DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 21 2004

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Dara Corrigan
Acting Principal Deputy Inspector General

SUBJECT: Review of Tennessee's Intergovernmental Transfers (A-04-02-02018)

Attached is an advance copy of our final report on Tennessee's intergovernmental transfers (IGTs). We will issue this report to the Tennessee Medicaid agency within 5 business days.

An IGT is a transfer of funds from a local government to a State government. According to section 1902(a)(2) of the Social Security Act, a State may fund up to 60 percent of its State matching payments with local funds. In State fiscal year 2000, Tennessee began using IGTs as a means of funding its public nursing homes. We initiated this audit because our prior work showed, in some cases, that public providers returned Medicaid funds to States through IGTs. Once returned, States could use the funds for purposes unrelated to the Medicaid program.

Our objectives were to determine (1) whether the sources of IGTs were public funds eligible for Federal matching funds, (2) how the State used IGTs and related Federal funds, and (3) whether the State's upper-payment-limit calculations were in accordance with Federal regulations.

Under Federal regulations, public funds are eligible for Federal matching as long as they do not include Federal funds. In addition, Federal regulations provide that a State's proposed Medicaid payment rate not exceed the upper payment limit, which is an estimate of the maximum amount that would be paid to a group of facilities, such as nursing homes, under Medicare payment principles. State expenditures that exceed the applicable upper payment limit are not eligible for Federal matching funds.

The results of our review, which covered State fiscal years 2000 through 2002, are summarized below:

- Because the six counties that funded IGTs commingled IGT funds with other county funds, we could not confirm that they had not used prior Federal dollars to fund IGTs. Therefore, we could not determine whether IGTs were eligible for Federal matching funds.

- The State used IGTs to maximize Federal reimbursement at little or no cost to the State. Moreover, the State did not use the funds primarily for the benefit of public nursing homes, for which the funds were designed.

Of the total $398 million in IGT funds provided by the counties, $182 million was placed in the State Medicaid agency's reserve account for use at the State legislature's discretion, $146 million funded the State's share of upper-payment-limit payments to public nursing homes, $62 million funded the State's share of other payments to private and public nursing homes, and $8 million funded administrative fee payments to counties. Rather than using the $146 million in upper-payment-limit payments to provide services to Medicaid beneficiaries, the public nursing homes returned the entire amount to the counties. Thus, the net cost to the counties and the net cash outlay by the State were zero.

- The State's upper-payment-limit calculations for State fiscal years 2001 and 2002 exceeded the Medicare upper payment limit by $23,690,384. Of this amount, $21,772,923 represented an overpayment; the State has not yet claimed the balance of $1,917,461.

We recommend that the State:

- direct the counties to improve recordkeeping procedures to ensure that no prior Federal funds are included in IGTs submitted for Federal matching

- establish review procedures to ensure the accuracy of upper-payment-limit calculations

- report an adjustment to CMS to disallow public nursing home payments totaling $21,772,923 ($13,856,288 Federal share) and not claim the $1,917,461 ($1,220,272 Federal share) in available spending

In response to our draft report, the State concurred with our recommendations.

If you have any questions or comments about this report, please do not hesitate to call me or one of your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Charles J. Curtis, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

MAY 25 2004

Report Number: A-04-02-02018

Mr. Keith Gaither
Director of Administrative Services
Department of Finance and Administration
Bureau of TennCare
729 Church Street
Nashville, Tennessee 37247-6501

Dear Mr. Gaither:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Tennessee's Intergovernmental Transfers." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports are made available to members of the press and the general public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-04-02-02018 in all correspondence.

