policy 0315, “Abuse Registry Policy,” included language that informs individuals they can request a hearing no later than 30 days from receipt of the letter. According to Section 1200-08-38-.05(2) of the Rules, however, the “Notice of Intent to Place” letter “shall contain . . . [n]otification that the individual may, within thirty (30)
**Recommendation 4: Commission management should ensure moving forward that the language in the letter agrees with language cited in commission policy and rules to avoid confusion for individuals who wish to appeal their placement on the abuse registry.**

**Managements’ Comments to Recommendation 4**

**Health Facilities Commission**

We concur. HFC management will ensure that language in the Notice of Intent to Place letter is amended to closely mirror Tenn. Comp. R. & Regs. 1200-08-38-.05(2).

**Department of Health**

We concur with this recommendation and suggest the following in the above first recommendation response. To review Section 1200-0-8-38-.05(2) of the *Rules of the Department of Health, Office of Health Care Facilities*, for clarity regarding interpretation of date of notice.

**Recommendation 5: Commission management should assess whether they need a records disposition authorization for abuse registry files**

According to the department’s Records Disposition Authorization (RDA) 1920, “Complaint/Case Investigation Records,” the department must maintain its complaint files at the department for 5 years and then send the files to the State Records Center for storage for another 5 years. After the 10-year period, the department should follow the state’s approved methods to destroy the files. Commission management should establish an RDA for the abuse registry files or determine if the records fall under an existing RDA.

**Managements’ Comments to Recommendation 5**

**Health Facilities Commission**

We concur. HFC management has been made aware by staff that prior to July 1, 2022, records were destroyed by Department of Health management without the appropriate and requisite certificates of destruction. Going forward, HFC management will ensure that all RDAs are updated appropriately, that appropriate destruction procedures are followed, and if destruction is warranted, that items are scanned and certificates of destruction are produced in compliance with the law.

**Department of Health**

We concur with this recommendation and suggest that the Health Facilities Commission create their own RDA. RDA 1920 is specific to TDH.
**Recommendation 6:** Commission management should prioritize efforts to comply with healthcare facilities’ survey timeframes given the Centers for Medicare and Medicaid Services has established January 9, 2023, as the goal for compliance

According to the Centers for Medicare and Medicaid Services (CMS) *State Operations Manual*, which contains the regulations and guidance for states to follow to manage complaints and incidents involving healthcare facilities, the department was required to abide by maximum timeframes for the on-site investigation of complaints and incidents involving licensed healthcare facilities. These timeframes vary based on the complaint or incident’s assigned priority and the type of provider involved. For example, for cases considered immediate jeopardy, where a provider failed to comply with federal requirements intended to prevent serious harm, injury, or death to an individual, the department must have begun an on-site survey within two business days of receiving the complaint.

Due to the COVID-19 pandemic, on March 23, 2020, CMS suspended all healthcare facility surveys unless there was a risk that an individual would be in immediate jeopardy. On May 12, 2020, the Governor signed an executive order that suspended healthcare licensing inspections and investigations. The surveys resumed in November 2021. As such, CMS and the department agreed that the department will catch up on surveys and reach compliance with the federal investigation timeframes by January 9, 2023. Commission management should meet this date or consult with CMS if more time is needed.

**Managements’ Comments to Recommendation 6**

**Health Facilities Commission**

We concur. HFC is actively working on survey backlog and is currently combining complaint and recertification surveys wherever possible to meet the January 9, 2023 goal.

**Department of Health**

We concur in part with this recommendation. The January 9, 2023, date was submitted by the Office of Health Care Facilities to the Centers for Medicare and Medicaid Services (CMS) upon resumption of typical surveying as part of the state plan to address the backlog due to the public health emergency. This date was not extended or revised by the Office of Health Care Facilities pending the merger, as to allow the new commission to determine if any adjustments were needed that they would then resubmit in their quarterly updates with CMS. There is an understanding by CMS regarding challenges each State Survey Agency is encountering in their attempts to resolve the backlog and the date may be adjusted if needed and agreed upon by the two entities. We recommend for the Health Facilities Commission to collaborate with CMS to ensure a reasonable date and feasible plan is in place for achieving backlog resolution.

**Auditor’s Comment**

Based on our review of the Department of Health’s comments, we did not revise our recommendations related to the state’s abuse registry.
Appendix 1
Objectives, Conclusions, and Methodologies

Uninsured Adult Healthcare Safety Net Program

1. Audit Objective: In response to the prior audit finding, did management update safety net contracts to require documentation, such as a reconciled list of quarterly patient encounters, to be submitted to the department when seeking reimbursement? Additionally, did management implement procedures to review the providers’ encounter data prior to approving the providers’ reimbursements?

Conclusion: Based on our review, management updated the contracts to require providers to prepare and submit a reconciled list of quarterly patient encounters. However, based on our review, management did not implement adequate procedures to ensure program staff reviewed the providers’ quarterly encounters prior to payment. We found that management paid providers for duplicate encounters and ineligible individuals. See Finding 1.

2. Audit Objective: In response to the prior audit finding, did management establish the necessary controls to ensure that the Uninsured Adult Healthcare Safety Net Annual Report to the General Assembly was complete and accurate?

Conclusion: Based on our review, management did not establish controls, such as a review process, to ensure that the 2021 report (the report due during our audit period) was complete and accurate. See Finding 2.

