TENNESSEE COMPTROLLER OF THE TREASURY

TennCare Examination

United Neighborhood Health Services
Nashville, Tennessee

TennCare
Prospective Payment System
Visits and Payments

April 1, 2017, Through March 31, 2022

Jason E. Mumpower
Comptroller of the Treasury

DIVISION OF STATE AUDIT

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TENNESSEE COMPTROLLER OF THE TREASURY

TENNESSEE COMPTROLLER OF THE TREASURY

JASON E. MUMPOWER
Comptroller

May 15, 2024

The Honorable Bill Lee, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
Mr. Stephen Smith, Deputy Commissioner
Division of TennCare
Department of Finance and Administration
310 Great Circle Road, 4W
Nashville, Tennessee 37243

Ladies and Gentlemen:

Pursuant to Section 71-5-130, *Tennessee Code Annotated*, and a cooperative agreement between the Comptroller of the Treasury and the Department of Finance and Administration, the Division of State Audit performs examinations of Federally Qualified Health Centers (FQHCs) participating in the Tennessee Medical Assistance Program under Title XIX of the Social Security Act (Medicaid).

Submitted herewith is the report of the direct examination of TennCare Prospective Payment System visits and payments of United Neighborhood Health Services in Nashville, Tennessee, for the period April 1, 2017, through March 31, 2022.

Sincerely,

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

KJS/pn
23/021

DIVISION OF STATE AUDIT • TENNCARE EXAMINATION • MAY 2024

UNITED NEIGHBORHOOD HEALTH SERVICES

NASHVILLE, TENNESSEE

EXAMINATION HIGHLIGHTS

Examination Scope

TennCare Prospective Payment System Visits and Payments for the Period April 1, 2017, Through March 31, 2022

Monetary Finding

United Neighborhood Health Services did not accurately report TennCare Prospective Payment System visits and payments on its submitted quarterly settlement requests, which resulted in a net overpayment of $167,047

United Neighborhood Health Services overreported 1,380 TennCare Prospective Payment System visits and $32,247 in payments for the period April 1, 2017, through March 31, 2022. The overreporting of visits resulted in the clinic receiving increased TennCare quarterly settlements, which were partially offset by the overreported payments.

TennCare Examination
United Neighborhood Health Services, Nashville, Tennessee
TennCare Prospective Payment System Visits and Payments
April 1, 2017, Through March 31, 2022

Contents

Introduction

Purpose and Authority of the Examination

The terms of contract between the Tennessee Department of Finance and Administration and the Tennessee Comptroller's Office authorize the Comptroller of the Treasury to perform examinations of Federally Qualified Health Centers (FQHCs) that participate in the Tennessee Medicaid Clinic Prospective Payment System (PPS) Program.

Under their agreements with the state and as stated on cost reports submitted to the state, participating FQHCs have asserted that they are in compliance with the applicable state and federal regulations covering services provided to Medicaid-eligible recipients. The purpose of our examination is to render an opinion on whether paid TennCare PPS visits and payments received on behalf of TennCare enrollees are reported in accordance with the Tennessee State Plan under Title XIX of the Social Security Act Medical Assistance Program and guidance from the Division of TennCare for FQHCs.

General Background

Tennessee's Medicaid Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) is described in Attachment 4.19-B of the Tennessee State Plan under Title XIX of the Social Security Act Medical Assistance Program. FQHCs are eligible to apply to the Centers for Medicare and Medicaid Services for reimbursement under Medicare and Medicaid payment methodologies. The defining legislation for FQHCs is Section 1905(1)(2)(B) of the Social Security Act. A clinic's initial PPS rate is established using the allowable costs and visits as reported on the FQHC's cost report. After the initial rate is determined, the PPS rate is increased at the beginning of the state's fiscal year (July 1) based on the current change in the Medicare Economic Index.

After the end of each quarter, clinics submit a settlement request to the Office of the Comptroller of the Treasury with the number of PPS visits and payments for TennCare services. A clinic's PPS rate is multiplied by the clinic's self-reported visits to calculate the Medicaid PPS reimbursable costs. TennCare remits a quarterly settlement payment to the clinic for the difference between the clinic's Medicaid PPS reimbursable costs and the payments reported by the clinic.

PPS visits are medically necessary, face-to-face medical, mental health, or qualified preventive visits between the patient and a qualifying provider during which a qualified FQHC service is furnished, consistent with the federal regulations found in Title 42, *Code of Federal Regulations,* Part 405, Section 2463, and Part 440, Section 20(b)-(c). Behavioral health must be in the FQHC's scope of services approved by the state to be included in the settlement calculation.

PPS payments are all payments that the FQHC receives on behalf of TennCare enrollees; this includes amounts received on all services that were paid for the TennCare enrollee, even if it does not constitute a visit itself (such as labs, injections, or X-rays). FQHC payments include Managed Care Organization (MCO) payments, as well as all third-party liability, all patient liability, and any capitation payments received from MCOs. The Division of TennCare has issued guidance requiring payments for certain services to be excluded on settlement requests.

Maternity claims include a range of services related to pregnancy and delivery. These services are consolidated under a Global Obstetrical Package, which covers maternity care across three stages: antepartum (prenatal) care, delivery services, and postpartum care. MCOs generally pay maternity claims as a global bundled payment, and the actual payment for such visits only occurs after the pregnancy has ended. After receiving the payment, providers need to report the global payment in the quarter in which the pregnancy ended and report the related maternity visits on the settlement request in the quarter in which services were rendered. Providers must amend any prior quarter's settlement request to report the visit in the quarter in which that visit occurred.

Visits and payments for Medicare and dual enrollees are reimbursed on the Medicare payment system; therefore, they are not eligible for the TennCare PPS quarterly payment. For purposes of this program, dual enrollees are individuals enrolled in both Medicaid and Medicare Part B (or any Medicare-approved plan that includes Medicare Part B, such as Medicare Advantage). Medicare is the primary payor for dual enrollees. Chapter 1200-13-13-.09 of the *Rules of the Tennessee Department of Finance and Administration* states, "TennCare shall be the payor of last resort, except where contrary to federal or state law."

CoverKids is Tennessee's Children's Health Insurance Program, authorized by Title XXI of the Social Security Act and jointly financed and administered by the federal and state governments. CoverKids is available to children under age 19 and pregnant women who are not eligible for TennCare Medicaid. FQHCs should submit a separate quarterly settlement request to the Office of the Comptroller of the Treasury that contains the number of PPS visits and payments for CoverKids services. The state will make quarterly payments to the clinic for the difference between the clinic's Medicaid PPS reimbursable costs and payments reported by the clinic. This process for submitting settlement requests and receiving quarterly settlements is similar to TennCare's quarterly reimbursement; however, CoverKids visits and payments must be separately reported and paid due to the distinctly allotted federal funds. Therefore, CoverKids visits and payments are not included in the calculation of TennCare PPS visits and payments.

Before reporting any visits and payments on the settlement requests, all claims must be submitted to and deemed "paid" by the TennCare MCO.

United Neighborhood Health Services

United Neighborhood Health Services in Nashville, Tennessee, provides FQHC services and participates in Tennessee's Medicaid Prospective Payment System. The board of directors' members are as follows:

Claudia Barajas, President
Barb Zipperian, Vice-President
Ashia Cooper-Colquitt, Treasurer
Luis Sura, Secretary
Angela Ballou
John E. Baldwin
James Comer
Amanda Lowe
Brian Marshall
Brenda Morrow
Nick Scudellari
JD Thomas
John Zirker

The following PPS rates were in effect for the period covered by this examination:

Period	Prospective Payment System (PPS) Rate (044-1820)
April 1, 2017, through June 30, 2017	$150.14
July 1, 2017, through September 30, 2017	$151.94
October 1, 2017, through June 30, 2018	$163.16
July 1, 2018, through June 30, 2019	$165.44
July 1, 2019, through June 30, 2020	$167.93
July 1, 2020, through June 30, 2021	$171.12
July 1, 2021, through March 31, 2022	$173.51

The facility requested a change in scope; the request was approved, and a new rate was effective October 1, 2017. A change in the scope of services is defined as a change in the type, intensity, duration, or number of services.

Examination Scope

Our direct examination covers certain financial-related requirements of the Medicaid Federally Qualified Health Centers Prospective Payment System Program. The requirements covered are referred to in the Independent Accountant's Report. Our examination does not cover quality of care or clinical or medical provisions.

Prior Examination Findings

This is the first examination of this clinic.