Sincerely,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures

Direct Reply to HHS Action Official:

Renard L. Murray
Associate Regional Administrator
Division of Medicaid and State Operations, Region IV
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF TENNESSEE'S INTERGOVERNMENTAL TRANSFERS

MAY 2004
A-04-02-02018

EXECUTIVE SUMMARY

BACKGROUND

State Medicaid programs have considerable flexibility in determining payment rates for health care providers. The Centers for Medicare & Medicaid Services (CMS) allows States to pay different rates to the same types of providers, such as hospitals or nursing facilities, as long as the payments to that type of provider, in the aggregate, do not exceed the upper payment limit. The upper payment limit is an estimate of the maximum amount that would be paid to that type of provider under Medicare payment principles.

An intergovernmental transfer (IGT) is a transfer of funds from a local government to a State government. A State may fund up to 60 percent of its State matching payments with local funds. In State fiscal year (SFY) 2000, Tennessee began using IGTs as a means of funding its public nursing homes under the upper-payment-limit rules. Six counties participate.

OBJECTIVES

Our objectives were to determine (1) whether the sources of IGTs were public funds eligible for Federal matching funds, (2) how the State used IGTs and related Federal funds, and (3) whether the State's upper-payment-limit calculations were in accordance with Federal regulations.

SUMMARY OF FINDINGS

Eligibility of IGTs for Federal Matching Funds

Federal regulations provide that public funds may be considered as the State's share in claiming Federal matching funds as long as the public funds do not include Federal funds. Because the counties commingled IGT funds with other county funds, we could not confirm that they had not used prior Federal dollars to fund IGTs. Therefore, we could not determine whether IGTs were eligible for Federal matching funds.

Use of IGTs

The State used IGTs to maximize Federal reimbursement at little or no cost to the State. Moreover, the State did not use the funds primarily for the benefit of public nursing homes, for which the funds were designed.

Of the total $398 million in IGT funds provided by the counties from SFY 2000 through 2002, $182 million was placed in the State Medicaid agency's reserve account for use at the State legislature's discretion, $146 million funded the State's share of upper-payment-limit payments to public nursing homes, $62 million funded the State's share of other payments to private and public nursing homes, and $8 million funded administrative fee payments to counties. The public nursing homes did not retain any of the $146 million in

upper-payment-limit funds to provide services to Medicaid beneficiaries; instead, the nursing homes made an equal transfer of funds to their respective counties.

Upper-Payment-Limit Calculations

The State's upper-payment-limit calculations for SFYs 2001 and 2002 exceeded the Medicare upper payment limit by $23,690,384. Of this amount, $21,772,923 represented an overpayment; the State has not yet claimed the balance of $1,917,461. These overstatements occurred because the State did not have adequate procedures to review the accuracy and reasonableness of its calculations.

RECOMMENDATIONS

We recommend that the State:

- direct the counties to improve recordkeeping procedures to ensure that no prior Federal funds are included in IGTs submitted for Federal matching

- establish review procedures to ensure the accuracy of upper-payment-limit calculations

- report an adjustment to CMS to disallow public nursing home payments totaling $21,772,923 ($13,856,288 Federal share) and not claim the $1,917,461 ($1,220,272 Federal share) in available spending

STATE'S COMMENTS

In response to our draft report, the State concurred with our recommendations and said that it was taking steps to implement them.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Under Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to needy persons. Medicaid is a jointly funded Federal and State program administered by the States in accordance with State plans approved by CMS. The Federal Government pays its share of Medicaid expenditures to States according to a defined formula, and States have an obligation to pay their own matching share. In Tennessee, the Bureau of TennCare (TennCare) administers the Medicaid program.

Upper Payment Limits

State Medicaid programs have considerable flexibility in determining payment rates for health care providers. CMS allows States to pay different rates to the same types of providers, such as hospitals or nursing facilities, as long as the payments to that type of provider, in the aggregate, do not exceed the "upper payment limit," which is defined as an estimate of the maximum amount that would be paid to that type of provider under Medicare payment principles. Beginning in SFY 2000, TennCare made payments to nursing homes based on its calculation of the amount that would be paid under Medicare payment principles.

