

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**TENNESSEE MEDICAID CLAIMED  
HUNDREDS OF MILLIONS  
OF FEDERAL FUNDS FOR  
CERTIFIED PUBLIC  
EXPENDITURES THAT WERE NOT  
IN COMPLIANCE WITH  
FEDERAL REQUIREMENTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



Christi A. Grimm  
Principal  
Deputy Inspector General

October 2021  
A-04-19-04070

# *Office of Inspector General*

<https://oig.hhs.gov>

---

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

## *Office of Audit Services*

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

## *Office of Evaluation and Inspections*

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

## *Office of Investigations*

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## *Office of Counsel to the Inspector General*

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

# *Notices*

---

**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at <https://oig.hhs.gov>

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

## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

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

## Report in Brief

Date: October 2021

Report No. A-04-19-04070

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Audit

Under a Medicaid waiver, Tennessee was allowed to claim as certified public expenditures (CPEs) the uncompensated cost of care (UCC) at public hospitals for Medicaid enrollees and uninsured patients. For State fiscal years (SFYs) 2009–14, Tennessee claimed a total of \$2 billion in CPEs.

For SFYs 2010–13, Tennessee each year claimed the same amount of \$373.8 million, indicating that it may not have calculated specific estimates of the CPEs for each of those years, as required. Additionally, a recent audit found that another State had improperly paid \$686 million in Medicaid supplemental pool payments.

Our objective was to determine whether Tennessee complied with Federal requirements for claiming CPEs for public hospital unreimbursed costs.

### How OIG Did This Audit

Our audit covered the \$2 billion in CPEs that Tennessee claimed for SFYs 2009–14 (audit period), which were the most recent SFYs for which supporting calculations of actual CPEs were available. We compared the CPEs that Tennessee claimed to its summaries of actual CPEs for each SFY and reviewed the UCC calculations and supporting documentation for five hospitals that received disproportionate share hospital payments and five institutions for mental diseases (IMDs).

## Tennessee Medicaid Claimed Hundreds of Millions of Federal Funds for Certified Public Expenditures That Were Not in Compliance With Federal Requirements

### What OIG Found

Tennessee did not comply with Federal requirements for claiming CPEs for public hospital unreimbursed costs. Of the \$2 billion in CPEs that Tennessee claimed during our audit period, \$909.4 million was allowable and supported. However, the remaining \$1.1 billion (\$767.5 million Federal share) exceeded the amount allowed. This amount included \$482.1 million (\$337.5 million Federal share) of excess CPEs that Tennessee claimed but did not return after calculating actual CPEs.

In addition, the actual CPEs that Tennessee calculated included another \$609.4 million (\$430 million Federal share) that exceeded the allowable amount. It was composed of \$522.3 million (\$370.1 million Federal share) of unsupported net costs of caring for IMD uninsured patients, \$53.6 million (\$37.9 million Federal share) of unallowable net costs of caring for TennCare IMD patients between the ages of 21 and 64, and \$33.5 million (\$22 million Federal share) of overstated costs because of incorrect calculations.

### What OIG Recommends and Tennessee Comments

We recommend that Tennessee: (1) refund \$397.4 million in overpayments to the Federal Government for CPEs that it claimed in excess of the allowable amount; (2) provide support for or refund to the Federal Government \$370.1 million for the net costs of caring for uninsured IMD patients for which it did not provide detailed supporting documentation; and (3) establish additional policies and procedures to ensure compliance with Federal requirements. The detailed recommendations are listed in the body of the report.

In written comments on our draft report, Tennessee disagreed with our first recommendation, objecting to the years covered by our audit and to our interpretation of Federal requirements governing costs related to IMD patients between the ages of 21 and 64. Tennessee disagreed with our second recommendation, stating that, in addition to its disagreement regarding Federal requirements, it provided sufficient data to support uninsured IMD costs. Tennessee generally agreed with our third recommendation to establish additional policies and procedures except that it did not agree that it should establish policies to identify and exclude costs for IMD patients between the ages of 21 and 64. After considering Tennessee's comments, we maintain that our findings and recommendations are valid for the reasons detailed in the report.

## TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Audit.....	1
Objective.....	1
Background.....	2
Medicaid Program.....	2
Medicaid Demonstration Projects.....	2
Special Terms and Conditions.....	2
Uncompensated Cost of Care for the Audit Period.....	5
How We Conducted This Audit.....	6
FINDINGS.....	6
The State Agency Did Not Return Federal Overpayments of Certified Public Expenditures Identified Through Reconciliation.....	8
The State Agency’s Calculated Actual Certified Public Expenditures Included Unsupported Costs for Uninsured Patients Who Received Services From Institutions for Mental Diseases.....	8
The State Agency’s Calculated Actual Certified Public Expenditures Included Institutions for Mental Diseases Costs for TennCare Enrollees Aged 21 to 64.....	10
The State Agency’s Calculated Actual Certified Public Expenditures Included Incorrectly Calculated Institutions for Mental Diseases Inpatient Routine Costs.....	10
Errors Resulting in Incorrect Costs Per Day.....	11
Allocation of Patient Days Did Not Match Supporting Documentation.....	11
The State Agency Did Not Have Adequate Internal Controls in Place.....	12
RECOMMENDATIONS.....	13
STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE.....	13
Recommendation To Refund \$397.4 Million in Overpayments.....	14
State Agency Comments.....	14
Office of Inspector General Response.....	14

Recommendation To Provide Support for or Refund \$370.1 Million in Institutions for Mental Diseases Costs for Uninsured Patients .....	16
State Agency Comments .....	16
Office of Inspector General Response .....	17
 Recommendation To Establish Additional Policies and Procedures To Ensure Compliance With the Special Terms and Conditions .....	17
State Agency Comments .....	17
Office of Inspector General Response .....	18

APPENDICES

A: Audit Scope and Methodology .....	19
B: Federal Requirements .....	22
C: Unallowable Costs Claimed as Certified Public Expenditures .....	24
D: State Agency Comments .....	25

## INTRODUCTION

### WHY WE DID THIS AUDIT

In 2002, the Centers for Medicare & Medicaid services (CMS) approved Tennessee’s Research and Demonstration Waiver for Medicaid reform, TennCare II (waiver). The waiver allowed Tennessee’s State Medicaid agency (State agency) to claim the uncompensated cost of care (UCC) experienced by public hospitals caring for Medicaid beneficiaries (TennCare enrollees) and uninsured patients as certified public expenditures (CPEs).<sup>1</sup> In this report, we refer to TennCare enrollees and uninsured patients collectively as “low-income patients.”

For State fiscal years<sup>2</sup> (SFYs) 2009–14, the State agency claimed about \$2 billion in CPEs for low-income patients treated at 28 hospitals. For SFYs 2009 and 2014, it claimed about \$386 million and \$120 million, respectively. However, for SFYs 2010–13, the State agency each year claimed the same amount of \$373.8 million,<sup>3</sup> indicating that it may not have calculated estimates of the CPEs for each of those years, as required.

Additionally, a recent audit found that another State had improperly paid \$686 million (\$412 million Federal share) in Medicaid supplemental pool payments<sup>4</sup> that were not in accordance with its waiver and applicable Federal regulations.<sup>5</sup>

### OBJECTIVE

Our objective was to determine whether the State agency complied with Federal requirements for claiming CPEs for public hospital unreimbursed costs.

---

<sup>1</sup> Public funds may be considered part of the State’s share and eligible for Federal financial participation (FFP) if they are certified by the contributing public agency (in this case, public hospitals) as representing expenditures eligible for FFP (42 CFR § 433.51).

<sup>2</sup> Tennessee’s State fiscal year is July 1 through June 30.

<sup>3</sup> The actual amount claimed each year was \$373,799,863 for SFYs 2010, 2011, and 2013 and \$373,799,861 for SFY 2012.

<sup>4</sup> The State made the supplemental payments as part of its Low Income Pool program, which it established to compensate providers for the cost of care given to low-income patients.