Methodology to Address the Audit Objectives

To address all of our audit objectives, we reviewed

- Sections 68-1-123 and 71-5-148, Tennessee Code Annotated;
- the department’s Tennessee’s Health Care Safety Net for Uninsured Adults Program Guidelines;
- the Uninsured Adult Healthcare Safety Net Annual Report released in 2019 through 2022, available on the department’s website;
- the department’s grant contracts for the provision of safety net program services; and
- the department’s 2021 Financial Integrity Act Risk Assessment.
We interviewed the Director of the Office of Rural Health, the current Safety Net Director, and the Assistant Commissioner of Compliance and Ethics and performed walkthrough procedures to gain an understanding of the state’s safety net program and internal controls significant to our audit objectives and assessed management’s design and implementation of internal controls related to the safety net program.

To assess the operating effectiveness of internal control for audit objective 1 and to determine compliance with state statute governing the Healthcare Safety Net Program, we obtained the payment methodology spreadsheet for fiscal year 2021 and the first two quarters of fiscal year 2022. The spreadsheet detailed a list of safety net providers the department paid for each quarter based on reported patient encounters for that quarter. From a population of 574 payments to safety net providers in fiscal year 2021 through quarter 2 of fiscal year 2022, we selected a nonstatistical, random sample of 60 quarterly provider payments to determine if management paid providers for unduplicated encounters for eligible individuals. To determine if management paid providers at the correct rate, we analyzed the encounters paid and the total payment to each provider per quarter from the payment methodology spreadsheets.

Food Service Establishment Inspections

1. **Audit Objective:** In response to the prior observation, does the division have the ability to readily review inspection data to monitor compliance with inspection timeliness?

   **Conclusion:** Based on our discussions, management has not requested reporting capabilities from the vendor to monitor inspection timeliness. Instead, management relies on workarounds performed by supervisors and managers. See **Finding 3.**

2. **Audit Objective:** Did inspectors complete food service establishment inspections in accordance with the department’s Inspection Frequency Policy and alternative work plans, if applicable?

   **Conclusion:** Based our review, we found inspectors did not complete food service establishment inspections in accordance with the department’s policy and alternative work plans. See **Finding 3.**

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44 Of the sample of 60, we tested 39 payments made in fiscal year 2021 and 21 payments made in fiscal year 2022.
Methodology to Address the Audit Objective

To address our audit objective, which includes gaining an understanding of the process the department uses to inspect food service establishments, we reviewed

- Section 68-14-101 et seq., *Tennessee Code Annotated*;
- Chapter 1200-23-01 of the *Rules of the Tennessee Department of Health*;
- the Department of Health’s Inspection Frequency Policy for food service establishment inspections;
- approved alternative work plans for calendar year 2021; and
- the department’s 2021 Financial Integrity Act risk assessment.

We interviewed the Director and Assistant Director of the Division of Environmental Health and the Regional Supervisors and Field Office Managers from the division’s Northwest and Mid Cumberland Region. We performed walkthrough procedures of a food service establishment inspection with a department Environmental Health Inspection staff from the Mid Cumberland Region, and a subsequent follow-up inspection.

To determine compliance with the state’s food service establishment inspection requirements, we obtained from the Director of Environmental Health a population of 31,680 food service establishment permits as of March 15, 2022, and verified the population of food service establishment permits by running a report in HealthSpace to verify that the population was complete. From the population of active permits, the department issued 16,242 permits and local government contract counties issued 15,438 permits. We selected a nonstatistical random sample of 6,045 department-issued permits and 2,546 local government issued contract county permits from all risk categories to evaluate whether inspection staff conducted food service establishment inspections in calendar year 2021, as required by the department’s Inspection Frequency Policy.

Joint Annual Report

1. **Audit Objective:** Did the department’s Division of Health Planning have a process to verify that the hospitals’ self-reported JARs data was reasonably accurate?

   **Conclusion:** Based on our review, we found the Division of Health Planning did not implement sufficient controls to verify the data in hospitals’ JARs. In

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45 We randomly selected 10 permits from category 3, 34 from category 2, and 15 from category 1. The department identified one establishment as category 4, which we tested.

46 We randomly selected 5 permits from category 3, 14 from category 2, and 5 from category 1. Of the active permits issued by the 5 contract counties, they identified only one category 4 food service establishment, which we tested.
addition, the division did not create policies and procedures to verify and independently review JAR data as required by state statute. See Finding 4.

2. Audit Objective: In response to the prior audit finding, did the Division of Health Planning process ensure compliance with statute by initiating the deficiency process for noncompliant hospitals?

Conclusion: Based on our review, we found that the Division of Health Planning’s process was insufficient due to lack of documentary evidence that staff achieved compliance with statute. See Finding 4.

Methodology to Address Audit Objectives

To address audit objectives 1 and 2, including gaining an understanding of the JAR process and assessing management’s design of internal controls significant to our audit objectives, we interviewed the Director of Policy, Planning, and Assessment; the Director of the Division of Health Planning; the Director of Licensure and the Board for Licensing Health Care Facilities, and the Department of Finance and Administration’s Division of Strategic Technology Solutions Lead Developer. We reviewed

- Sections 68-11-310 and 68-11-1615, Tennessee Code Annotated;
- Chapters 1200-08-06, 1200-08-10, 1200-08-24, 1200-08-25, 1200-08-26, 1200-08-27, and 1200-08-35 of the Rules of the Department of Health;
- Hospital Summary Reports for 2019 and 2020; and
- the department’s 2021 Financial Integrity Act risk assessment.