The Federal regulations that limit aggregate State Medicaid payments for nursing homes to a reasonable estimate of the amount that would have been paid under Medicare payment principles are found at 42 CFR § 447.272. To address States' abuses of the upper-payment-limit rules, CMS made substantial changes to these regulations in 2001.

Regulations Before March 13, 2001

Until March 13, 2001, 42 CFR § 447.272 specified two categories of providers to which upper payment limits applied: State government owned or operated facilities and all others. Because no separate aggregate limit applied to non-State public facilities, they were grouped with other public and private facilities when calculating the upper payment limit. This created a financial incentive for States to overpay non-State public facilities and yet stay within the upper payment limit by decreasing the aggregate payments for proprietary and nonprofit facilities. The 2001 regulations sought to curtail this practice.

Regulations After March 13, 2001

Effective March 13, 2001, the modified regulations at 42 **§** CFR 447.272 created three categories of providers for determining the aggregate upper payment limit applicable to all facilities in the State: those owned or operated by the State, those owned or operated by a non-State governmental entity, and those that are privately owned or operated. A purpose of the change was to prevent States from shifting payments from nonprofit and proprietary facilities to non-State government facilities as a way to increase Federal matching payments without any corresponding increase in Medicaid services. The modified regulations also created transition

periods for State compliance, depending on when the related State plan amendments were submitted, approved, and effective.

Intergovernmental Transfers

According to section 1902(a)(2) of the Act, a State may fund up to 60 percent of its State matching payments with local funds. Transfers of funds to the State government for this purpose are known as intergovernmental transfers, or IGTs. When used in conjunction with the upper-payment-limit rules, States have relied on IGTs to augment Federal reimbursement without having to increase State Medicaid services.

In SFY 2000, TennCare began using IGTs to fund payments to public nursing homes under the upper-payment-limit rules. During our audit period, six counties participated by providing IGTs to the State.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine (1) whether the sources of IGTs were public funds eligible for Federal matching funds, (2) how the State used IGTs and related Federal funds, and (3) whether the State's upper-payment-limit calculations were in accordance with Federal regulations.

Scope and Methodology

Our review covered IGTs during SFYs 2000, 2001, and 2002.

To accomplish our objectives, we met with CMS regional office staff and reviewed their records on Tennessee's Medicaid program. At TennCare, we interviewed personnel and reviewed records supporting funding pool calculations, provider payments, and IGTs. We obtained IGT agreements and other documentation at the State, county, and provider levels to determine how the provider payments were funded, transferred, and used. We reviewed sources and uses of funds related to $119 million in IGTs for SFY 2000 and $279 million in IGTs for SFYs 2001 and 2002.

Because IGTs funded provider payments based on the State's calculation of the upper payment limit, we conducted a limited review of the SFY 2001 ($163 million) and 2002 ($309 million[1]) upper-payment-limit calculations. We reviewed the basic Medicare Resource Utilization Group rates and the required adjustments to those rates for proper application and compliance with Federal regulations. We did not review and offer no opinion on the accuracy of the following components of the SFY 2001 and 2002 UPL calculations: the Medicaid Level I payment "gross up" for therapy and pharmacy, Minimum Data Set frequency data, and estimated Medicaid days.

[1] For SFY 2002, the aggregate upper payment limit comprised $209,447,535 in facility-specific upper-payment-limit payments plus $99,630,713 in SFY 2001 transition period excess Medicaid payments over the upper payment limit.

Additionally, we did not review the SFY 2000 upper-payment-limit calculation and offer no opinion on its accuracy.

At an exit conference with TennCare officials, we presented our findings. We requested that they review our corrected upper-payment-limit calculations for SFYs 2001 and 2002 and advise us of any disagreements before issuance of our draft report.

We conducted our review in accordance with generally accepted government auditing standards. We conducted fieldwork from June through August 2002 at TennCare in Nashville, TN, and at the CMS regional office in Atlanta, GA. We also visited three of the counties (Davidson, Knox, and Lincoln) that funded IGTs.