Jason E. Mumpower
Comptroller

Independent Accountant's Report

August 10, 2023

The Honorable Bill Lee, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
Mr. Steven Smith, Deputy Commissioner
Division of TennCare
Department of Finance and Administration
310 Great Circle Road, 4W
Nashville, Tennessee 37243

Ladies and Gentlemen:

We have examined TennCare Prospective Payments System (PPS) visits and payments for United Neighborhood Health Services for the period April 1, 2017, through March 31, 2022. United Neighborhood Health Services management is responsible for reporting TennCare PPS visits and payments in accordance with the Tennessee State Plan under Title XIX of the Social Security Act Medical Assistance Program and guidance from the Division of TennCare for Federally Qualified Health Centers (FQHCs).

Our responsibility is to obtain reasonable assurance by evaluating TennCare PPS visits and payments against the Tennessee State Plan under Title XIX of the Social Security Act Medical Assistance Program and guidance from the Division of TennCare for FQHCs to determine whether TennCare PPS visits and payments were reported in accordance with the Tennessee State Plan under Title XIX of the Social Security Act Medical Assistance Program and guidance from the Division of TennCare for FQHCs, in all material respects, as well as performing other procedures to obtain sufficient appropriate evidence to express an opinion that conveys the results of our evaluation based on our examination.

Our examination was conducted in accordance with attestation standards for a direct examination engagement established by the American Institute of Certified Public Accountants. Those standards require that we obtain reasonable assurance by evaluating TennCare PPS visits and payments against

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the Tennessee State Plan under Title XIX of the Social Security Act Medical Assistance Program and guidance from the Division of TennCare for FQHCs as well as perform other procedures to obtain sufficient appropriate evidence to express an opinion that conveys the results of our evaluation of TennCare PPS visits and payments. The nature, timing, and extent of the procedures selected depend on our judgment, including an assessment of the risks of material misstatement of the reporting of TennCare PPS visits and payments in accordance with the Tennessee State Plan under Title XIX of the Social Security Act Medical Assistance Program and guidance from the Division of TennCare for FQHCs whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our modified opinion. Our examination does not provide a legal determination on the entity's compliance with specified requirements.

We are required to be independent of United Neighborhood Health Services and to meet our other ethical responsibilities, in accordance with relevant ethical requirements relating to the examination engagement.

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

- United Neighborhood Health Services did not accurately report TennCare Prospective Payment System visits and payments on its submitted quarterly settlement requests, which resulted in a net overpayment of $167,047.

In our opinion, because of the significance of the matter described above, TennCare PPS visits and payments for United Neighborhood Health Services for the period April 1, 2017, through March 31, 2022, were not correctly reported, in all material respects, in accordance with the Tennessee State Plan under Title XIX of the Social Security Act Medical Assistance Program and guidance from the Division of TennCare for FQHCs.

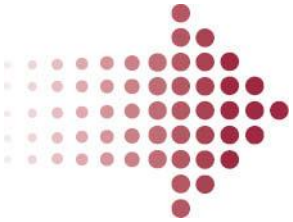
This report is intended solely for the information and use of the Tennessee General Assembly and the Tennessee Department of Finance and Administration and is not intended to be and should not be used by anyone other than these specified parties. However, this report is a matter of public record, and its distribution is not limited.

Sincerely,

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

KJS/pn

Finding and Recommendation



Finding

United Neighborhood Health Services did not accurately report TennCare Prospective Payment System visits and payments on its submitted quarterly settlement requests, which resulted in a net overpayment of $167,047

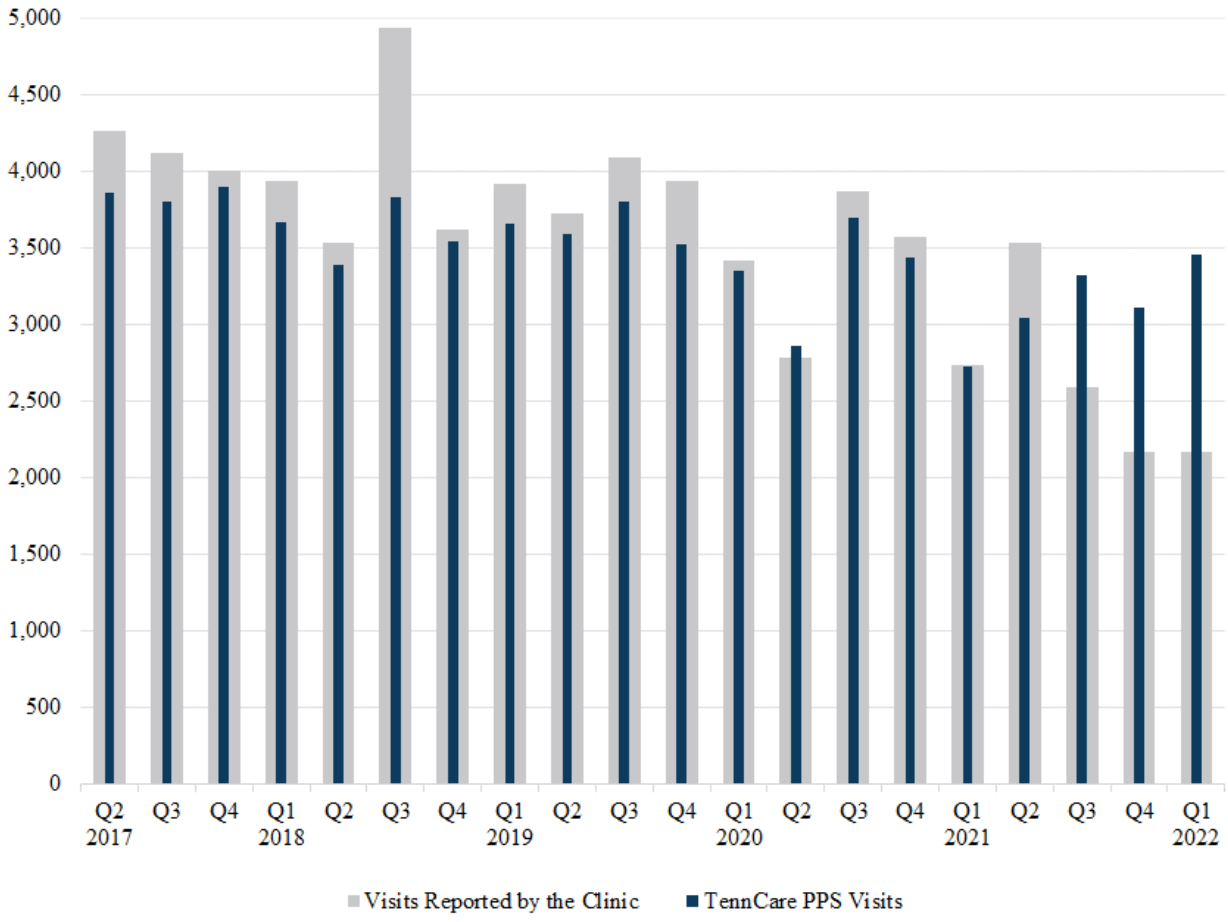
United Neighborhood Health Services (UNHS) did not accurately report TennCare Prospective Payment System (PPS) visits and payments for the audit period April 1, 2017, through March 31, 2022. Auditors used TennCare claims data and the clinic's electronic medical records to determine the number of TennCare PPS visits and payments for the entire examination period. The clinic overreported 1,380 visits for the period April 1, 2017, through March 31, 2022, and overreported $32,247 in payments for the same period. Auditors concluded that UNHS received a net overpayment of $167,047 for the period April 1, 2017, through March 31, 2022.