In addition, we observed a walkthrough of the JAR reporting portal to determine how hospitals submit their self-reported JAR data and how management conducts the edit check process.

Grant Contract Monitoring

1. Audit Objective: In response to the prior audit finding, did management ensure that all safety net provider grant contracts were subject to monitoring?

Conclusion: Based on our review, management ensured that safety net provider grant contracts were classified as recipients/subrecipients and included in the monitoring population.
2. **Audit Objective:** In response to the prior audit finding, did safety net program management revise monitoring procedures to include a review of the accuracy of reported encounters to the department for payment purposes?

**Conclusion:** Based on our review, safety net program management updated the monitoring procedures to include a review to ensure the accuracy of reported encounters to the department.

3. **Audit Objective:** Did management ensure that the department’s annual subrecipient monitoring plans were complete and in compliance with CPO Policy 2013-007 before submission to the CPO’s office?

**Conclusion:** Overall, management and staff stated they were unaware of the most current CPO policy governing the state’s monitoring requirements and have not adequately designed internal controls to achieve full compliance with the CPO policy which includes federal monitoring requirements. As a result, management did not ensure that their monitoring plans included all required components, such as subrecipient risk assessments and a current list of subrecipients who had completed federal Single Audits. As such, the department’s management and staff did not perform sufficient monitoring of state and federal grant awards. See **Finding 5**.

**Methodology to Address the Audit Objectives**

To address all of our audit objectives—including gaining an understanding of the department’s grant monitoring process, determining if management complied with CPO policy, including the federal Uniform Guidance, and obtaining an understanding and assessing management’s design of internal controls significant to our audit objectives—we reviewed

- Central Procurement Office Policy 2013-007, “Grant Management and Subrecipient Monitoring Policy and Procedures” (2015 and 2020 versions);
- 2 CFR Part 200 Subpart F;
- the department’s monitoring plans for 2018-2019, 2019-2020, 2020-2021, and 2021-2022; and
- safety net program management’s monitoring procedures.

We also interviewed the Assistant Commissioner of Compliance and Ethics and the Auditor 4 who oversees the department’s subrecipient monitoring team.
Appendix 1
(Continued)

**Contract Procurement**

1. **Audit Objective:** In response to the prior audit finding, did procurement management ensure that contracts were correctly classified as recipient/subrecipient or vendor?

   **Conclusion:** Based on our review, procurement management ensured that contracts were classified as recipients/subrecipients or vendors.

2. **Audit Objective:** For contracts with vendors, did management procure the goods or services in accordance with the state’s procurement policies?

   **Conclusion:** Based on our review, management procured goods or services in accordance with the state’s procurement policies.

3. **Audit Objective:** For contracts with vendors, did the program manager or staff ensure services were rendered or goods were received prior to approving payment?

   **Conclusion:** Based on our review, program staff ensured services were rendered or goods were received prior to approving vendor contract payments.

4. **Audit Objective:** For emergency purchases, did procurement management ensure the emergency purchases complied with state emergency purchase policies?

   **Conclusion:** Based on our review, procurement management’s emergency purchases complied with state policies.

**Methodology to Address the Audit Objectives**

To address audit objectives 1 and 2, including gaining an understanding of department management’s procurement process and assessing management’s design and implementation of internal controls significant to our audit objectives as it relates to objectives 1 and 2, we reviewed

- Section 4-56-105(4), *Tennessee Code Annotated*;
- the *Rules of the Department of General Services Central Procurement Office*;
- the *Amended Procurement Procedures Manual of the Central Procurement Office*, dated January 20, 2022;
- *Central Procurement Office (CPO) Policies*
  - 2013 – 002: *CPO Procurement Methods Policy and Procedures*,
  - 2013 – 003: *CPO Non-Competitive Procurement Policy and Procedures*,

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Appendix 1
(Continued)

- 2013 – 004: CPO Contract Management Policy and Procedures,
- 2013 – 006: CPO Delegation of Authority Policy, and
- 2013 – 007: CPO Grant Management and Subrecipient Monitoring Policy and Procedures; and

- the department’s 2021 Financial Integrity Act risk assessment.

We interviewed CPO management and staff responsible for the department’s procurements. We also interviewed the Department of Health’s Assistant Commissioner for the Division of Administrative Services, the Director of the Procurement Management Office, the Director of Business and Grants Management, the Director of Service Procurement, the Director of Goods Procurement, the Assistant Director for Contracts and Compliance, the Grant Analyst 2, and the Agency Contract Coordinator. We performed walkthrough procedures of the department’s processes to classify contractors as either recipients/subrecipients or vendors. We also performed walkthrough procedures to determine if management procured goods and services in accordance with the state’s procurement policies.

To address audit objective 3, which included gaining an understanding of the procurement management’s process to document that contract services were rendered or goods were received and assessing management’s design and implementation of internal controls significant to our audit objective, we interviewed key program personnel responsible for contract management and observed operational processes related to the approval of contract payments.

To assess the operating effectiveness of internal controls and compliance with state procurement policies for audit objectives 1, 2, and 3, from a population of 1,186 Department of Health contracts (981 subrecipient, 9 recipient, and 196 vendor contracts) executed from October 1, 2018, through January 20, 2022, we tested a nonstatistical random sample of 70 contracts to determine if management correctly classified the contracts as either recipient/subrecipient or vendor contracts; and for vendor contracts, we tested to determine if management procured the contracts in accordance with state procurement policies. We also reviewed a nonstatistical random sample of 17 of 196 vendor contracts to determine if management received the contracted services or goods prior to approving payment.