FINDINGS AND RECOMMENDATIONS

ELIGIBILITY OF IGTS FOR FEDERAL MATCHING FUNDS

Regulations at 42 CFR § 433.51 state:

> (a) Public funds may be considered as the State's share in claiming FFP [Federal financial participation] if they meet the conditions specified in paragraphs (b) and (c) of this section.
>
> (b) The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.
>
> (c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

We were unable to determine whether IGTs from the six participating counties were eligible for Federal matching funds. After TennCare received the IGTs from the counties, it provided upper-payment-limit funds (Federal and State shares) to the eligible nursing homes in those counties. The nursing homes, in turn, transferred the same amount of funds back to their respective county governments. These transactions occurred on the same day. All counties but one[2] deposited the funds received from the nursing homes in their local accounts. These same accounts were the source of funds for IGTs in SFYs 2000 through 2002.

Our analysis of these accounts found no indication that the county funds used for IGTs were from typical public funding sources, such as county property taxes, sales taxes, or special taxing districts. Considering the sources of the funds, the account balances, the amount of IGT funds in the accounts, and the timing and flow of funds, it appeared that the SFYs 2001 and 2002 IGTs from the counties included prior Federal funds. However, because the IGT funds returned to

[2] One county used bank loans to fund its IGTs for SFYs 2000 through 2002. This county used funds transferred from the nursing home to repay the loans.

each county were commingled in one account with other county funds, we could not reach this conclusion with certainty.

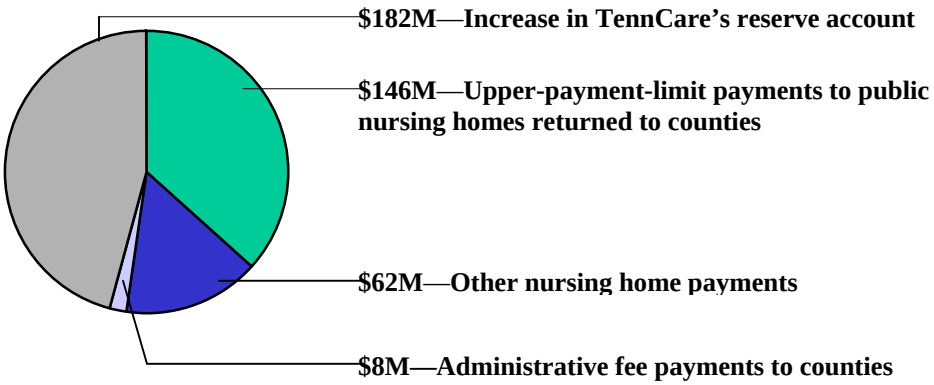
USE OF IGTS

Medicaid regulations at 42 CFR Part 440, Subpart A describe the medical or remedial care and services that are eligible for Federal funding under the State plan. Section 1902(a)(30) of the Act requires that payments be consistent with efficiency, economy, and quality of care.

We found that TennCare used IGTs to maximize Federal reimbursement at little or no cost to the State. Moreover, TennCare did not use the funds primarily for the benefit of nursing homes, for which the funds were designed. The largest portion of the funds was placed in TennCare's reserve account.

From SFY 2000 through 2002, TennCare used $398 million in IGTs as illustrated in Figure 1 and discussed below. The details are provided in Appendix A.

Figure 1: Use of $398 Million in IGTs



- IGTs generated a $182 million increase in TennCare's reserve account. Any excess TennCare funds, including excess IGTs over uses, annually reverted to this account. Subject to annual State legislature approval in the appropriations bill, TennCare reserve funds could be carried forward and used by TennCare.

- IGTs funded the State's $146 million share of upper-payment-limit payments to six public nursing homes. However, these payments provided no direct benefit to the public nursing homes because they did not retain any of the funds. Upon receipt of the funds, the nursing homes returned an equal amount to their respective county governments. Thus, the net cost to the counties and the net cash outlay by TennCare were zero.