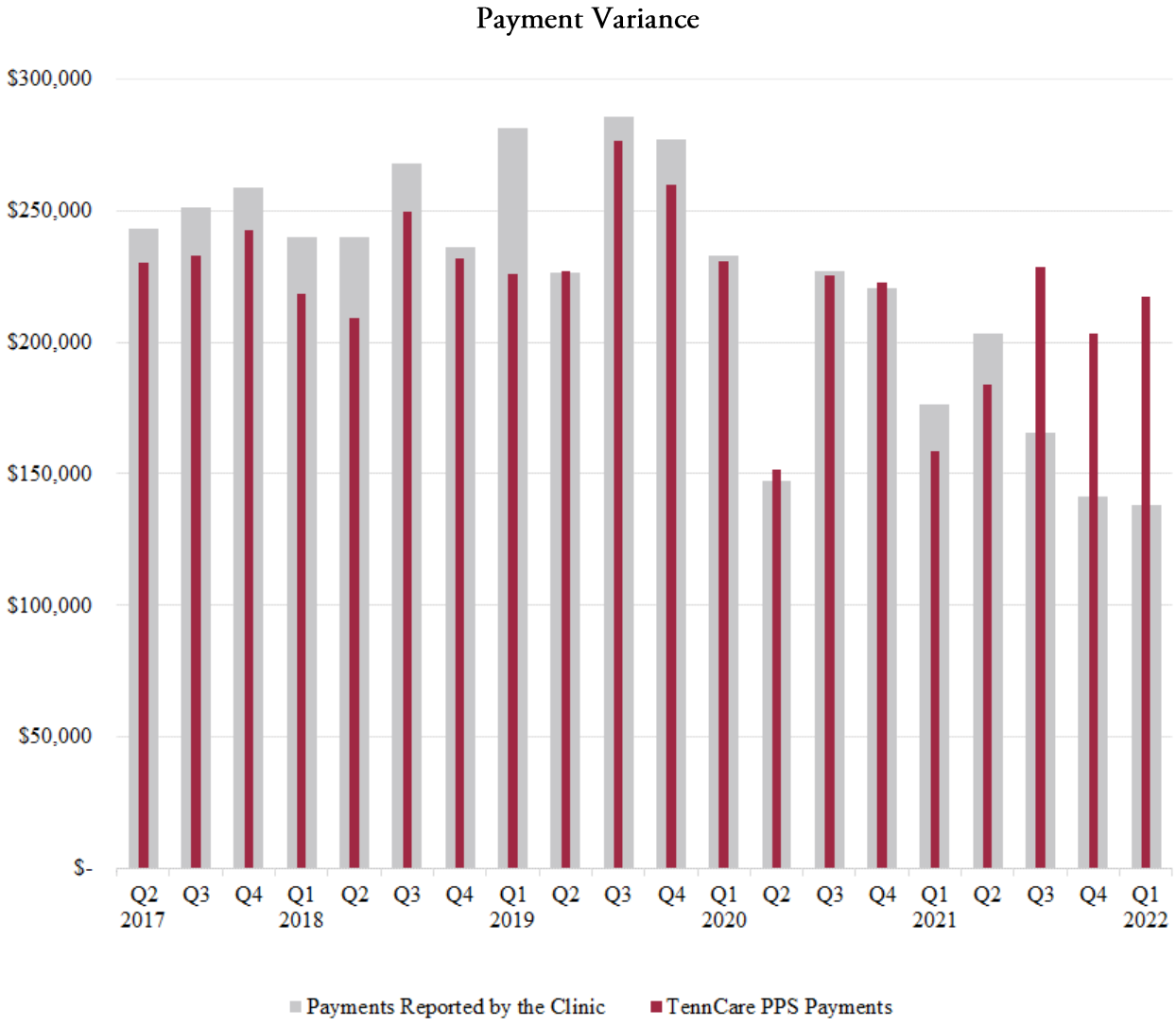
Of the $167,047 over-collected by the clinic, $475,223 was over-collected for the first 17 quarters during the examination, April 1, 2017, through June 30, 2021, and $308,174 was under-collected for the last three quarters, July 1, 2021, through March 31, 2022, resulting in a net overpayment of $167,047 for the audit period.

In the process of high-level review of United Neighborhood wrap around requests between November 2, 2021, and November 8, 2022, auditors discovered material discrepancies between the TennCare claims requests sent by UNHS and the supporting documentation UNHS provided for the last three quarters of the examination period. During the review process, auditors noted that dual enrollees were included in the wrap around requests submitted by the provider. Additionally, the clinic management acknowledged the requests were prepared based on payment date rather than the required reporting based on date of service. Auditors and the facility's representatives participated in numerous meetings discussing the discrepancies in the facility's report.

Auditors worked with clinic personnel throughout the year to get an accurate report; however, by the time the examination was opened, no accurate detailed supporting documentation was provided. At the beginning of the examination, auditors communicated to UNHS management to not include amendments to any quarters within the audit period, as they were going to be a part of the examination settlement calculation. As a result, settlements for the last three quarters of the examination period were considered incomplete at the start of the examination.

Visit Variance





Auditors selected two calendar quarters for further testing. The purpose was to determine how the clinic was preparing the quarterly settlement requests and what the clinic was including in the self-reported visits and payments. During the examination period, the clinic performed a hand count of the visits and payments from copies of the remittance advices. A cover sheet was prepared to summarize the visits and payments from the remittance advices. The visits and payments were then reported on an accumulation log, which was used to prepare the quarterly settlement requests. Auditors noted significant discrepancies while reviewing the remittance advices and accumulation logs. The amounts on the accumulation log did not always agree with the remittance advice summary. Manual counting of the visits and payments without a process to review for errors resulted in the clinic making clerical errors. Examples of errors noted in this process included the following:

- The payment amount of $680.49 was incorrectly included in the visit column on the accumulation log. The actual number of visits was 11.

- The accumulation log incorrectly documented 93 visits noted on a remittance advice when the actual total was 33.
- The accumulation log incorrectly documented 148 visits noted on a remittance advice when the actual total was 50.
- Ineligible procedure codes were counted as visits.
- Vaccine administration payments, which are not required to be included on the settlement request, were self-reported, which resulted in a reduced wrap around payment to the clinic.

To ensure that clinics are appropriately reimbursed for administering vaccines, the Division of TennCare determined that revenue received for vaccine administration fees with a date of service on or after January 1, 2021, should not be included in the PPS settlement reports.

Auditors provided United Neighborhood management with claims data to support visits and payments on the settlement calculation. This data included each paid TennCare claim-by-claim line with the patient's name, date of birth, date of service, procedure code, payment, and a visit indication denoting PPS visits. Additionally, auditors shared examples with the facility's management to demonstrate the discrepancies found during the review process.

Criteria

Title 42, *United States Code* (USC), Section 1320a-7k(d), contains obligations for health care providers regarding reporting and returning overpayments from the Division of TennCare or one of its contractors. Overpayments that are not returned within 60 days from the date the overpayment was identified can trigger a liability under the False Claims Act. The overpayment will be considered an "obligation" as this term is defined in 31 USC 3729(b)(3). The False Claims Act subjects a provider to a fine and triple the damages, called "treble damages," if he or she knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay money to the federal government.

Recommendation

United Neighborhood Health Services should establish procedures to ensure that it submits accurate quarterly settlement requests to the Office of the Comptroller of the Treasury. The requests should reflect the actual paid TennCare PPS visits and all monies received for TennCare services for each quarter reported.

Management's Comment

(Excerpts from the letters exhibited in their entirety in the Appendix)*

We respectfully disagree with the finding in the revised draft report for the reasons described herein and in our letter dated December 21, 2023.

The audit your office conducted makes no reference to (or even appear to use) the extensive data we compiled at the request of your staff.… We are unclear why your staff made such extensive, time-consuming requests of us when they ultimately relied on MCO-provided source data and accumulation logs.

We ask you to characterize all suspected discrepancies in precisely these terms rather than implying or stating these are substantiated overpayments.

The report states, "Overpayments that are not returned within 60 days of the date the overpayment was identified can trigger a liability under the False Claims Act." As previously noted, we dispute any characterization or treatment of suspected discrepancies as substantiated overpayments. We also note that absence in the draft report from August of any clarifications about (a) next steps in the process and (b) coordination with TennCare about formal notice, appeal rights, recoupment, etc. We remain concerned this wording may arguably trigger a legal liability for our health center without any instructions as to what we should do to address the underlying concern.

We have several times asked about the next steps in the process once your office issues its final report. Specifically, we asked whether and how TennCare or the Comptroller may demand (and accept) repayment – or whether TennCare or the Comptroller may simply recoup funds from future PPS payments (and if so, when and in what amounts). We also asked what if any written notice either your office or TennCare may provide in this regard. We continue to ask you to clarify this in the final report or in a parallel communication.

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* The excerpts above are the comments that are directly responsive to the finding.

Auditor's Comment

Auditors relied on the claims data obtained from the Division of TennCare and provided United Neighborhood Health Services with claims data to support the visits and payments on the settlement calculation. United Neighborhood Health Services could not provide detailed supporting documentation that agreed with the visits and payments reported by the clinic on its quarterly report. It is our understanding that management acknowledged the manual counting system was inevitably subject to unintended errors. Additionally, management made efforts to minimize these errors by transitioning from a manual calculation process to providing electronic data to a third-party contractor to ensure more accurate submissions. United Neighborhood Health Services has a responsibility to accurately report paid TennCare visits and payments on a quarterly basis, and the health center should maintain verifiable supporting documentation that agrees with the TennCare visits and payments reported by the clinic on its quarterly reports. Pursuant to Section 71-5-130, *Tennessee Code Annotated*, the Comptroller of the Treasury has the authority to audit this data. Upon the Division of TennCare's approval, State Audit will reprocess all quarterly settlements and transmit them to TennCare for recoupment of the overpayment. The Division of TennCare will make a final determination concerning payback.