To address audit objective 4, which included gaining an understanding of management’s process to document the necessity of emergency procurements and assessing management’s design and implementation of internal controls, we interviewed CPO management as well as the department’s Deputy Commissioner of Operations and the Director of the Procurement Management Office. To assess the operating effectiveness of internal controls and compliance with the state’s emergency procurement policies, we obtained from department management a population of 44 emergency procurements made from April 2020 through June 2021, to determine if management complied with the state’s emergency procurement policies. We also watched the December 17, 2020, hearing of the
Tennessee General Assembly’s Fiscal Review Committee to obtain testimonial evidence related to a state contract to secure laboratory equipment, supplies, and personal protective equipment for the state’s COVID-19 response.

**State Abuse Registry**

1. **Audit Objective:** Did management ensure the department’s abuse registry contained accurate and up-to-date information so that state agencies or their clients can rely on the information for employee or volunteer decisions?

**Conclusion:** Based on the information provided by the external entities, we found that management did not accurately or immediately place referred individuals on the registry. See *Communication of Audit Recommendations for the State’s Abuse Registry*.

We also reviewed the county court clerks that referred individuals to the department for placement on the abuse registry and found that only 42 of the state’s 95 counties made referrals. The department should ensure the counties without referrals have the resources they need to ensure compliance with the statute. See *Communication of Audit Recommendations for the State’s Abuse Registry*.

2. **Audit Objective:** In order to timely address complaints, did the Office of Health Care Facilities management track complaints involving the abuse or neglect of a vulnerable person, or the misappropriation or exploitation of their property?

**Conclusion:** Based on our review, although the department was required to conduct surveys at healthcare facilities that involve complaints and incidents of abuse or harm against patients, the department has not complied with federal survey timeframes. See *Communication of Audit Recommendations for the State’s Abuse Registry*.

3. **Audit Objective:** Did the department ensure it placed individuals on the abuse registry after allowing the individual to appeal the decision?

**Conclusion:** Although we found, based on our testwork, that management notified the individuals of their placement on the abuse registry, it took management between 20 to 143 days to mail the “Notice of Intent to Place” letters, which delayed the individuals’ placement on the registry. In addition, management should ensure the letter’s language on appeal timeframes matches the
language in the department’s rules. See Communication of Audit Recommendations for the State’s Abuse Registry.

4. Audit Objective: Did management remove deceased individuals from the abuse registry, as required by federal regulations?

Conclusion: Based on our analysis, we found that management does not consistently match individuals on the abuse registry against death data from the department’s Office of Vital Records and Statistics. See Communication of Audit Recommendations for the State’s Abuse Registry.

5. Audit Objective: Did management evaluate their records management needs related to documentation for the abuse registry?

Conclusion: Based on our review, although management is allowed to destroy abuse registry files after 10 years, management informed us that they were not aware that they could. See Communication of Audit Recommendations for the State’s Abuse Registry.

Methodology to Address the Audit Objectives

To address audit objectives 1, 3, and 5, which includes gaining an understanding of the process to accurately add individuals to the department’s abuse registry and obtaining an understanding of and assessing management’s design and implementation of internal control significant to our audit objective, we interviewed

- the Director of Health Care Facilities,
- the Assistant Deputy Director of the Office of Health Care Facilities (OHCF),
- the Public Health Nursing Consultant Manager over the abuse registry, and
- the Administrative Services Assistant 2 responsible for adding individuals to the abuse registry.

We reviewed the following sections of Tennessee Code Annotated related to the abuse registry: Section 68-11-1001, Section 68-11-1002, and Section 68-11-1004.

We reviewed Rule 1200-08-38 of the Rules of the Department of Health, Office of Health Care Facilities; Title 42, Code of Federal Regulations, Section 483, Part 156; policies and procedures for the department’s abuse registry; and the department’s 2021 annual risk assessment. Furthermore, we observed operational processes related to accurately adding individuals to the abuse registry.
Appendix 1
(Continued)

We completed testwork to assess the operating effectiveness of internal control and to determine if management placed individuals on the abuse registry in accordance with federal and state statutes, rules, and regulations. From a population of 421 individuals that the department placed on the abuse registry from October 1, 2018, through February 23, 2022, we tested a nonstatistical, random sample of 76 individuals. Of the 76 sampled items, we stratified the sample to test

- 32 individuals referred by other state agencies,
- 28 individuals referred by county court systems, and
- 16 individuals added to the abuse registry through the department’s internal processes.

Audit objective 2 includes gaining an understanding of the process to track complaints the Office of Health Care Facilities receives that involve the abuse or neglect of vulnerable persons, or the misappropriation or exploitation of their property; ensuring complaints are addressed and completed timely; and obtaining an understanding of and assessing management’s design and implementation of internal controls significant to our audit objective. To address this objective, we interviewed and performed walkthrough procedures with

- the Director of Health Care Facilities;
- Public Health Nursing Consultant 1s, who are responsible for conducting investigations at hospitals and long-term care facilities; and
- the General Counsel.

We reviewed the Centers for Medicare and Medicaid Services State Operations Manual, which contains regulations and guidance to states for their complaint intake units. We also reviewed the OHCF complaint logs for the West, Middle, and East grand divisions for our audit period.

