
SECTION I

REPORTING AND AUDITING REQUIREMENTS MEDICAID COST REPORT ENGAGEMENTS

Reporting Requirements and Examination Procedures for Medicaid Cost Report Engagements

Introduction

The Tennessee Department of Finance and Administration is the single state agency responsible for administering the Tennessee nursing facility program which is part of the Tennessee Medical Assistance Program under Title XIX of the Social Security Act. The Centers for Medicare and Medicaid Services, Department of Health and Human Services, specifies certain conditions states must meet to participate in the Title XIX program. One of those conditions is that single state agencies must conduct or contract to conduct examinations of nursing facilities participating in the program. States are given flexibility in determining the scope and extent of the examinations.

The Tennessee Department of Finance and Administration, in meeting its obligation, has contracted with the Tennessee Comptroller of the Treasury to perform the examinations. The department has specified certain procedures for the Comptroller to conduct on the nursing facilities. These procedures are specified in detail in an attachment to the contract between the department and the Comptroller.

Medicaid nursing home examinations are intended to meet the following objectives:

1. The first objective to be attained by performing the examinations is to determine if income, expenses, and statistical information reported on nursing facility cost reports submitted to the Tennessee Comptroller's Office are reasonable, allowable, and in accordance with state and federal rules, regulations, and Medicare principles of reimbursement issued by the Department of Health and Human Services, Centers for Medicare and Medicaid Services.
2. The second objective to be attained is to determine whether resident days reported on the Medicaid Cost Report have been counted in accordance with state regulations and whether Medicaid resident days billed to the state for periods when residents were hospitalized or on therapeutic leave are in accordance with the 85% occupancy rule and therapeutic leave rule.

Reporting and Auditing Requirements – Medicaid Cost Report Engagements - Section I

3. The third objective to be attained is to determine whether charges made to nursing facility residents or residents' personal funds are in compliance with state and federal regulations. The standards under which these examinations are performed include the department's regulations, bulletins, and manuals issued which address the requirements, and the contracts between the state and the participating nursing facilities.
4. The final objective is to make recommendations to correct deficiencies discovered in completing the examination. The department has, in its procedures, also specified that the Comptroller shall include certain background about the nursing facility and shall provide each nursing facility the opportunity to include its comments on the results of the examination in the report. In addition, the department has specified that the Comptroller shall make necessary rate adjustments as a result of the examination. The department is responsible for implementation and enforcement of rate adjustments and collection of monetary refunds from contracting nursing facility providers resulting from the Comptroller's recommendations.

Medicaid Rules and Regulations

The state regulations that govern the administration of the Tennessee Medicaid nursing home program with respect to reimbursement and coverage issues are contained in Chapter 1200-13 of the Rules of the Department of Finance and Administration. Chapter 1200-8-6 contains the nursing home minimum standards that deal with matters such as building standards, safety requirements, and other quality of care rules. Since the nursing home payment methodology is based on Medicare principles of reimbursement, the *Medicare and Medicaid Guide* also serves as a regulatory source. Medicaid nursing home coverage in general is set forth in the Nursing Facility Manuals published by the Department of Finance and Administration. From time to time, the department issues "Medicaid Bulletins" to update providers on policy changes or interpretations of current policy.

Cost Reporting Requirements

Nursing homes are required to submit an annual cost report to the Comptroller's Office. The Level I nursing facility cost report (formerly known as the intermediate care cost report) forms and instructions are contained within Chapter 1200-13 of the state regulations and are due within 90 days of their fiscal year end. The Medicaid Level II nursing facility program (formerly known as the skilled program) uses the Medicare nursing home cost report form and are due within 5 months of their fiscal year end.

Examinations

The examination procedures to be conducted by the Tennessee Comptroller's Office are given below in condensed form along with the associated criteria. It should be noted that the Department's nursing home manual was issued January 1987. Although the manual has not

Reporting and Auditing Requirements – Medicaid Cost Report Engagements - Section I

been revised, a number of Medicaid bulletins have been issued for rule revisions. We have made revisions in the criteria given below where appropriate.