- IGTs funded the State's $62 million share of an estimated $158 million in other payments to private and public nursing homes. These payments were part of the facility-specific

per diem rate, were retained by the nursing homes, and were the only direct benefit of IGTs. The six public nursing homes involved in IGTs received an estimated $13.3 million ($5.2 million State share), public nursing homes not involved in IGTs received an estimated $10 million ($3.9 million State share), and private nursing homes not involved in IGTs received an estimated $134.7 million ($53.2 million State share).

- IGTs returned $8 million ($2.67 million per year) in administrative fee payments, representing 2 percent of the counties' IGTs, to the funding county governments. This $8 million was the only direct benefit to the counties.

The $182 million placed in the TennCare reserve account was commingled with other funds; thus, we could not determine how these dollars were used. We noted that from SFY 2000 through 2002, $169.1 million of reserve funds was legislatively appropriated for TennCare program use. Of this amount, only $800,000 was for nursing home grant assistance; the remaining appropriations were non-nursing-home related. About $98 million funded TennCare's essential provider payments to hospitals. Although the appropriated funds were used for Medicaid purposes, very little of the funding benefited the nursing homes involved in IGTs.

The $182 million placed in the TennCare reserve represented State funds reasonably expected to generate additional Federal funds of $318 million. Thus, the combined State and Federal funds available to fund additional TennCare expenditures would be approximately $500 million.

UPPER-PAYMENT-LIMIT CALCULATIONS

Federal Laws and Regulations

Under Federal regulations at 42 CFR § 447.253(b)(2), a State Medicaid agency's proposed payment rate may not exceed the upper payment limit. In addition, regulations at 42 CFR § 447.272 state that the upper payment limit for each type of health care facility (hospitals, nursing facilities, and intermediate care facilities) is the aggregate, maximum amount that one can reasonably estimate would have been paid under Medicare payment principles. Although Federal regulations do not define the methodology for calculating the estimated upper payment limit, a State's methodology and related payments must comply with the approved State plan. State expenditures that exceed the applicable upper payment limit are not eligible for Federal matching funds.

Federal regulations at 42 CFR Part 413, Subpart J implement section 1888(e) of the Act, which provides for a prospective payment system for skilled nursing facilities. This payment system is based on standardized payment rates, classified as either rural or urban, for each of 44 Resource Utilization Groups. Under 42 CFR § 413.345, CMS annually updates these rates and publishes them, along with the wage index, in the Federal Register. Resource Utilization Group III rates are the current version of the nursing facility payment rates.

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 also

provided updates to the Resource Utilization Group rates. The BBRA adjustment increased reimbursement to nursing homes by providing a 20-percent add-on for certain Resource Utilization Group rates and a 4-percent across-the-board add-on. BIPA further adjusted the rates, specifically, the rehabilitation Resource Utilizations Groups' add-on percentages, to correct an anomaly created by BBRA. Incorrect application of any of these factors would result in an inaccurate and unreasonable calculation of the upper payment limit.

Calculation Overstatements

Our limited review of TennCare's upper-payment-limit calculations for SFYs 2001 ($163,424,270) and 2002 ($309,078,248) found that the calculations exceeded the Medicare upper payment limit by $23,690,384 ($15,076,560 Federal share). Contrary to Federal regulations, TennCare incorrectly applied basic Resource Utilization Group III rates, wage index factors, and BBRA and BIPA adjustments. As a result, TennCare received $13,856,288 in excess Federal funds in SFY 2002 and potentially could receive an additional $1,220,272 in excess Federal funds. These overstatements occurred because TennCare did not have adequate procedures to review the accuracy and reasonableness of the calculations.

The calculation errors are detailed below.

SFY 2001: Resource Utilization Group III Rates Improperly Applied

TennCare improperly applied rural Resource Utilization Group III rates to counties that should have been classified as urban for 9 of the 12 months in SFY 2001. This resulted in a $465,825 overpayment in SFY 2002.