To address audit objective 4, including gaining an understanding of the process to remove individuals from the department’s abuse registry upon their death and assessing management’s design of internal controls significant to our audit objective, we interviewed and performed walkthrough procedures with the Public Health Nursing Consultant Manager over the abuse registry. To determine if management removed individuals upon their death as required by federal regulation, we compared individuals on the abuse registry to death data from the department’s Division of Vital Records and Statistics.

47 Of the 421 individuals in our population, other state agencies referred 198 individuals, county court systems referred 179 individuals, and the department placed 44 individuals based on its internal processes.
Appendix 2
Internal Control Significant to the Audit Objectives

The U.S. Government Accountability Office’s *Standards for Internal Control in the Federal Government* (Green Book) sets internal control standards for federal entities and serves as best practice for non-federal government entities, including state and local government agencies. As stated in the Green Book overview, Internal control is a process used by management to help an entity achieve its objectives . . . Internal control helps an entity run its operations effectively and efficiently; report reliable information about its operations; and comply with applicable laws and regulations.

The Green Book’s standards are organized into five components of internal control: control environment, risk assessment, control activities, information and communication, and monitoring. In an effective system of internal control, these five components work together to help an entity achieve its objectives. Each of the five components of internal control contains principles, which are the requirements an entity should follow to establish an effective system of internal control. We illustrate the five components and their underlying principles below:

<table>
<thead>
<tr>
<th>Control Environment</th>
<th>Control Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principle 1</td>
<td>Demonstrate Commitment to Integrity and Ethical Values</td>
</tr>
<tr>
<td>Principle 2</td>
<td>Exercise Oversight Responsibility</td>
</tr>
<tr>
<td>Principle 3</td>
<td>Establish Structure, Responsibility, and Authority</td>
</tr>
<tr>
<td>Principle 4</td>
<td>Demonstrate Commitment to Competence</td>
</tr>
<tr>
<td>Principle 5</td>
<td>Enforce Accountability</td>
</tr>
<tr>
<td>Principle 6</td>
<td>Define Objectives and Risk Tolerances</td>
</tr>
<tr>
<td>Principle 7</td>
<td>Identify, Analyze, and Respond to Risks</td>
</tr>
<tr>
<td>Principle 8</td>
<td>Assess Fraud Risk</td>
</tr>
<tr>
<td>Principle 9</td>
<td>Identify, Analyze, and Respond to Change</td>
</tr>
<tr>
<td>Principle 10</td>
<td>Design Control Activities</td>
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<tr>
<td>Principle 11</td>
<td>Design Activities for the Information System</td>
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<tr>
<td>Principle 12</td>
<td>Implement Control Activities</td>
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<tr>
<td>principle 13</td>
<td>Use Quality Information</td>
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<tr>
<td>Principle 14</td>
<td>Communicate Internally</td>
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<tr>
<td>Principle 15</td>
<td>Communicate Externally</td>
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<td>Principle 16</td>
<td>Perform Monitoring Activities</td>
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<tr>
<td>Principle 17</td>
<td>Evaluate Issues and Remediate Deficiencies</td>
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</tbody>
</table>

In compliance with generally accepted government auditing standards, we must determine whether internal control is significant to our audit objectives. We base our determination of significance on whether an entity’s internal control impacts our audit conclusion. In the following matrix, we list our audit objectives, indicate whether internal control was significant to our audit objectives, and identify which internal control components and underlying principles were significant to those objectives.

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49 For further information on the Green Book, please refer to [https://www.gao.gov/greenbook/overview](https://www.gao.gov/greenbook/overview).
### Internal Control Components and Underlying Principles Significant to the Audit Objectives

<table>
<thead>
<tr>
<th>Audit Objectives</th>
<th>Significance</th>
<th>Control Environment</th>
<th>Risk Assessment</th>
<th>Control Activities</th>
<th>Information &amp; Communication</th>
<th>Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 In response to the prior audit finding, did management update safety net contracts to require documentation, such as a reconciled list of quarterly patient encounters, to be submitted to the department when seeking reimbursement? Additionally, did management implement procedures to review the providers’ encounter data prior to approving the providers’ reimbursements?</td>
<td>Yes</td>
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<tr>
<td>2 In response to the prior audit finding, did management establish the necessary controls to ensure that the <em>Uninsured Adult Healthcare Safety Net Annual Report</em> to the General Assembly was complete and accurate?</td>
<td>Yes</td>
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<td>Yes</td>
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<tr>
<td>3 In response to the prior observation, does the division have the ability to readily review inspection data to monitor compliance with inspection timeliness?</td>
<td>No</td>
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<tr>
<td>4 Did inspectors complete food service establishment inspections in accordance with the department’s Inspection Frequency Policy and alternative work plans, if applicable?</td>
<td>No</td>
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<tr>
<td>5 Did the department’s Division of Health Planning have a process to verify that the hospitals’ self-reported JARs data was reasonably accurate?</td>
<td>Yes</td>
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<td>Yes</td>
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<td>6 In response to the prior audit finding, did the Division of Health Planning process ensure compliance with statute by initiating the deficiency process for noncompliant hospitals?</td>
<td>Yes</td>
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<tr>
<td>7 In response to the prior audit finding, did management ensure that all safety net provider grant contracts were subject to monitoring?</td>
<td>Yes</td>
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<td>8 In response to the prior audit finding, did safety net program management revise monitoring procedures to include a review of the accuracy of reported encounters to the department for payment purposes?</td>
<td>Yes</td>
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</table>
## Appendix 2
(Continued)