Expenses–Criteria

The cost report footnotes and instructions and the nursing facility Level I accounting principles are the primary source for criteria concerning allowable costs. These documents are found in state rule Chapter 1200-13 and are also available on the Secretary of State’s website. If an item is not addressed in the footnotes or apportionment principles, Medicare principles of retrospective cost reimbursement apply, and reference should be made to the *Medicare and Medicaid Guide*.

Expenses–Procedures

1. Compare salaries on the cost report to the provider’s quarterly wage reports. If the wage reports are not available, use the home’s payroll records. Variances exceeding 2% should not be written off as immaterial.
2. Review the quarterly wage reports for reasonableness. Any non-owner employee’s salary that exceeds \$20,000 per quarter should be checked for reasonableness.
 - a. Note the employee’s title and duties.
 - b. Note the percentage of time he or she works.
 - c. Determine if that employee is overlapping or duplicating the duties of another employee.
3. Obtain a signed statement from owner-employees or their relatives, stating their duties, percentage of time working, and compensation, including all fringe benefits. This data is then used to test the accuracy of the maximum allowable salary limits for the provider. The rules for applying the salary limits are given in the cost report apportionment principles.
4. Select transactions from other expense accounts for review. The transactions selected for review should cover the entire examination period, if feasible. Describe the method for selecting the transactions reviewed.
5. Scan the ledgers and journals for unusual items.
6. For the selected test transactions, examine the paid check and invoice. Determine if the expense is allowable.
7. If this is the first cost report, verify that property is properly recorded at cost and is present at the facility.

Reporting and Auditing Requirements – Medicaid Cost Report Engagements - Section I

8. Review the depreciation computations for the examination period and the accuracy of useful lives.
9. Obtain and review support for interest expense and trace the amounts to the cost report.
10. Review the adjustments made to section G of the cost report.
11. Determine if the general ledger control account is supported by a listing of accounts payable or if the open items can in some way be identified.
12. If considered necessary, verify that year-end payables have been paid in the subsequent period.

Resident Days–Criteria

The criteria governing resident days are found in Sections 321 through 325.1 of the January 1987 *Intermediate Care Facility Manual*. (Note: Since the last issue of the manual, Intermediate Care (ICF) is now referred to as Level 1 nursing facility care.)

Resident Days–Procedures

1. Trace total resident days from the nursing home census (or resident log) to the cost report.
2. Foot monthly totals.
3. List the monthly totals and compare them to the available days for that month.
4. For any month in which capacity is below 85%, verify if any hospital or therapeutic days have been billed to the program.
5. Selecting the month with the largest variance (actual to available days), test the census records for proper accumulation.
6. Review the census records for Medicaid residents who were either in the hospital or on therapeutic leave over 10 days. Verify that days over 10 have not been billed to the Medicaid program during any state fiscal year.
7. In the test month, verify the accuracy of admission and discharge dates with the admission records.

Trust Funds–Criteria

Medicaid recipients who are residents in nursing homes are permitted \$50 per month for personal spending needs. The \$50 is generally deducted from each recipient’s income, and the remainder is applied to room and board charges. State Rule Chapter 1200-8-6 and *Tennessee Code Annotated*, Section 68-11-906 provide rules and regulations governing trust funds. The Nursing Facility Manuals provide guidance on the treatment of resident deposits.

Sections 66-29-101 through 66-29-133, *Tennessee Code Annotated*, govern the disposition of balances owed to residents after they have left the facility. Generally, the law requires nursing homes to report unclaimed property and credit balances to the State Treasurer each year. However, nursing homes may, at their option, elect to hold the funds for the statutory period from the date of last account activity before reporting to the State Treasurer. However, if the nursing home holds the funds for the statutory period, then it must document that it has made a reasonable attempt to locate the owner of the funds. At the end of the statutory period, any accrued interest must also be reported and returned to the State Treasurer.

Generally, residents should not be charged for “covered services.” Covered services are items and services included in the per diem rate for all routine services. An exception is permitted when a resident or his or her doctor requests a special brand item not normally stocked by the nursing home.