We identified 10 instances in which TennCare used the wrong rates. For example, TennCare used rural rates of $416.50 and $425.05 for the Cheatham County Nursing Home when it should have used urban rates of $392.22 and $400.93. This resulted in an upper-payment-limit variance of $31,504 for this nursing home.

SFY 2001: Wage Index Factors Improperly Applied

TennCare improperly applied the wage index adjustment factors in its SFY 2001 computations, resulting in an $843,836 upper-payment-limit overpayment in SFY 2002.

TennCare made one error in all nursing home computations: it used a single wage index adjustment factor for the entire year, rather than the two factors required by regulations. For example, TennCare used a rural wage index factor of 78.38 percent for Elmhurst Nursing Home for the entire year. It should have used a factor of 94.49 percent for the first 3 months and 94.90 percent for the last 9 months.

SFY 2001: BBRA Adjustments Not Applied

TennCare did not apply the BBRA adjustments, which were to be applied to services on or after April 1, 2000, to its calculations until April 1, 2001. This error resulted in a $15,458,944 overpayment in SFY 2002.

SFY 2001: BIPA Adjustments Not Applied

TennCare did not apply the BIPA adjustments, which were to be applied to services on or after April 1, 2001, to its calculations until July 1, 2001. This error resulted in a $5,742,433 overpayment in SFY 2002.

SFY 2002: Resource Utilization Group III Rates Improperly Applied

In all nursing home computations during SFY 2002, TennCare used a single Resource Utilization Group rate for the entire year rather than the two rates required by regulations. A $939,576 overpayment in SFY 2002 resulted.

SFY 2002: Wage Index Factors Improperly Applied

In all nursing home computations during SFY 2002, TennCare used a single wage index adjustment factor for the entire year rather than the two factors required by regulations. A $239,770 overpayment in SFY 2002 resulted.

Cumulative Effect of All Errors

The cumulative effect of these errors was an overstatement of the SFY 2002 upper payment limit by $23,690,384. Of this total, $21,772,923 represented an overpayment already received by TennCare; TennCare has not yet claimed the balance of $1,917,461.

The Federal share of the payments in excess of the allowable Medicare upper payment limit is as follows:

Federal share of overpayment (63.64% of $21,772,923)	$13,856,288
Federal share of potential claim (63.64% of $1,917,461)	1,220,272
Total	**$15,076,560**

RECOMMENDATIONS

We recommend that the State:

- direct the counties to improve recordkeeping procedures to ensure that no prior Federal funds are included in IGTs submitted for Federal matching

- establish review procedures to ensure the accuracy of upper-payment-limit calculations

- report an adjustment to CMS to disallow public nursing home payments totaling $21,772,923 ($13,856,288 Federal share) and not claim the $1,917,461 ($1,220,272 Federal share) in available spending

STATE'S COMMENTS

The State concurred with our findings and recommendations and said that it had taken specific actions to implement each recommendation. We have considered the State's specific comments and, where appropriate, changed our final report.

APPENDICES

SOURCES AND USES OF IGTS AND RELATED FEDERAL FUNDS FOR STATE FISCAL YEARS 2000 THROUGH 2002

I. Sources of IGTs	State Share	Federal Share	Total Funding
IGTs From Counties			
Bradley County Government	$ 36,189,252	$ 0	$ 36,189,252
Hamilton County Government	13,046,646	0	13,046,646
Knox County Government	144,400,973	0	144,400,973
Lincoln County Government	46,165,845	0	46,165,845
Metro Davidson County Government	100,072,176	0	100,072,176
Shelby County Government	58,020,848	0	58,020,848
I. Total Sources of IGTs	**$397,895,740**	**$ 0**	**$397,895,740**