Per the Division of TennCare, a repayment obligation is not triggered from the release of the examination report, until such time that TennCare identifies that an overpayment exists in a formal notice of action. See 42 CFR 433.300 et seq. When TennCare determines that an identifiable overpayment exists, consistent with TennCare Rule 1200-13-18-.04, a notice of action will be sent to the clinic or its representative detailing the action.

United Neighborhood Health Services
Settlement Calculation
Dates of Service 4/1/2017 to 3/31/2022

Year and Calendar Quarter	Visits Reported by Clinic	Payments Reported by Clinic	TennCare PPS Visits	TennCare PPS Payments	PPS Rate	Reimbursable Cost[1]	Quarterly Settlement Payments remitted to the Clinic	Total Payments[2]	Difference Between Total Payments and Reimbursable Cost
2017 Q2	4,264	243,064	3,860	230,125	150.14	579,540	397,132	627,257	(47,717)
Q3	4,118	$ 251,115	3,807	$ 232,941	$ 151.94	$ 578,436	$ 374,580	$ 607,521	$ (29,085)
Q4	4,007	258,480	3,904	242,760	163.16	636,977	395,302	638,062	(1,086)
2018 Q1	3,940	$ 239,827	3,665	$ 218,238	$ 163.16	$ 597,981	$ 403,023	$ 621,261	$ (23,279)
Q2	3,539	239,915	3,395	208,969	163.16	553,928	337,508	546,477	7,451
Q3	4,939	$ 267,921	3,837	$ 249,562	$ 165.44	$ 634,793	$ 549,208	$ 798,770	$ (163,977)
Q4	3,624	236,184	3,548	231,769	165.44	586,981	363,386	595,155	(8,174)
2019 Q1	3,923	$ 281,599	3,664	$ 226,128	$ 165.44	$ 606,172	$ 367,439	$ 593,567	$ 12,605
Q2	3,725	226,173	3,588	226,911	165.44	593,599	390,107	617,018	(23,419)
Q3	4,093	$ 285,485	3,809	$ 276,757	$ 167.93	$ 639,645	$ 401,836	$ 678,593	$ (38,948)
Q4	3,941	277,199	3,522	260,045	167.93	591,449	384,597	644,642	(53,193)
2020 Q1	3,422	$ 233,009	3,353	$ 230,939	$ 167.93	$ 563,069	$ 341,633	$ 572,572	$ (9,503)
Q2	2,786	147,425	2,860	151,718	167.93	480,280	320,417	472,135	8,145
Q3	3,874	$ 227,164	3,698	$ 225,480	$ 171.12	$ 632,802	$ 435,740	$ 661,220	$ (28,419)
Q4	3,577	220,678	3,435	222,888	171.12	587,797	391,406	614,294	(26,497)
2021 Q1	2,736	$ 176,287	2,724	$ 158,757	$ 171.12	$ 466,131	$ 291,888	$ 450,645	$ 15,486
Q2	3,537	203,117	3,040	183,696	171.12	520,205	402,122	585,818	(65,613)
Q3	2,588	$ 165,468	3,322	$ 228,639	$ 173.51	$ 576,400	$ 283,581	$ 512,220	$ 64,180
Q4	2,170	141,096	3,107	203,532	173.51	539,096	235,425	438,957	100,139
2022 Q1	2,172	$ 138,179	3,457	$ 217,284	$ 173.51	$ 599,824	$ 238,685	$ 455,969	$ 143,855
Total	70,975	$ 4,459,385	69,595	$ 4,427,138		$ 11,565,106	$ 7,305,015	$ 11,732,153	$ (167,047)

Under collected by Clinic: Overreported Payments	32,247
Over collected by Clinic: Overreported Visits	(199,294)
Over collected by Clinic	**$ (167,047)**

[1]Reimbursable Cost is calculated as number of TennCare PPS Visits multiplied by the clinic's effective PPS Rate for the period.

[2]Total Payments represents the sum of TennCare PPS Payments and Quarterly Settlement Payments remitted to the Clinic.

Appendix
United Neighborhood's Letters Containing Management's Comments, Addressed to State Audit Director Kathy Stickel

March 8, 2024, Comments

I am responding to the email from Maya Angelova dated February 28, 2024, and the revised examination report of TennCare visits and PPS payments for United Neighborhood Health Services (dba Neighborhood Health).

Before forwarding to me the revised report, Ms. Angelova and Karen Degges requested a conference call with me on that date to discuss the revised report. During this call, Ms. Angelova thanked me for the extensive comments we provided in our letter dated December 21, 2023, regarding the initial draft of the report. Ms. Angelova explained how the audit team had thoughtfully considered the extensive comments we submitted. Ms. Angelova noted she and her team, working with you, made several clarifying revisions to the draft audit report for Neighborhood Health. While Ms. Angelova said you did not feel you could not adopt all the recommendations we made or change certain things in this specific audit, she said your office is already using our comments and recommendations as you make several revisions to the current process. Thank you.

Ms. Angelova asked whether I would reconsider my earlier comments and submit revised comments in response to the new draft report. I agreed, and I promised to get you my new comments by this week. I summarize my comments below.

The Comptroller's staff dedicated extensive time and devoted considerable effort to this audit process. We appreciate their work and their helpfulness to us. We understand their work (and yours) helps to ensure the trustworthiness of our organizations. Before going any further, we want to say thank you again.

Response to Revisions

The revised report we received on February 28, 2024, includes on the cover a date reading "November 2023" (see the fourth page of the attachment Ms. Angelova provided). We assume this is a typographical error and that we are reviewing the latest draft that reflects our discussion and letter from December 2023. However, we do want to confirm this with you.

Based on our review of the revised report we received on February 28, 2024, we believe the authors made the following changes:

a) On Page 7, the report authors moved the figure/chart entitled "Visit Variance" to page 8.

By way of response, we have no objection to this change.

b) On Page 7, the report authors added one sentence to the first paragraph describing their process.

By way of response, our letter dated December 21, 2023, explains in detail our concerns about the lack of a written, consistently applied methodology and data collection. We continue to believe the auditors should address the methodological concerns raised in pp. 2-4 in our earlier letter. We incorporate by reference the full text of our December 21, 2023 letter in these formal responses, which I attach.

c) On Page 7, the authors added a paragraph describing the content in the figure/chart entitled "Visit Variance" in which the note Neighborhood Health overreported claims in some quarters and underreported claims in other (more recent quarters).

By way of response, we appreciate this descriptive clarification.

d) On Page 7, the authors added a sentence explaining how they found alleged discrepancies involved enrollees who are dually eligible for TennCare and Medicare.

By way of response, we are unclear about the intention of inserting this new sentence since the initial and revised reports both address this issue on page 2. Please advise if we may misunderstand the significance of this. Otherwise, we suggest you delete this new sentence.

e) On Page 7, the authors note Neighborhood Health management supplied data to auditors based on date of payment rather than date of service.

By way of response, Neighborhood Health did provide the requested data by date of service. Because the initial few requests also asked for the remittance advice number and/or check number, we mistakenly generated data based on date of payment (to match these other requests). However, we subsequently corrected this error and provided the data by date of service. Thus, we are unclear why the authors added this new sentence, and we request you remove it.

f) The authors added a paragraph in which they imply Neighborhood Health did not provide accurate detailed supporting documentation.

By way of response, please see our comments regarding (e) above. Also, our letter dated December 21, 2023, describes in detail the extent of data we provided. Thus, we believe this newly added paragraph to be incorrect, and we ask you to remove it.

g) On Page 10, the authors added a sentence to clarify how TennCare treats vaccine administration payments.

By way of response, we appreciate the addition of this new sentence. We believe the authors

should provide additional detail to address the underlying question and specific request we made in our letter dated December 21, 2023.

h) On page 10, the authors added a paragraph about the MCO data they provided to Neighborhood Health.

By way of response, we appreciate the addition of this new paragraph. We believe the authors should provide additional detail to address the underlying question and specific request we made in our letter dated December 21, 2023.

We apologize if we failed to notice any other changes in the revised report.

Following Up on Previous Requests

In our letter dated December 21, 2023, we provided 13 pages of detailed comments to the initial draft of the report. We also made seven specific requests. We restate these below and follow up with our updated comments:

1. We asked you to detail the audit methodology in writing so federally qualified health center (FQHCs) can provide feedback and suggestions. This transparency and technical review should help to refine and improve the process and avoid likely errors. It should also help to avoid unnecessary requests and expenditures.

   After reviewing the revised report, we continue to make this request of the authors and/or auditors for the reasons we detail in our letter dated December 21, 2023.

2. We asked you to clarify the net effect of any inclusion of vaccine administration payments on the settlement requests and what (if any) action is required. We also ask you to clarify the process to address qualified but mis-coded encounters.

   Please see our response above to (g) above.

3. We asked you to characterize all suspected discrepancies in precisely these terms rather than implying or stating these are substantiated overpayments.