<sup>5</sup> Department of Health and Human Services, Office of Inspector General report number A-04-17-04058, “Florida Medicaid Paid Hundreds of Millions in Unallowable Payments to Jackson Memorial Hospital Under Its Low Income Pool Program.” Available online at <https://oig.hhs.gov/oas/reports/region4/41704058.asp>.

## **BACKGROUND**

### **Medicaid Program**

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. A State plan establishes which services the Medicaid program will cover. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Federal Government pays its share of a State's medical assistance costs based on the Federal medical assistance percentage, which varies depending on a State's relative per capita income. In Tennessee, the State agency administers the Medicaid program.

### **Medicaid Demonstration Projects**

The State agency operates the waiver, which CMS approved in 2002 under section 1115 of the Social Security Act (the Act).<sup>6</sup> Section 1115 of the Act gives CMS authority to approve experimental, pilot, or demonstration projects that it considers likely to assist in promoting the objectives of the Medicaid program. The purpose of these projects, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate State-specific policy approaches to better serve Medicaid populations.

### **Special Terms and Conditions**

To implement a State demonstration project, States must comply with the special terms and conditions (STCs) of the agreement between CMS and the State.<sup>7</sup> STCs specify the nature, character, and extent of Federal involvement in the waiver and a State's obligations to CMS during the life of the waiver.

#### *Authorization of Certified Public Expenditures*

The waiver's STCs included a provision for the Unreimbursed Public Hospital Costs Pool for CPEs under which the State agency was allowed to claim CPEs for actual unreimbursed costs incurred by Government-operated hospitals for the provision of inpatient and outpatient

---

<sup>6</sup> This waiver is a continuation of the original waiver, TennCare, which began in January 1994.

<sup>7</sup> Three versions of the STCs were in effect during our audit period: One was effective July 1, 2008, through June 30, 2010 (STC-a); a second was effective July 1, 2010, through June 30, 2013 (STC-b); and a third was effective July 1, 2013, through June 30, 2014 (STC-c).



TennCare services provided to low-income patients.<sup>8</sup> To claim CPEs, the State agency was required to document actual costs that exceeded the amounts paid by various sources for providing the TennCare services (STC-a, paragraph 54(h), STC-b, paragraph 57(h), and STC-c, paragraph 55(h)).

### *Certified Public Expenditure Methodology and Protocol*

The STCs include the methodology for calculating CPEs.<sup>9</sup> A State agency contractor calculated UCC for public hospitals during the audit period. Federal law requires that States make disproportionate share hospital (DSH) payments<sup>10</sup> to a qualifying hospital that serves a large number of Medicaid and uninsured individuals.<sup>11</sup> The contractor calculated UCC for DSHs using the DSH survey form. The contractor calculated UCC for non-DSHs using an identical methodology but did not use the DSH survey forms.<sup>12</sup> To calculate UCC, the contractor used Medicare cost reports<sup>13</sup> as well as low-income patient days, ancillary charges, and payments that it obtained from the hospitals' UCC surveys and Tennessee's Medicaid paid claims listing.<sup>14</sup> Although the UCC calculations include the costs of caring for patients with various payor sources, to calculate CPEs the State agency removes from these calculations the costs net of payments for all patients except TennCare enrollees and the uninsured. The UCC surveys included a certification from a representative of each hospital stating that the data used in the calculation of UCC were "true and accurate to the best of our ability and supported by the financial and other records of the hospital."

---

<sup>8</sup> The Unreimbursed Public Hospital Costs Pool for CPEs was included in a group of cost pools that had a combined annual limit of \$540 million for the period July 1, 2008, through June 30, 2016.

<sup>9</sup> The methodology is included in Attachment F of both STC-b and STC-c and was approved retroactively to July 1, 2008.

<sup>10</sup> DSH payments are designed to pay hospitals for the UCC incurred for treating Medicaid and uninsured patients.

<sup>11</sup> The Act §§ 1902(a)(13)(A)(iv) and 1923.

