May 25, 2010

TO: Marilyn Tavenner
Acting Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services

FROM: /Joseph E. Vengrin/
Deputy Inspector General for Audit Services

SUBJECT: Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Tennessee (A-04-09-04040)

Attached, for your information, is an advance copy of our final report on the quarterly Medicaid statement of expenditures for the Medical Assistance Program in Tennessee. We will issue this report to the Bureau of TennCare within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Services Audits, at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov or Peter J. Barbera, Regional Inspector General for Audit Services, at (404) 562-7750 or through email at Peter.Barbera@oig.hhs.gov. Please refer to report number A-04-09-04040.

Attachment

Office of Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3141
Atlanta, GA 30303

May 28, 2010

Report Number: A-04-09-04040

Mr. Darin Gordon
Deputy Commissioner
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Gordon:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Tennessee.* We will forward a copy of this report to the HHS action official noted below.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please direct them to the HHS action official. Please refer to report number A-04-09-04040 in all correspondence.

Sincerely,

/Peter J. Barbera/
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE QUARTERLY MEDICAID STATEMENT OF EXPENDITURES FOR THE MEDICAL ASSISTANCE PROGRAM IN TENNESSEE

Daniel R. Levinson
Inspector General

May 2010
A-04-09-04040

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

American Reinvestment and Recovery Act of 2009

The American Recovery and Reinvestment Act of 2009 (the Recovery Act), P.L. No. 111-5, enacted February 17, 2009, provides fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provides an estimated $87 billion in additional Medicaid funding based on temporary increases in States' Federal medical assistance percentages (FMAP). Section 5000 of the Recovery Act provides for these increases to help avert cuts in health care payment rates, benefits, or services and to prevent changes to income eligibility requirements that would reduce the number of individuals eligible for Medicaid. Sections 5001(a), (b), and (c) of the Recovery Act provide that a State's increased FMAP during the recession adjustment period will be no less than its 2008 FMAP increased by 6.2 percentage points and that a State may receive an increase greater than 6.2 percentage points based on increases to its average unemployment rate.

CMS reimburses States based on the FMAP for the majority of Medicaid expenditures claimed. For the quarter ended December 31, 2008, Tennessee's regular FMAP for Medicaid expenditures was 64.28 percent and the temporarily increased FMAP was 73.25 percent.

TennCare Managed Care Program

In Tennessee, the Bureau of TennCare (State agency) administers the Medicaid program. Since 1994, under a waiver approved by CMS, the State agency has operated its Medicaid program as a statewide managed care demonstration program (TennCare).[1] Medicaid-eligible individuals are enrolled in and receive most of their State plan services through TennCare's delivery system.[2] TennCare provides comprehensive benefits to Medicaid beneficiaries, uninsured residents with income below specified limits, and uninsured residents at any income level if they have medical conditions that make them uninsurable.

[1] In 2002, the original TennCare program was replaced by TennCare II.

[2] Medicaid beneficiaries that are only eligible for payment of Medicare premiums are not enrolled in TennCare. Also, the State agency does not provide long-term care services under TennCare.

The State agency contracts with managed care organizations (MCO) to provide all health services and reimburses the MCOs based on a capitated rate. Using actuarial studies, the State agency develops payment rates for the various aid categories and age groups.

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

The State agency claims Medicaid expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). The Form CMS-64 is the accounting statement that the State agency, pursuant to 42 CFR § 430.30(c), must submit to CMS within 30 days after the end of each quarter. This form shows the disposition of Medicaid funds for the quarter being reported and any prior-period adjustments. It also accounts for any overpayments, underpayments, refunds received by the State agency, and income earned on Medicaid funds.

The amounts reported on the Form CMS-64 and its attachments must represent actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is available at the time the claim is filed. CMS considers claims developed through the use of sampling (other than under an approved cost allocation or administrative claiming plan), projections, or other estimating techniques to be estimates, which are not allowable.

Oversight of Quarterly Medicaid Statement of Expenditures

The CMS Regional Office conducts quarterly reviews of the Form CMS-64. During these reviews, CMS Regional Office staff members review the amounts reported in the accounting records the State agency used to support the Form CMS-64 and perform additional procedures in accordance with the CMS *Financial Review Guide for the Quarterly Medicaid Statement of Expenditures*. The Tennessee State Auditor also conducts reviews of the Form CMS-64.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's claim for Federal reimbursement of Medicaid expenditures was adequately supported by actual recorded expenditures.

Scope

The State agency claimed Medicaid expenditures totaling $1.9 billion ($1.4 billion Federal share) for the quarter ended December 31, 2008. Our review covered six line items on the Form CMS-64 totaling $1.7 billion or 89 percent of the State agency's claimed expenditures for the quarter. The six line items were: Inpatient Hospital Services, Nursing Facilities Services,

Prescribed Drugs, Medicaid Health Insurance Payments, Prepaid Ambulatory Health Plan, and Home and Community Based Services.[3]

Our objective did not require a review of the overall internal control structure of the State agency. Therefore, we limited our internal control review to the State agency's procedures for accounting, documenting, and claiming Medicaid expenditures.

We conducted fieldwork at the State agency's offices in Nashville, Tennessee, from June through October 2009.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and the State plan,
- interviewed State agency officials to obtain an understanding of their policies and procedures for reporting Medicaid expenditures on the Form CMS-64,
- interviewed CMS personnel responsible for monitoring the Form CMS-64 and gained an understanding of the Form CMS-64 adjustment process,
- acquired an understanding of the systems used by the State agency for reporting Medicaid expenditures,
- acquired an understanding of the State agency's Medicaid waiver program,
- obtained the Form CMS-64 submitted by the State agency for the quarter ending December 31, 2008,
- verified that the State agency applied proper FMAPs for current and prior periods' expenditures and adjustments,
- traced overall totals claimed on the Form CMS-64 to the State agency's accounting records,
- selected for review six line items that made up 89 percent of the total claimed,
- selected and reviewed supporting documentation for a judgmental sample of 120 transactions for the six line items, and
- discussed our results with the State agency.

[3] We excluded the Disproportionate Share Hospital program and the State Children's Health Insurance Program (renamed the Children's Health Insurance Program as of February 4, 2009) because these programs did not receive increased funding under the Recovery Act.

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

RESULTS OF REVIEW

The State agency's claim for Federal reimbursement of Medicaid expenditures on the Form CMS-64 was adequately supported by actual recorded expenditures. Therefore, we are making no recommendations to the State agency.

OTHER MATTER

The State agency's fiscal control and accounting procedures must be sufficient to establish that funds have not been used in violation of the restrictions and prohibitions of applicable statutes (45 CFR § 92.20(a)(2)). Even though the State agency's claims for reimbursement of Medicaid expenditures on the Form CMS-64 were in accordance with Federal requirements, the State agency did not have written policies and procedures in place for the preparation of the Form CMS-64. State agency personnel began developing written policies and procedures before we completed our fieldwork.