   After reviewing the revised report, we continue to make this request of the authors for the reasons we detail in our letter dated December 21, 2023.

4. We asked you to remove the word "material" from any final report.

   After reviewing the revised report, we continue to make this request of the authors for the reasons we detail in our letter dated December 21, 2023.

5. We asked you to use a two-year lookback period for any final report, which we understand to be consistent with your future plans.

   After reviewing the revised report, we continue to make this request of the authors for the reasons we detail in our letter dated December 21, 2023.

6. We asked that you remove the False Claims Act language from any final report. If a final report does assert a potential liability under the False Claims Act, further detail and clarification on these points would be both appropriate and necessary.

   After reviewing the revised report, we continue to make this request of the authors for the reasons we detail in our letter dated December 21, 2023.

7. We asked that any final report acknowledge the issue of delayed PPS payments and the real costs we incurred as a result.

   After reviewing the revised report, we continue to make this request of the authors for the reasons we detail in our letter dated December 21, 2023.

Draft Finding in Revised Report

We respectfully disagree with the finding in the revised draft report for the reasons described herein and in our letter dated December 21, 2023.

Draft Recommendation in Revised Report

The revised draft report recommends Neighborhood Health establish procedures to ensure it submits accurate quarterly settlement requests. To that end, we believe the Division of TennCare's adoption of clearer, more consistent policy guidance on October 17, 2023, is a hugely helpful first step that will facilitate this goal. As we have previously shared with you, Neighborhood Health has transitioned from a manual calculation process to providing electronic data to FORVIS, a third-party contractor, to ensure accurate submissions. Taken together, we had hoped these developments would minimize the risk of suspected discrepancies in the future.

During the meeting on November 16, 2023, at TennCare, TennCare officials and Julie Rogers of your staff explained the State plans to rely on the MCO-provided source data. We believe the transition to the use of MCO-supplied source data to be a reasonable step forward **provided that** TennCare and your office address the source data concerns we have previously highlighted.

Requested Clarification

We have several times asked about the next steps in the process once your office issues its final report. Specifically, we asked whether and how TennCare or the Comptroller may demand (and accept) repayment – or whether TennCare or the Comptroller may simply recoup funds from future PPS payments (and if so, when and in what amounts). We also asked what if any written notice either your office or TennCare may provide in this regard. We continue to ask you to clarify this in the final report or in a parallel communication.

Looking Forward: Addressing Source Data Concerns

As we discussed in December 2023, we understand no data source or dataset is perfect. We also agree the MCO-provided source data, while sometimes incomplete or erroneous, may be the best available data for your purposes. As evidenced by this response and the technical suggestions we have shared, we want to work collaboratively to refine an approach to minimize the difference between (a) suspected discrepancies and (b) actual discrepancies.

Even with our best collective efforts the MCO-provided source data will not (and cannot be expected to be) 100% accurate or reliable. A recent example illustrates this challenge. One of the TennCare MCOs, United Healthcare, recouped payments from Neighborhood Health for several hundred encounters with dates of service during 2021 and 2022 because United's representatives said United paid us using the wrong fee schedule. United remitted the corrected payment amounts in Q3 of CY 2023 for1,892 encounters with dates of service during 2021.These issues obviously affect any MCO-provided source data for PPS payments. Thus, any reliance on MCO-provided source data to automate the process does not guarantee 100% accuracy, and manual intervention would still be required. The challenge here is compounded if the TennCare MCOs do not consistently apply exactly the same procedure when addressing these types of situations.[1]

Given this context, TennCare and the Comptroller could develop an approach consistent with federal requirements and responsive to the underlying source data concerns. Specifically:

1. **While auditors would report all suspected discrepancies, the auditors could use a "PERM-like" threshold for further inquiry.** The quality of the MCO-provided source data and the inherent methodological limitations of the audits will necessarily yield estimates with margins of error or confidence intervals. In this context, we think the federal three percent PERM standard (or similar threshold) might best guide audits and decision-making.[2]

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[1] Please be assured we are manually removing the affected encounters from any future request for PPS payments we submit using the FORVIS system.

[2] Following *Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 529 U.S. 765 (2000), state agencies may not be subject to federal False Claims Act in the same way FQHCs are. However, this does not moot the relevance of the federal three percent PERM standard in the context of these audits of PPS payments to FQHCs. Paralleling the FCA requirements that apply to FQHCs, state agencies have similar obligations (albeit without treble damages) under other statutes such as the federal Improper Payments Act (Pub. L. 107-300), as amended, and their implementing regulations, etc.

By way of illustration, an audit team from the Comptroller's Office could document and report 157 suspected discrepancies between MCO-provided source data and PPS payments at one FQHC. The audit team could decide that the proportion of these 157 suspected discrepancies to 42,384 total payments during the same period (i.e., 0.37%) did not merit further review because of the inherent data limitations. (The audit team would still, of course, report their findings of suspected discrepancies). Conversely, the same audit team may conclude additional scrutiny to be appropriate if the suspected discrepancies exceeded 1.00%, 2.00%, or 3.00%. Again, the audit team would in all situations report their findings regarding suspected discrepancies – but focus further reviews where the preliminary results are most indicative of overpayments.

2. **TennCare and the Comptroller would allow for an administrative review process for any denials of PPS payments.** If and as TennCare and the Comptroller's Office transition to the use of MCO-provided source data for PPS payments, the Comptroller could request paid claims data directly from the MCOs, apply the appropriate filtering criteria to the MCO-provided source data, and remit to FQHCs only the PPS payments the Comptroller believes are due based on the MCO-provided source data. The Comptroller could then give FQHCs the opportunity to request PPS payments for eligible claims the MCOs may not have provided to the Comptroller or for which the Comptroller chose not to remit a PPS payment. Alternatively, the State could require the MCOs remit PPS payments directly to FQHCs as is done in Medicare, by Medicare Advantage plans.[3] Importantly, though, the Comptroller may want to exclude all such successfully appealed claims and resulting PPS payments from further audit since each such item will already have received close scrutiny.

As I shared during our meeting with you and your team on December 14, 2023, I am happy to work closely with your team on these issues. While I will be on extended leave starting this week through mid-June 2024, I look forward to connecting upon my return and helping in any way I can.

Again, we appreciate the work and dedicated efforts of the Comptroller's staff. We understand these issues are inherently complex, and I am grateful to you for the opportunity to provide this response.

[3] Indeed, the federal statute governing Medicaid PPS payments in managed care contexts at 42 U.S.C. § 1396(bb)(5)-(6) would permit both approaches.

December 21, 2023, Comments

I am responding to the letter to Ivan Figueredo, our Chief Financial Officer, dated October 17, 2023, regarding the draft examination report of TennCare visits and PPS payments for United Neighborhood Health Services (dba Neighborhood Health). Per the extension we received from Julie Rogers in your office allowing us to draft a more complete response, this letter supersedes and entirely replaces our preliminary response to Julie Rogers dated October 27, 2023. We respectfully dispute the preliminary findings in the draft report for the reasons I detail below.

The Comptroller's staff dedicated extensive time and devoted considerable effort to this audit process. We appreciate their work and their helpfulness to us. We understand their work (and yours) helps to ensure the trustworthiness of our organizations. Before going any further, we want to say thank you.

Because I take so seriously our obligations as a recipient of public funds, I personally wrote this response and have attended each meeting referenced above. Throughout, I try to share detailed examples, substantive footnotes with authoritative references, and suggestions as to possible improvements. I also include below 7 specific requests. I request you include this response in full (unedited) with any final report.

Background

The letter dated October 17, 2023, includes a draft report dated August 10, 2023. The draft report from August summarizes the recent audit of Prospective Payment System (PPS) payments to United Neighborhood Health Services (dba Neighborhood Health) between April 1, 2017, to March 31, 2022. The draft report from August appears to rely entirely on data from TennCare managed care organizations (MCOs). The draft report from August notes suspected discrepancies in actual compared to billed encounters during this period. Of the total $11,732,153 payments to Neighborhood Health during this time, the draft report from August found that the auditors were able to substantiate $11,565,106 (or 98.6% of the total payments). The draft report from August indicates auditors may not have been able to substantiate or justify $167,047 (or 1.4% of the total net payments). The draft report from August noted not all suspected discrepancies were in favor of Neighborhood Health; in several quarters, Neighborhood Health actually may have underbilled the State.

Given the complexity of the issues involved and the number of FQHCs affected, Libby Thurman of the Tennessee Primary Care Association (TPCA) requested a meeting of TennCare officials, Julie Rogers, and the Chief Executive Officers of several FQHCs. We met on November 16, 2023, at TennCare. Libby Thurman subsequently scheduled a meeting with you and your team at the Comptroller's Office, and we met with you on December 14, 2023. We thank you for taking time to discuss these matters. This letter references and follows up on several points we discussed during those meetings.