Trust Funds–Procedures

1. As of a specific date, balance the trust fund subsidiary accounts to the general ledger control account.
2. Balance cash on hand and in bank to the general ledger control account.
3. Select 10% of Medicaid trust fund accounts (minimum of 3, maximum of 10), and for the examination period, test each account for
 - a. receipt of the monthly personal needs allowance;
 - b. documentation that withdrawals are for personal needs only and not for covered services;
 - c. placement of all funds in excess of \$100 per recipient in an insured interest-bearing account.
4. Check the trust fund accounts of deceased or discharged Medicaid recipients for credit balances.

Resident Accounts–Criteria

The criteria for examining resident accounts are general in nature and do not differ significantly from procedures for examining accounts receivable. However, several special circumstances are explained in the following paragraphs.

Medicaid residents must not be charged above the private rate for comparable services. If private-pay residents are charged extra for central supplies or other items that are included in the rate for Medicaid residents, these items should be added to the private resident charge to arrive at a comparable service for this test.

Form 2362 is initiated periodically by the county Department of Human Services and indicates the amount the resident is to pay toward his or her room and board. A copy is sent to the nursing home and a copy to the Medicaid fiscal agent for data entry.

Testing for extra charges is similar to testing the trust fund for covered services.

Nursing homes should use a separate ledger card for the transactions of a Medicaid Level II facility and for a Medicaid Level I facility.

Resident Accounts–Procedures

1. Select at least two private-pay resident accounts and determine the private room and board amount charged. This information can be used to determine that Medicaid residents are not charged more than private-pay residents for comparable services.
2. Select one Medicaid resident account for every 20 licensed beds (maximum 10) for review. Verify the use of the correct resident liability from Form 2362. Test the ledger entries for six months to determine that the charges, collections, and balances are correct and accurately recorded.
3. Scan all ledger accounts for unrefunded credit balances for only deceased or discharged residents.
4. Determine whether the facility maintained evidence that the resident's authorized representative was notified of a credit balance.
5. Test the selected accounts for nonallowable extra charges.

Independent Accountant’s Report

(Date)

The Honorable Bill Haslam, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and

Mr. Darin Gordon, Deputy Commissioner
Bureau of TennCare
310 Great Circle Road, 4W
Nashville, Tennessee 37243

Ladies and Gentlemen:

We have examined management’s assertions, included in its representation letter dated _____, that _____ complied with the following requirements on the “Medicaid Nursing Facility Level 1 Cost Report” for the period _____, through _____, and to the facility’s resident accounts for the period _____, through _____.

- Income and expenses reported on the cost report are reasonable, allowable, and in accordance with state and federal rules, regulations, and reimbursement principles.
- Resident days reported on the cost report have been counted in accordance with state regulations. Medicaid resident days billed to the state for periods when residents were hospitalized or on therapeutic leave are in accordance with the 85% occupancy rule and hospital and therapeutic leave rule in effect for the period tested.
- Charges to residents and charges to residents’ personal funds are in accordance with state and federal regulations.

As discussed in management’s representation letter, management is responsible for ensuring compliance with those requirements. Our responsibility is to express an opinion based on our examination.

Our examination was made in accordance with attestation standards established by the American Institute of Certified Public Accountants, and accordingly, included examining on a test basis, evidence about _____’s compliance with those requirements and performing such other procedures as we considered necessary under the circumstances. We believe that our examination provides a reasonable basis for our

Reporting and Auditing Requirements – Medicaid Cost Report Engagements - Section I

opinion. Our examination does not provide a legal determination on _____'s compliance with specified requirements.

Our examination disclosed the following instances of material noncompliance applicable to state and federal regulations:

- _____

In our opinion, except for the instances of material noncompliance described above, _____ complied with, in all material respects, the aforementioned requirements for the “Medicaid Nursing Facility Level 1 Cost Report” for the period _____, through _____, and for resident accounts for the period _____, through.

This report is intended solely for the information and use of the Tennessee General Assembly and the Tennessee Department of Finance and Administration. However, this report is a matter of public record, and its distribution is not limited.

Sincerely,

Arthur A. Hayes, Jr., CPA
Director