<sup>12</sup> Both the DSH survey form and the identical calculation for non-DSHs that the State agency's contractor prepares are calculations of a hospital's costs net of payments (i.e., UCC) for TennCare enrollees, uninsured patients, patients eligible for Medicaid and Medicare (i.e., dual eligible patients), patients eligible for Medicaid and other insurance, and out-of-State Medicaid patients.

<sup>13</sup> The Medicare cost report is a form that all hospitals must submit to CMS to determine program payments and support Federal program management.

<sup>14</sup> Hospitals prepared UCC surveys that provided patient data summary totals for uninsured patients, dual eligible patients, Medicaid eligible patients with other insurance coverage, and out-of-State Medicaid patients.

### *Calculation of Hospital Uncompensated Care*

The STCs describe the steps hospitals should perform to calculate the costs of caring for low-income patients in this way:

- determine the total hospital costs per day by inpatient routine cost center and the total cost-to-charge ratio by ancillary cost center;<sup>15</sup>
- multiply each inpatient routine cost center's low-income patient days<sup>16</sup> by the costs per day for the cost center; and
- multiply each ancillary cost center's inpatient and outpatient low-income charges by the cost-to-charge ratio for the cost center (STCs, Attachment F,<sup>17</sup> section I).

Hospitals should reduce the calculated low-income costs (i.e., costs of caring for low-income patients) by payments received on the related low-income accounts to arrive at UCC.

### *Interim Reconciliation*

Each year, the State claims estimates of CPEs on the CMS-64s and receives Federal financial participation (FFP).<sup>18</sup> However, hospitals are not required to file Medicare cost reports until 5 months after a fiscal year ends. Once hospitals file their Medicare cost reports for the payment year, the State agency must reconcile the estimated CPEs previously claimed to the UCC calculated using the Medicare cost reports for that year (i.e., the actual CPEs). In this report, we refer to the UCC calculated by the State agency for this interim reconciliation as the "actual CPEs."

---

<sup>15</sup> Costs, days, and ancillary charges are included in the Medicare cost-report worksheets B part I, S-3, and C part I, respectively (STCs, Attachment F). The data on these cost-report worksheets are broken down into cost centers based on the hospital services to which they relate. Examples of inpatient routine service cost centers are the adults and pediatrics unit, intensive care unit, and coronary care unit. Examples of ancillary cost centers are operating room, recovery room, and radiology. Worksheet C of the Medicare cost report includes the ratio of total costs to total charges for each ancillary cost center (i.e., cost-to-charge ratio).

<sup>16</sup> Low-income patient days refers to the total of days of service for all low-income patients during which those patients were inpatients at a hospital.

<sup>17</sup> Only STCs b and c have an Attachment F; however, both documents note that CMS approved the cost calculation protocol from Attachment F for use beginning July 1, 2008, which was the beginning date for our audit period.

<sup>18</sup> The CMS-64 "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" is a summary of expenditures derived from source documents such as invoices, cost reports, and eligibility records that Medicaid State agencies use to report program costs to CMS for FFP.

If the State agency determines that the payments to a hospital together with the claimed CPEs exceeded the actual cost of caring for low-income patients—i.e., the hospital was overpaid—then the State agency must credit the excess to the Federal Government. But if the State agency determines that a hospital was underpaid, then the State agency should claim the difference as additional CPEs. According to the STCs, the State agency is required to revise its FFP claim “to reconcile actual CPEs with the CPE estimates” within 12 months of the end of a SFY (STC-a, paragraph 54(h), STC-b, paragraph 57(h), and STC-c, paragraph 55(h)).

#### *Reconciliation to the Finalized Medicare Cost Report*

The STCs require that the State agency repeat the reconciliation process after a Medicare administrative contractor (MAC)<sup>19</sup> finalizes Medicare cost reports.<sup>20</sup> Again, the State agency should credit to the Federal Government any overstatements of CPEs (STCs, Attachment F, section IV).