Where We Can Agree

The draft report from August on p. 9 states, "Manual counting of the visits and payments without a process to review for errors resulted in the clinic making clerical errors." We agree the manual counting system is inefficient and prone to error. We adopted this approach because it was the only mechanism available to us (and many other FQHCs) at that time to generate the PPS settlement requests in the form and with the frequency the State required. Based on our review to date, we agree these manual processes may have led to some potential errors. However, we remain unclear as to the net effect of these errors and other appropriate adjustments.

We also agree a more automated system would avoid these errors. We have already replaced the manual system with a new, more automated approach. However, the business context and administrative actions by MCOs will always require some level of manual review and intervention.[1] Also, subsequent developments at the State may again require us to adopt a different approach.

Unnecessary Requests and Expenditures

Before we respond in more detail to the content of the draft report from August, I would be remiss if I neglected to share two over-arching concerns about the audit process and the methodology:

1. **The audit your office conducted makes no reference to (or even appear to use) the extensive data we compiled at the request of your staff.** Initially, we understood your staff to have requested roughly five years of MCO payment data from us based on dates of encounters. Your staff later followed up and changed the request such that it was based on dates of payments from the TennCare MCOs. The MCO payments at the beginning of this period were by paper check, and the remittance advices were not in a form we could upload to our electronic health record (NextGen, which is the electronic health record most FQHCs use). When we brought this to the attention of your team, they told us we nonetheless had to figure out a way to comply with their requests and these specific parameters. Consequently, we had to manually search individual records, match payments with remittances and encounters, and laboriously compile data sets using the revised parameters. We also produced boxes of paper-based content (e.g., copies of checks from MCOs, etc.) which your staff reviewed.

   We spent hundreds of hours working to fulfill these requests within the relatively short deadlines provided, and this work had a substantial impact to our health center. The manual matching work induced our senior data analyst to retire early, which was a significant loss to our small organization. We also had to incur the costs to hire temp staff to help us assemble the requested data so our regular billing staff did not fall too far behind in their daily work.

[1] See pp. 3 and 8 *supra*.

In addition, we estimate we lost substantial TennCare revenues because the efforts to respond to these data requests from your team caused us to miss claim filing or appeal deadlines. Yet, the draft report from August appears to rely exclusively on MCO-provided source data (or "835 files") and "accumulation logs,"[2] which entirely moots most of the requests your staff made of our team and effectively renders much of our work meaningless. We are unclear why your staff made such extensive, time-consuming requests of us when they ultimately relied on MCO-provided source data and accumulation logs.

2. **Based on the representations of your staff, we also made plans and continue to incur expenses on third party contractors in an effort to be prepared for such reviews that now appear to be unnecessary.** Specifically, we (and several other FQHCs) signed contracts with FORVIS, and we have spent countless additional hours with them to refine their algorithm and data architecture (as well as hours spent inputting data into their platform to facilitate reporting) to meet the needs your team had articulated. We did this to ensure we had appropriate systems in place to ensure the integrity of our submissions using the parameters your team had shared. If your team had from the beginning said they would rely solely on MCO-provided source data both for this audit and on a prospective basis, we could have saved this time and expense and instead invested these resources in patient care.

We remain deeply concerned about these issues and the impact to us (both in financial terms and in staff morale) and to our patients. We welcome the opportunity to discuss these further with the goal of preventing any re-occurrence of these issues.

Uncertain Methodology

The draft report from August states on p. 9, "Auditors used TennCare claims data and the clinic's electronic medical records to determine the number of TennCare PPS visits and payments for the entire examination period." Elsewhere in the document, the draft report from August references accumulation logs and other business records. The draft report from August does not share the date on which the MCO-provided source data was provided and received, nor were staff from the Comptroller's staff able to clarify for us the ways in which the MCO- provided source data accounted for retroactive eligibility, recoupments/repayments, and other administrative adjustments. These issues of retroactive eligibility and recoupments/repayments can be significant.[3]

> ***Specific Request #1:*** We ask you to detail the audit methodology in writing so FQHCs can provide feedback and suggestions. This transparency and technical review should help to refine and improve the process and avoid likely errors. It should also help to avoid unnecessary requests and expenditures.

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[2] We assume this term refers to spreadsheet logs we use internally. Please advise if this is incorrect.

[3] *See* pp. 4-5 and 8-9 *supra*.

The draft report from August also states on p. 9, "Vaccine administration payments, which are not required to be included on the settlement request, were included." As we interpret this comment, we included revenues from MCOs for vaccine administration, which were erroneously deducted from our PPS payments. However, neither the draft report from August nor the spreadsheet detail explains these implications or the net effects. Likewise, the draft report from August states, "Ineligible procedure codes were counted as visits." We are unclear whether the potential error here is in the MCO-provided source data or in our records. We are also unclear as to how we should address situations in which we may have mis-coded a truly qualified encounter and how we should address such situations to document the validity of the associated PPS payment.

> ***Specific Request #2:*** We ask you to clarify the net effect of any inclusion of vaccine administration payments on the settlement requests and what (if any) action is required. We also ask you to clarify the process to address qualified but mis-coded encounters.

Suspected Rather Than Actual Discrepancies

Several factors may yield suspected discrepancies between PPS payment data and MCO- provided source data, only some of which yield actual discrepancies (and potential overpayments). By way of illustration:

1. **Both TennCare and FQHCs appear to agree that the extant policy detail and procedural guidance from the State available during this period was woefully insufficient.**
   The draft report from August alleges Neighborhood Health did not report PPS encounters correctly "…in all material respects, in accordance with the Tennessee State Plan under Title XIX and guidance from the Division of TennCare for FQHCs." However, the State Plan contains very little information about the operation of the PPS program.[4] Further, the Division of TennCare lacked clear, consistent policy guidelines and interpretive guidance related to the Prospective Payment System (PPS) at the beginning of the audit period in early 2017.[5] In the intervening years, the Division of TennCare, the Comptroller's Office, and representatives from TPCA and its member FQHCs worked collaboratively to address this

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[4] *See* Tennessee State Plan, Attachment 4.19B, pp. 8-11, https://www.tn.gov/content/dam/tn/tenncare/documents2/4-19-b.pdf. As of the August date of the draft report, TennCare had not updated this content since September 20, 2006.

[5] Federal policy guidance about PPS payments to FQHCs in the Medicaid content has been equally vague, and the absence of implementing regulations has confounded the challenge. *See generally* Centers for Medicare and Medicaid Services, "FQHC and RHC Supplemental Payment Requirements and FQHC, RHC, and FBC Network Sufficiency under Medicaid and CHIP Managed Care," State Health Official (SHO) Letter # 16-006, April 26, 2016, available at https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/SMD16006.pdf, accessed October 23, 2023 (summarizing the limited federal guidance on this topic).

lack of policy specificity and interpretive guidance. In fact, the Division of TennCare just revised and reissued the PPS Settlement Manual earlier this month.[6] We fear this acknowledged uncertainty, particularly during the earlier part of the audit period, was a factor leading to suspected discrepancies.

2. **The MCO-provided source data may be dated, imprecise, or simply inaccurate.** These limitations may undermine the methodology of this audit.[7] For example, Neighborhood Health provides care to a disproportionate number of individuals who qualify for Supplemental Security Income (SSI) and, thus, TennCare on the basis of disability.[8] As a federally qualified health center (FQHC), we provide this care to these individuals while they are uninsured and waiting for their SSI determination (and enrollment in TennCare). Prior to the pandemic, these individuals waited on average 25 months for their SSI determination and typically remained uninsured during this period.[9] (The wait time has only increased since the onset of the COVID pandemic in March 2020.) When Social Security approves an individual's SSI application, the individual's SSI benefits (and, consequently, his or her TennCare coverage) is retroactively effective back to the date of the SSI application. Given the retroactive TennCare coverage, Neighborhood Health may submit claims for services rendered during this period – but months and even years after the date of service. We are unclear how the MCOs, TennCare, or the Comptroller's Office account for these encounters, update their data, or correct or adjust for the effects. This is just one example where suspected discrepancies may arise and yet, the underlying claim for a PPS payment from an FQHC would be entirely valid and appropriate to pay. **Stated differently, a suspected discrepancy is not the same as a substantiated overpayment and should not be characterized or treated as such.**

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6 Division of TennCare, Prospective Payment System (PPS) Settlement Manual, rev. October 2023, available at https://www.tn.gov/content/dam/tn/tenncare/documents/PPSSettlementManualForFQHCAndRHCProviders.pdf, accessed October 23, 2023. On October 17, 2023, Libby Thurman, Chief Executive Officer of TPCA, shared related news; we include as Attachment A her update.