### Internal Control Components and Underlying Principles

#### Significant to the Audit Objectives

<table>
<thead>
<tr>
<th>Audit Objectives</th>
<th>Significance</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td>9 Did management ensure that the department’s annual subrecipient monitoring plans were complete and in compliance with CPO Policy 2013-007 before submission to the CPO’s office?</td>
<td>Yes</td>
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<td>10 In response to the prior audit finding, did procurement management ensure that contracts were correctly classified as recipient/subrecipient or vendor?</td>
<td>Yes</td>
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<td>11 For contracts with vendors, did management procure the goods or services in accordance with the state’s procurement policies?</td>
<td>Yes</td>
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<td>12 For contracts with vendors, did the program manager or staff ensure services were rendered or goods were received prior to approving payment?</td>
<td>Yes</td>
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<td>13 For emergency purchases, did procurement management ensure the emergency purchases complied with state emergency purchase policies?</td>
<td>Yes</td>
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<tr>
<td>14 Did management ensure the department’s abuse registry contained accurate and up-to-date information so that state agencies or their clients can rely on the information for employee or volunteer decisions?</td>
<td>Yes</td>
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<td>15 In order to timely address complaints, did the Office of Health Care Facilities management track complaints involving the abuse or neglect of a vulnerable person, or the misappropriation or exploitation of their property?</td>
<td>Yes</td>
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</tr>
<tr>
<td>16 Did the department ensure it placed individuals on the abuse registry after allowing the individual to appeal the decision?</td>
<td>Yes</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>Yes</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>Yes</td>
<td>–</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>17 Did management remove deceased individuals from the abuse registry, as required by federal regulations?</td>
<td>Yes</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>Yes</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>18 Did management evaluate their records management needs related to documentation for the abuse registry?</td>
<td>No</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
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<td>–</td>
<td>–</td>
<td>–</td>
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<td>–</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3

Department of Health Operations

The Commissioner directly oversees the Office of Communications and Media Relations, the Office of Compliance and Ethics, and the Office of General Counsel, which are described below.

The Office of Communications and Media Relations is responsible for effectively communicating the mission of the Department of Health, clearly defining the department’s role and responsibilities, and promoting better health for people in Tennessee. Along with being responsible for the department’s internal and external communication, the office provides information to the media and coordinates with all department divisions and programs to distribute public information. The office oversees marketing and advertising functions, manages promotional campaigns, and develops and coordinates social media content and departmental messaging. The office supports the department’s publications and its internal and external websites.

The Office of Compliance and Ethics provides independent audits, investigations, analyses, compliance, and strategic efforts. Within the office are internal audit, subrecipient monitoring, internal affairs, HIPAA/privacy, and civil rights. The internal audit group works in partnership with the Department of Finance and Administration (F&A) Office of the Executive Internal Auditor, which indirectly oversees the internal audit function.

The Office of General Counsel provides legal advice to the Commissioner, senior leadership, and all health-related boards. In addition to providing legal advice, the office drafts and approves contracts, processes human resources complaints, responds to open records requests, drafts all administrative rules for the Commissioner and each respective board, and presents charges in contested case hearings before each board for those licensees alleged to have violated the licensee’s respective rules and practice act.

The department is organized into areas of responsibilities, which are described below.

The Chief Medical Officer oversees the following functional areas:

- **Communicable Environmental Disease and Emergency Preparedness** works with regional and local health departments to provide epidemiological services to protect the citizens of the state from infectious diseases. This division is also responsible for the statewide Public Health Emergency Preparedness Program, which promotes state, local, and regional

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50 HIPAA stands for the Health Insurance Portability and Accountability Act of 1996, which places privacy protections on personally identifiable information and protected health information maintained by the healthcare and health insurance industries.
preparedness for public threats and emergencies, such as acts of bioterrorism and infectious outbreaks like the global COVID-19 pandemic.

- **Community Health Services** oversees the operations of the 89 county health departments and 8 regional offices that provide healthcare and preventive programs across the state. The division administers multiple federal programs focused on delivering health-related services to rural areas and places health professionals and other related workers into areas of the state experiencing shortages of those professions.

- **Informatics and Analytics** collects and maintains health-related data across the department’s operations. To ensure the department’s information systems effectively support existing and future public health programs, the office provides training, advocacy, leadership, and services to define, develop, and deploy best practices in informatics.

- **Laboratory Services** comprises the environmental and microbiological laboratories in Knoxville and Nashville that perform a wide range of microbiological and other testing in support of various state departments, including Environment and Conservation, Transportation, and Labor.

- **Overdose Response Coordination** collects data on drug overdose cases and deaths. Because the office considers overdoses a public health situation, it develops plans to treat and mitigate substance abuse instead of prosecuting users as criminals.

- **Quality Improvement** handles quality-of-care issues at county health departments. The office works to ensure the county health departments provide care that is effective, efficient, proper, and within established protocols.

The **Deputy Commissioner for Population Health** oversees the following functional areas:

- **Family Health and Wellness** manages various health programs provided in all 95 counties by the urban and rural health departments. Programs include Maternal and Child Health, Special Supplemental Nutrition, and Chronic Disease and Health Promotion programs.