II. Uses of State and Federal Funds			
Upper-Payment-Limit Payments			
Bradley Health Care and Rehabilitation Center	$ 13,271,305	$ 22,917,947	$ 36,189,252
Hamilton County Nursing Home	4,814,212	8,232,434	13,046,646
Hillcrest Nursing Institute (Knox County)	52,966,532	91,434,441	144,400,973
Lincoln & Donelson Care Centers	16,928,608	29,237,237	46,165,845
Nashville Metro Bordeaux Hospital (Davidson)	36,705,869	63,366,307	100,072,176
Oakville Health Care Center (Shelby County)	21,276,789	36,744,059	58,020,848
A. Total Upper-Payment-Limit Payments	**$145,963,315**	**$251,932,425**	**$397,895,740**
Full-Funding Payment Increases (1)			
Bradley Health Care and Rehabiliation Center	$ 875,470	$ 1,338,697	$ 2,214,167
Hamilton County Nursing Home	1,369,126	2,093,555	3,462,681
Hillcrest Nursing Institute (Knox County)	1,057,016	1,616,303	2,673,319
Lincoln & Donelson Care Centers	10,237	15,655	25,892
Nashville Metro Bordeaux Hospital (Davidson)	1,113,604	1,702,832	2,816,436
Oakville Health Care Center (Shelby County)	817,377	1,249,866	2,067,243
Total public nursing homes involved in IGT funding	$ 5,242,830	$ 8,016,908	$ 13,259,738
Other public nursing homes	3,896,995	5,958,969	9,855,964
Private nursing homes	53,239,928	81,410,160	134,650,088
B. Full-Funding Payment Increases	**$ 62,379,753**	**$ 95,386,037**	**$157,765,790**
Total Nursing Home Expenditures (IIA + IIB)	**$208,343,068**	**$347,318,462**	**$555,661,530**
2% Administrative Fee Payments to Counties			
Bradley County Government	$ 723,785	$ 0	$ 723,785
Hamilton County Government	260,933	0	260,933
Knox County Government	2,888,019	0	2,888,019
Lincoln County Government	934,369	0	934,369
Metro Davidson County Government	2,001,444	0	2,001,444
Shelby County Government	1,160,417	0	1,160,417
C. Total Administrative Fee Payments	**$ 7,968,967**	**$ 0**	**$ 7,968,967**
II. Total Uses of State and Federal Funds (IIA + IIB + IIC)	**$216,312,035**	**$347,318,462**	**$563,630,497**

	State Share	Federal Share	Total Funding
III. Excess IGTs Over Uses: TennCare Reserve Increase (I - II)	$181,583,705 (2)		
IV. Impact of TennCare Reserve Increase	$181,583,705	$317,821,425 (3)	$ 99,405,130 (4)
V. Total State and Potential Federal Funds From IGTs (II + III)	$397,895,740	$665,139,887 (5)	$1,063,035,627

NOTES:

(1) This appendix reflects audited/actual amounts except for those related to full-funding payment rate increases totaling $158 million (IIB). TennCare provided the grand totals, and we estimated the provider totals based on TennCare data and our review of SFY 2000 payments. These payments represent the "other" nursing home payments mentioned in the body of the report.

(2) Excess SFYs 2000 through 2002 IGTs funded approximately $182 million of increases in the TennCare reserve. These funds were available at the State legislature's discretion to meet the State's share of other TennCare-related expenditures potentially eligible for Federal matching funds.

(3) Authority for TennCare to carry forward any TennCare reserve excess is provided in the State's annual appropriations bill. This bill also authorizes certain expenditures from the TennCare reserve; if TennCare applied these funds to Medicaid spending that qualified for Federal matching, the $182 million could generate additional Federal funds of approximately $318 million. For SFYs 2000 through 2002, $169 million was appropriated from the TennCare reserve. Of this amount, $800,000 was for nursing home grant assistance; otherwise, the appropriations were non-nursing-home related.

(4) The $182 million in excess IGTs placed in the TennCare reserve represented State funds reasonably expected to generate additional Federal funds of $318 million. Thus, the combined State and Federal funds available to fund additional TennCare expenditures would be almost $500 million.