7 The Comptroller's past reliance on FQHC-supplied data to calculate and remit PPS payments suggests at least tacit recognition the MCO data may be dated, imprecise, or inaccurate. See additional comments and another example on pp. 8-9 *supra*.

8 Tennessee is a "1634" state, meaning TennCare automatically enrolls individuals who qualify for SSI when the Social Security Administration transmits notice of eligibility to TennCare via the SDX interface. *See* Social Security Administration, "SI 01730.005: Social Security Administration/State Agreements under Section 1634," Program Operations Manual System (POMS), available at http://policy.ssa.gov/poms.nsf/lnx/0501730005, accessed October 24, 2023 (summarizing 1634 agreements and Medicaid eligibility). *See also* "SI 01715.020 List of State Medicaid Programs for the Aged, Blind and Disabled," available at http://policy.ssa.gov/poms.nsf/lnx/0501715020, accessed October 24, 2023 (listing 1634 agreements with states including Tennessee).

9 This is an estimate of the current median processing time in Nashville's Social Security field office. This assumes four months for initial decisions with an approval rate of 30%, four additional months for reconsideration decisions with an approval rate of 10%, and 14 additional months for hearings (or re-hearings) with an approval rate of 80%. We rely on pre-pandemic estimates of processing times in our modeling estimates. *See* Social Security's data at https://www.ssa.gov/open/data/program-service-centers.html#dataDictionary and https://www.ssa.gov/appeals/DataSets/01_NetStat_Report.html.

When we raised this issue about retroactivity and timing of claims during the meeting with you on December 14, 2023, you said you were unfamiliar with the technical details (which we certainly understand). Your staff who attended the meeting were also unable to clarify the matter or explain which MCO files they used, the date on which they obtained these, and the manner in which the MCOs adjust for these concerns. You said your office would carefully review this and consult with TennCare on these issues. In hopes of being helpful, we offered several technical suggestions that might prove helpful to avoid these issues in similar audits going forward.[10] Thank you for your consideration of our concerns and our recommendations here.

Notwithstanding these concerns, we began a review of the suspected discrepancies your staff provided. We suspended that review following our meeting on December 14, 2023, when you and your staff indicated may be making multiple changes.

> ***Specific Request #3:*** We ask you to characterize all suspected discrepancies in precisely these terms rather than implying or stating these are substantiated overpayments.

Materiality

We disagree with any characterization of the suspected discrepancies and alleged noncompliance as "material." Federal policy in this area is particularly instructive. The federal government itself has a Payment Error Rate Measurement (PERM) it uses to assess erroneous and improper payments in State-administered Medicaid and Children's Health Insurance (CHIP) programs.[11] That program establishes a three (3) percent threshold under which the State is essentially "held harmless" for any suspected overpayments.[12] Here, the suspected discrepancies are less than half the federal threshold. Particularly given the methodological issues in the audit noted herein, the federal PERM standard should arguably govern here both in respect to what is considered "material" and whether any recoupment or repayment is warranted. This is particularly true for the five-year retrospective period that is the subject of the present audit.

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[10] Specifically, I suggested your staff could use different lookback periods for different eligibility codes or aid groups. For example, your staff working in early 2024 might review claims for 2021-2022 for aid codes for those enrollees for whom TennCare uses the modified adjusted gross eligibility (MAGI) rules (i.e., minor children, parents/caretaker relatives, and pregnant women) while using a lookback period of 2019-2020 for those whom TennCare conferred eligibility based on a data interface transaction with Social Security (i.e., SSI recipients). These and other approaches should help to minimize the difference between suspected and actual discrepancies and focus on those most likely to have generated overpayments.

[11] *See* 42 C.F.R. § 4431.800 *et seq*. *See also*, Centers for Medicare and Medicaid Services, "Improper Payment Measurement Programs: Laws and Regulations," [website], available at https://www.cms.gov/data- research/monitoring-programs/improper-payment-measurement-programs/payment-error-rate-measurement- perm/laws-and-regulations, accessed October 20, 2023 (summarizing applicable federal statute and regulations on this topic).

[12] 42 U.S.C § 1396b(u); 42 C.F.R. § 431.1010. *See generally*, Centers for Medicare and Medicaid Services, Payment Error Rate Measurement (PERM) Manual, May 2020, available at https://www.cms.gov/files/document/perm- manual.pdf, accessed October 24, 2023 (summarizing the sampling and assessment process and three percent error threshold).

Specific Request #4: We ask you to remove the word "material" from any final report.

When we raised this concern in the meeting with you on December 14, 2023, you said your office would carefully review this language and use of the word "material." Thank you for your consideration of our concerns in this regard.

Lookback Period

Your office shared with us on October 17, 2023, a draft report from August for the period April 1, 2017, to March 31, 2022. Given the long delays in the Comptroller's audit process and other concerns detailed herein, we believe it unreasonable and inconsistent with other governmental standards to attempt to recoup overpayments to Neighborhood Health more than six years prior to the date of the reports identifying the suspected discrepancies.

While TennCare itself has not set the lookback period that applies, each relevant authority has generally set a maximum six-year lookback period. The federal False Claims Act, as amended, generally has a six-year limit for such claims (though it can extend to 10 years in certain circumstances, none of which apply here).[13] Similarly, the Tennessee Medicaid False Claims Act (TMFCA) generally has a six-year limit for civil actions, though it, too, can be extended in the same manner as the federal law.[14] Intentionally mirroring the six-year lookback period under the False Claims Act, the federal Centers for Medicare and Medicaid Services adopted a six-year lookback period for overpayments from Medicare to health care providers.[15] Interestingly, these lookback periods are all substantially longer than the lookback periods under Tennessee law for overpayments to health care providers by regulated health insurance entities outside of TennCare.[16]

You certainly can use shorter lookback periods. As your recent comments to us suggest, you have the authority to use a shorter lookback period than any six-year maximum. During the meeting on December 14, 2023, you and your staff indicated future audits would have a shorter, two-year lookback period. Thank you for making this change.

> ***Specific Request #5:*** We ask you to use this same two-year lookback period for any final report, which we understand to be consistent with your future plans.

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13 31 USC §§ 3731(b)(1) and 3808(a).

14 Tenn. Code Ann. § 71-5-184(b); Tenn. Comp. R. & Regs. 1200-13-18-.03(8).

15 42 CFR § 401.305(f); 81 Fed. Reg. 7654-84, 7671 (Feb. 12, 2016).

16 *See* Tenn. Code Ann. § 56-7-110(c) (stating "Except in cases of fraud committed by the health care provider, a health insurance entity may only recoup reimbursements to the provider during the eighteen-month period after the date that the health insurance entity paid the claim submitted by the health care provider."); Op. Tenn. Atty. Gen. 09- 157 (September 16, 2009).

References to the False Claims Act

The draft report from August on p. 9 characterizes the suspected discrepancies as overpayments subject to the False Claims Act.[17] The report states, "Overpayments that are not returned within 60 days of the date the overpayment was identified can trigger a liability under the False Claims Act." As previously noted, we dispute any characterization or treatment of suspected discrepancies as substantiated overpayments. We also note that absence in the draft report from August of any clarifications about (a) next steps in the process[18] and (b) coordination with TennCare about formal notice, appeal rights, recoupment, etc. We remain concerned this wording may arguably trigger a legal liability for our health center without any instructions as to what we should do to address the underlying concern.

> ***Specific Request #6:*** We ask that you remove the False Claims Act language from any final report. If a final report does assert a potential liability under the False Claims Act, further detail and clarification on these points would be both appropriate and necessary.

When we raised this concern in the meeting with you on December 14, 2023, you said your office would carefully review this language and consult with TennCare on this issue. Thank you for your consideration of our concerns in this regard.

Payment Delays

The draft report from August did not reference the timing of the PPS payments and the extensive delays we experienced in receiving these funds. We do not believe the delay in these payments is consistent with the requirements of the Tennessee Prompt Pay Act of 1985, as amended.[19]

The amounts involved just to Neighborhood Health are considerable. Each year, we receive approximately $1.60 million in PPS payments. This is consistent with the amount reported in Table 1 below for CY 2021. However, the amount decreased by 40% to $0.96 million during CY 2022.

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17 31 U.S.C. § 3729(b)(3).

18 For example, neither the draft report from August nor extant policy documents nor procedural guidance clarify whether and how an FQHC should remit repayment to TennCare or the Comptroller – or whether TennCare or the Comptroller would seek to recoup these amounts from future payments.