- **Health Disparities** works with various state agencies, health professionals, and community and faith-based organizations to provide outreach to minority and other potentially disparate communities. Outreach includes education, health promotion campaigns, and seminar funding.

- **Population Health Assessment** provides data collection, analysis, and reporting of multiple federal and state public health surveillance systems. The division fulfills data requests for external public health entities, such as Vanderbilt University, that develop and create projects based on this data.
• *Primary Prevention* helps to disseminate grant funds for community-based public health improvement projects. During the pandemic, this office helped disburse the grant funds provided for hospital staffing assistance.

• *State Chief Medical Examiner* provides education and training for county, urban, and municipal medical examiners; maintains records of deaths investigated by medical examiners; and assumes investigative authority in cases of interest to the state, including mass fatalities and threats to public health.

• *Strategic Initiatives* develops strategic plans across the department. Working with health advocacy groups, the office promotes preventive health services across the state.

• *Vital Records and Statistics* provides and maintains all certificates of birth, deaths, marriages, and divorces filed in Tennessee.

The *Deputy Commissioner for Operations* is responsible for the following internal support functions:

• *Administrative Services* provides departmental administrative services, including financial management, budgeting, goods and services procurement, printing, and facilities management. Financial management works with Department of Finance and Administration’s (F&A) embedded accounting staff to coordinate comprehensive financial oversight.

• *Human Resources and Talent Management* provides departmental human resources support including employee relations, performance management, recruiting and retention efforts, training, and transactional human resource functions.

• *Information Technology Services* is a division of F&A’s Strategic Technology Solutions (STS) and is collaboratively supervised by the department. It oversees information technology support for the department through the maintenance of existing technology systems and the implementation of new technology systems.

The department’s *Chief of Staff* oversees the following functional areas:

• *Health Licensure and Regulation* regulates emergency medical services, healthcare facilities (transferred to the Health Facilities Commission, effective July 1, 2022), and health professionals.

• *Health Planning* works in conjunction with hospitals and medical experts across the state to issue the State Health Plan.\(^{51}\) The office takes input from stakeholders across the state,

\(^{51}\) The State Health Plan is an annual policy guide describing the state’s community health needs and establishing how the state will address those needs.
expert analysis of health challenges, and information collected from a variety of state and national resources to improve both health outcomes and the state’s healthcare system.

- *Legislative Affairs* works with executive leadership and legislators to propose and advise on legislation potentially affecting the Department of Health.

- *Patient Care Advocacy* provides guidance and training to long-term healthcare facilities. This office works like an ombudsman to improve quality of care across the state. The office responds to inquiries from patients, families, hospitals, medical professionals, long-term care facilities, and public officials.
Appendix 4
Organizational Chart

COMMISSIONER

Communications and Media Relations
- Informatics and Analytics
- Laboratory Services
- Overdose Response Coordination
- Quality Improvement

Compliance and Ethics
- Communicable Environmental Disease and Emergency Preparedness
- Community Health Services
- Informatics and Analytics
- Laboratory Services
- Overdose Response Coordination
- Quality Improvement

General Counsel

Chief Medical Officer
- Family Health and Wellness
- Health Disparities
- Population Health
- Primary Prevention
- State Chief Medical Examiner
- Strategic Initiatives
- Vital Records and Statistics

Population Health

Operations
- Administrative Services
- Human Resources and Talent Management
- Information Technology Services

Chief of Staff
- Health Licensure and Regulation
- Health Planning
- Legislative Affairs
- Patient Care Advocacy

Source: Department management.
### Table 10
**Department of Health**  
**Fiscal Year 2020**  
**Budget and Actual Expenditures and Revenues**

<table>
<thead>
<tr>
<th>Department of Health</th>
<th>FY 2020 Recommended Budget</th>
<th>FY 2020 Actual Expenditures and Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expenditures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payroll</td>
<td>$228,902,800</td>
<td>$214,472,900</td>
</tr>
<tr>
<td>Operational</td>
<td>412,976,300</td>
<td>533,139,700</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$641,879,100</td>
<td>$747,612,600</td>
</tr>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>$207,417,700</td>
<td>$172,268,000</td>
</tr>
<tr>
<td>Federal</td>
<td>247,714,900</td>
<td>378,196,600</td>
</tr>
<tr>
<td>Other</td>
<td>186,746,500</td>
<td>197,148,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$641,879,100</td>
<td>$747,612,600</td>
</tr>
</tbody>
</table>

Source: For the recommended budget, our source was the *Tennessee State Budget, Fiscal Year 2019-2020*. For actual expenditures and revenues, our source was the *Tennessee State Budget, Fiscal Year 2021-2022*.