(5) The State's share of $398 million could potentially generate Federal funds of $665 million. The State has already obtained Federal funds of $347 million and, as explained above, could obtain an additional $318 million.

State of Tennessee
Department of Finance and Administration
Bureau of TennCare
729 Church Street
Nashville, TN 37247-6501

Phil Bredesen
Governor

M. D. Goetz, Jr.
Commissioner

May 12, 2003

Mr. Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

Dear Mr. Curtis:

Attached is our response to Report Number A-04-02-02018 dated April 10, 2003 on your agency's review of Intergovernmental Transfers used by the Tennessee State Medicaid Agency during the State Fiscal Years 2000 through 2002.

We appreciate the opportunity to respond to the report. We are in the process of implementing corrective actions to address the recommendations made in the report. Please contact me or my staff if you need additional information.

Sincerely,

Manny Martins
Deputy Commissioner

MM:TG

Attachment

Bureau of TennCare
Response to Draft Audit Report Dated April 2003
Issued by the Department of Health and Human Services
Office of Inspector General
Review of Intergovernmental Transfers Used by the Tennessee State Medicaid Agency During the Fiscal Years 2000 through 2002

We concur with the recommendations made in this report and are taking the necessary steps to ensure they are implemented. Specific actions that we are taking are provided below after each OIG recommendation. We have also provided a clarification of the TennCare Reserve fund.

OIG Recommendation—Direct the counties to improve record keeping procedures to assure that the source of funds used to finance IGT are public funds eligible for FFP

Corrective Action—For SFY 2003, contracts with the county governments have been amended to include a certification to the State that the funds used for intergovernmental transfers are public funds that meet the criteria of 42 CFR 433.51.

OIG Recommendation—Establish review procedures for the UPL calculation to assure its accuracy

Corrective Action—Calculation errors identified in this report resulted from the misapplication of RUG-III rates and corresponding index factors for certain facilities and in our misapplication of BBRA and BIPA rate adjustments. These errors, while unintentional, resulted in an overestimation of the SFY 2002 UPL calculation. To ensure future calculations do not contain similar errors, we are implementing a secondary review process by the TennCare Fiscal Office. This review will take into account whether the facilities are appropriately classified as urban or rural, verification of rates and indexes, verification of adjustments to Medicare rates during the period and testing of formulas used in the supporting worksheets.

OIG Recommendation—Report an adjustment disallowing public nursing home DSPs in excess of the allowable SFY 2002 transition period UPL totaling $21,772,923 (federal share $13,856,288 based on the 63.64 percent FMAP for SFY 2002) on the next submitted CMS Form 64: and

Corrective Action—An adjustment to the CMS Form 64 will be made for the amount of disproportionate share payments in excess of the allowable UPL as soon as the final report is provided to us.

OIG Recommendation—Not claim the $1,917,461 (federal share $1,220,272 based on the 63.64 percent FMAP for SFY 2002) available spending currently reported as outstanding and unclaimed based on the submitted SFY 2002 UPL computation.

Corrective Action—We do not plan to claim the $1,917,461 (federal share $1,220,272 based on the 63.64 percent FMAP for SFY 2002) available spending currently reported as outstanding and unclaimed based on the submitted SFY 2002 UPL computation.

TennCare Reserve Fund—Excess funds in the TennCare program, including any excess intergovernmental transfer revenues are placed in the TennCare Reserve Fund for use by TennCare in subsequent periods. The fund is a reserved balance in the State's General Fund. While it is true that the state legislature has discretion, through the legislative process, over the uses of the General Fund revenues, amounts in the TennCare Reserve are set aside each year in the appropriation bill for use in the TennCare program. We believe the comments in the audit report are misleading in that the legislature has continued to set aside the TennCare Reserve balance for TennCare program uses and not for other General Fund purposes.

ACKNOWLEDGMENTS

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