19 Tenn. Code Ann. § 12-4-701 *et seq.*

Table 1: PPS Payments to Neighborhood Health by Year Received

Period We Received PPY Payments	Total PPS Payments Received
January 1 to December 31, 2021	$1,605,959.62
January 1 to December 31, 2022	$957,862.59
January 1 to December 20, 2023	$2,400,576.14

The staff from the Comptroller's Office instructed us not to submit PPS payment requests for certain encounters prior to April 1, 2022, which explains this precipitous decrease.[20] When we were eventually allowed to submit the pending PPS payment requests, we received many of the outstanding PPS payments later in 2023.

We have not previously complained about these delays or sought an estimated $41,250 in interest on the outstanding amounts that may have been due. However, the omission of this issue from draft report from August is concerning.

> ***Specific Request #7:*** We ask that any final report acknowledge the issue of delayed PPS payments and the real costs we incurred as a result.

Corrective Action

The draft report from August specifically asks us to identify the corrective actions we have implemented and are taking. We believe the Division of TennCare's adoption of clearer, more consistent policy guidance on or about October 17, 2023, is a hugely helpful first step. As noted earlier, Neighborhood Health has transitioned from a manual calculation process to providing electronic data to FORVIS, a third-party contractor, to ensure accurate submissions. Taken together, we had hoped these developments would minimize the risk of suspected discrepancies in the future.

During the meeting on November 16, 2023, at TennCare, TennCare officials and Julie Rogers of your staff explained the State plans to rely on the MCO-provided source data. We believe the transition to the use of MCO-supplied source data to be a reasonable step forward **provided that** TennCare and your office address the source data concerns we have outlined.

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[20] Specifically, the Comptroller's staff instructed us not to submit PPS payment requests with dates of service prior to April 1, 2022, for which the MCOs remitted payments to us after that date. Neighborhood Health and other FQHCs also experienced other delays in receiving PPS payments.

Looking Forward: Addressing Source Data Concerns

We understand no data source or dataset is perfect. We also agree the MCO-provided source data, while sometimes incomplete or erroneous, may be the best available data for your purposes. As evidenced by this response and the technical suggestions we have shared, we want to work collaboratively to refine an approach to minimize the difference between (a) suspected discrepancies and (b) actual discrepancies.

Even with our best collective efforts the MCO-provided source data will not (and cannot be expected to be) 100% accurate or reliable. A recent example illustrates this challenge. One of the TennCare MCOs, United Healthcare, recouped payments from Neighborhood Health for several hundred encounters with dates of service during 2021 and 2022 because United's representatives said United paid us using the wrong fee schedule. United remitted the corrected payment amounts in Q3 of CY 2023 for 1,892 encounters with dates of service during 2021. These issues obviously affect any MCO-provided source data for PPS payments. Thus, any reliance on MCO-provided source data to automate the process does not guarantee 100% accuracy, and manual intervention would still be required. The challenge here is compounded if the TennCare MCOs do not consistently apply exactly the same procedure when addressing these types of situations.[21]

Given this context, TennCare and the Comptroller could develop an approach consistent with federal requirements and responsive to the underlying source data concerns. Specifically:

1. **While auditors would report all suspected discrepancies, the auditors could use a "PERM-like" threshold for further inquiry.** The quality of the MCO-provided source data and the inherent methodological limitations of the audits will necessarily yield estimates with margins of error or confidence intervals. In this context, we think the federal three percent PERM standard (or similar threshold) might best guide audits and decision-making. [22] By way of illustration, an audit team from the Comptroller's Office could document and report 157 suspected discrepancies between MCO-provided source data and PPS payments at one FQHC. The audit team could decide that the proportion of these 157 suspected discrepancies to 42,384 total payments during the same period (i.e., 0.37%) did not merit further review because of the inherent data limitations. (The audit team would still, of course, report their findings of suspected discrepancies.) Conversely, the same audit team may conclude additional

[21] Please be assured we are manually removing the affected encounters from any future request for PPS payments we submit using the FORVIS system.

[22] Following *Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 529 U.S. 765 (2000), state agencies may not be subject to federal False Claims Act in the same way FQHCs are. However, this does not moot the relevance of the federal three percent PERM standard in the context of these audits of PPS payments to FQHCs. Paralleling the FCA requirements that apply to FQHCs, state agencies have similar obligations (albeit without treble damages) under other statutes such as the federal Improper Payments Act (Pub. L. 107-300), as amended, and their implementing regulations, etc.

scrutiny to be appropriate if the suspected discrepancies exceeded 1.00%, 2.00%, or 3.00%. Again, the audit team would in all situations report their findings regarding suspected discrepancies – but focus further reviews where the preliminary results are most indicative of overpayments.

2. **TennCare and the Comptroller would allow for an administrative review process for any denials of PPS payments.** If and as TennCare and the Comptroller's Office transition to the use of MCO-provided source data for PPS payments, the Comptroller could request paid claims data directly from the MCOs, apply the appropriate filtering criteria to the MCO-provided source data, and remit to FQHCs only the PPS payments the Comptroller believes are due based on the MCO-provided source data. The Comptroller could then give FQHCs the opportunity to request PPS payments for eligible claims the MCOs may not have provided to the Comptroller or for which the Comptroller chose not to remit a PPS payment. Alternatively, the State could require the MCOs remit PPS payments directly to FQHCs as is done in Medicare, by Medicare Advantage plans.[23] Importantly, though, the Comptroller may want to exclude all such successfully appealed claims and resulting PPS payments from further audit since each such item will already have received close scrutiny.

As I shared during our meeting with you and your team on December 14, 2023, I am happy to work closely with your team on these issues.

For ease of reference, I summarize our 7 specific requests here before closing:

1. We ask you to detail the audit methodology in writing so FQHCs can provide feedback and suggestions. This transparency and technical review should help to refine and improve the process and avoid likely errors. It should also help to avoid unnecessary requests and expenditures.

2. We ask you to clarify the net effect of any inclusion of vaccine administration payments on the settlement requests and what (if any) action is required. We also ask you to clarify the process to address qualified but mis-coded encounters.

3. We ask you to characterize all suspected discrepancies in precisely these terms rather than implying or stating these are substantiated overpayments.

4. We ask you to remove the word "material" from any final report.

[23] Indeed, the federal statute governing Medicaid PPS payments in managed care contexts at 42 U.S.C. § 1396(bb)(5)-(6) would permit both approaches.

5. We ask you to use a two-year lookback period for any final report, which we understand to be consistent with your future plans.

6. We ask that you remove the False Claims Act language from any final report. If a final report does assert a potential liability under the False Claims Act, further detail and clarification on these points would be both appropriate and necessary.

7. We ask that any final report acknowledge the issue of delayed PPS payments and the real costs we incurred as a result.

Again, we appreciate the work and dedicated efforts of the Comptroller's staff. We understand these issues are inherently complex, and I am grateful to you for the opportunity to provide this response.

Auditor's Comments to Appendix

Auditors relied on the claims data obtained from the Division of TennCare and provided United Neighborhood Health Services (UNHS) with the claims data that support the visits and payments on the settlement calculation. UNHS could not provide detailed supporting documentation that agreed with the visits and payments reported by the clinic on its quarterly reports. Since UNHS could not provide the detail supporting its reported visits and payments, auditors could not identify differences between the TennCare data and UNHS's reported visits and payments. UNHS did not provide auditors with any examples of discrepancies between the clinic's data and the TennCare claims data.

- *Third-party contractors:* The Comptroller's Office does not endorse or recommend third-party contractors. This is solely a decision for UNHS management.
- *Vaccine Administration payments:* As noted in the finding, inclusion of the vaccine administration payments on the settlement requests reduces the settlement payment to the clinic from the Division of TennCare by the dollar amount of the vaccine administration payments. Auditors removed these payments, which resulted in a lower amount due back to TennCare.
- *Miscoded Encounters:* If the facility miscodes encounters, it is the facility's responsibility to correct their error and resubmit the corrected claim to the MCO.
- *Policy detail and procedural guidance:* Federal Guidance related to the PPS program has been available since the program was established. When the Division of TennCare makes state-specific clarification to the PPS program, a notice of the change has been emailed to the clinics. The exclusion of vaccine administration revenue, reporting of F codes, and hospital visits are examples of updates made by the Division of TennCare.
- *Suspected discrepancies and MCO-provided source data:* We find the TennCare claims data to be reliable. In instances of differences, the auditee should provide examples for further

review. Auditors provided the TennCare claims data supporting the settlement calculations in the examination report, and auditors did provide feedback of discrepancies as noted in the finding. UNHS did not provide auditors with any examples of discrepancies between the clinic's supporting documentation and the TennCare claims data.

- *Response to Table*: The amounts in Table 1 do not agree with State Audit records. The table as presented does not take into account filing errors, such as filing based on paid date rather than date of service, inclusion of dual eligibles, and denied claims. Auditors did request that UNHS not submit amendments for the exam period; however, they were able to submit amendments for dates of service after March 31, 2022.