### Table 11
**Department of Health**  
**Fiscal Year 2021**  
**Budget and Actual Expenditures and Revenues**

<table>
<thead>
<tr>
<th>Department of Health</th>
<th>FY 2021 Recommended Budget</th>
<th>FY 2021 Actual Expenditures and Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expenditures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payroll</td>
<td>$238,101,000</td>
<td>$215,111,300</td>
</tr>
<tr>
<td>Operational</td>
<td>454,414,900</td>
<td>884,537,500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$692,515,900</td>
<td>$1,099,648,800</td>
</tr>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>$246,663,600</td>
<td>$204,031,400</td>
</tr>
<tr>
<td>Federal</td>
<td>259,651,700</td>
<td>586,823,900</td>
</tr>
<tr>
<td>Other</td>
<td>186,200,600</td>
<td>308,793,500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$692,515,900</td>
<td>$1,099,648,800</td>
</tr>
</tbody>
</table>

Source: For the recommended budget, our source was the *Tennessee State Budget, Fiscal Year 2020-2021*. For actual expenditures and revenues, our source was the *Tennessee State Budget, Fiscal Year 2022-2023*. 
Table 12
Department of Health
Fiscal Year 2022 Budget

<table>
<thead>
<tr>
<th>Department of Health</th>
<th>FY 2022 Recommended Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expenditures</strong></td>
<td></td>
</tr>
<tr>
<td>Payroll</td>
<td>$237,580,300</td>
</tr>
<tr>
<td>Operational</td>
<td>447,885,000</td>
</tr>
<tr>
<td>Total</td>
<td>$685,465,300</td>
</tr>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>$225,630,000</td>
</tr>
<tr>
<td>Federal</td>
<td>260,900,700</td>
</tr>
<tr>
<td>Other</td>
<td>198,934,600</td>
</tr>
<tr>
<td>Total</td>
<td>$685,465,300</td>
</tr>
</tbody>
</table>

Source: *Tennessee State Budget, Fiscal Year 2021-2022.*
Appendix 6
Regional Offices and County Health Departments
March 2022

* The six county health departments identified in dark orange operate under the authority of the local government.
Source: Created from the department’s website.

Regional Offices
- Northeast Region
- East Region
- Upper Cumberland Region
- Southeast Region
- Mid-Cumberland Region
- Southeast Region
- West – Jackson Region
- West – Union City Region
Appendix 7
Healthcare Safety Net Provider Locations

"LDH/LHD" stands for local department of health/local health department, "FQHC" stands for Federally Qualified Health Center, and "CFB" stands for community and faith-based organization.
Source: Department program management.
Appendix 8
Counties That Have Referred Individuals for Placement on the Abuse Registry
as of February 2022

<table>
<thead>
<tr>
<th>County</th>
<th>Number of Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson County</td>
<td>28</td>
</tr>
<tr>
<td>Bedford County</td>
<td>2</td>
</tr>
<tr>
<td>Blount County</td>
<td>2</td>
</tr>
<tr>
<td>Bradley County</td>
<td>4</td>
</tr>
<tr>
<td>Campbell County</td>
<td>1</td>
</tr>
<tr>
<td>Claiborne County</td>
<td>1</td>
</tr>
<tr>
<td>Cocke County</td>
<td>2</td>
</tr>
<tr>
<td>County Clerk*</td>
<td>16</td>
</tr>
<tr>
<td>Cumberland County</td>
<td>2</td>
</tr>
<tr>
<td>Davidson County</td>
<td>82</td>
</tr>
<tr>
<td>Franklin County</td>
<td>4</td>
</tr>
<tr>
<td>Gibson County</td>
<td>1</td>
</tr>
<tr>
<td>Greene County</td>
<td>10</td>
</tr>
<tr>
<td>Hamblen County</td>
<td>7</td>
</tr>
<tr>
<td>Hamilton County</td>
<td>2</td>
</tr>
<tr>
<td>Hancock County</td>
<td>1</td>
</tr>
<tr>
<td>Jefferson County</td>
<td>2</td>
</tr>
<tr>
<td>Johnson County</td>
<td>4</td>
</tr>
<tr>
<td>Knox County</td>
<td>137</td>
</tr>
<tr>
<td>Lauderdale County</td>
<td>1</td>
</tr>
<tr>
<td>Lawrence County</td>
<td>1</td>
</tr>
<tr>
<td>Loudon County</td>
<td>1</td>
</tr>
<tr>
<td>Madison County</td>
<td>1</td>
</tr>
<tr>
<td>Marion County</td>
<td>2</td>
</tr>
<tr>
<td>Maury County</td>
<td>1</td>
</tr>
<tr>
<td>McMinn County</td>
<td>4</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>2</td>
</tr>
<tr>
<td>Morgan County</td>
<td>8</td>
</tr>
<tr>
<td>Overton County</td>
<td>1</td>
</tr>
<tr>
<td>Putnam County</td>
<td>1</td>
</tr>
<tr>
<td>Robertson County</td>
<td>2</td>
</tr>
<tr>
<td>Rutherford County</td>
<td>4</td>
</tr>
<tr>
<td>Sevier County</td>
<td>5</td>
</tr>
<tr>
<td>Shelby County</td>
<td>4</td>
</tr>
<tr>
<td>Sullivan County</td>
<td>18</td>
</tr>
<tr>
<td>Sumner County</td>
<td>4</td>
</tr>
</tbody>
</table>
**Appendix 8**  
(Continued)

<table>
<thead>
<tr>
<th>County</th>
<th>Number of Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unicoi County</td>
<td>2</td>
</tr>
<tr>
<td>Van Buren</td>
<td>1</td>
</tr>
<tr>
<td>Warren County</td>
<td>2</td>
</tr>
<tr>
<td>Washington County</td>
<td>2</td>
</tr>
<tr>
<td>Wayne County</td>
<td>1</td>
</tr>
<tr>
<td>Williamson County</td>
<td>15</td>
</tr>
<tr>
<td>Wilson County</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>394</strong></td>
</tr>
</tbody>
</table>

**“County Clerk” indicates the department did not specify which county made the referral.**

Source: Department of Health’s Licensure and Regulatory System.