#### **Uncompensated Cost of Care for the Audit Period**

For the audit period, the State claimed estimates of CPEs on the CMS-64s of \$2 billion. For each year in the audit period, the State agency prepared interim reconciliation files in which it summarized by hospital the cost of care for low-income patients for all public hospitals for which it claimed CPEs and then compared the costs to payments received for those patients to arrive at the net UCC (actual CPEs). According to these interim reconciliation files, the total cost of caring for low-income patients for all public hospitals was \$4.1 billion<sup>21</sup> and the total payments received for these patients was \$2.6 billion<sup>22</sup> for net actual CPEs of \$1.5 billion for the audit period, as determined by the State agency.<sup>23</sup> UCC calculations that the State agency’s contractor prepared for individual public hospitals are the primary source documents for the summary interim reconciliation files.

---

<sup>19</sup> A MAC is a private health care insurer that contracts with CMS as the primary operational contact between the Medicare program and enrolled health care providers for a multistate region. A MAC performs many activities including enrolling providers in the Medicare program, processing and paying Medicare claims, and auditing Medicare cost reports.

<sup>20</sup> In Appendix A, we noted that in recalculating the low-income costs portion of actual CPEs we used data from finalized Medicare cost reports when available. However, there were only minor changes to low-income costs attributable to using the finalized Medicare cost report versions.

<sup>21</sup> The total cost was \$4,069,267,405.

<sup>22</sup> The total paid was \$2,550,410,335.

<sup>23</sup> The total net actual CPEs was \$1,518,857,070.

## HOW WE CONDUCTED THIS AUDIT

Our audit covered the \$2 billion<sup>24</sup> in CPEs that the State agency claimed for SFYs 2009–14 (audit period).<sup>25</sup> For each SFY in the audit period, we compared the CPEs that the State agency claimed on the CMS-64s with the actual CPEs according to the State agency’s summary interim reconciliation files.<sup>26</sup> We then reviewed the UCC calculations for the five DSHs with the highest costs of caring for low-income patients and for all five State-owned institutions for mental diseases (IMDs). We performed recalculations of UCC using Medicare cost reports and summary totals for low-income patient data (patient days and ancillary charges). We traced summary low-income patient data to the supporting details for 1 year for the five DSHs and for all years for the IMDs.<sup>27</sup>

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

We conducted our audit from May 2019 to April 2021. See Appendix A for the details of our scope and methodology and Appendix B for applicable Federal requirements.

## FINDINGS

The State agency did not comply with Federal requirements for claiming CPEs for public hospital unreimbursed costs. Of the \$2 billion in CPEs that the State agency claimed during our audit

---

<sup>24</sup> The total amount of CPEs claimed was \$2,000,994,010.

<sup>25</sup> SFY 2009 was the earliest SFY for which State officials indicated that they had not adjusted the CPE estimates to correct overpayments. SFY 2014 was the most recent year for which the State agency had completed its calculations of actual CPEs when we began our audit in 2019.

<sup>26</sup> On March 2, 2020, the State agency provided revised interim reconciliation files for SFY 2010 through SFY 2012 that reflected an increase in the actual CPEs of about \$329.5 million over the previous versions. These revisions included: (1) a \$291 million increase to include hospitals that the State agency had previously erroneously excluded (\$259.5 million for IMDs and \$31.5 million for other hospitals); (2) a \$32.7 million increase to reflect a reduction in DSH payments because of redistribution; and (3) other changes resulting in a net increase of \$5.8 million. We audited the revised versions of the interim reconciliation files for those years.

<sup>27</sup> We traced to patient-level detail for only 1 year for DSHs because DSHs had significantly more low-income patient data. Additionally, for IMDs we needed the patient-level detail for each year to identify low-income patient data related to patients between the ages of 21 and 64.

period, \$909.4 million<sup>28</sup> was allowable and supported. However, the remaining \$1.1 billion<sup>29</sup> (\$767.5 million<sup>30</sup> Federal share) that the State agency claimed exceeded the amount allowed by Federal requirements.

The \$2 billion that the State agency claimed in CPEs was \$482.1 million<sup>31</sup> (\$337.5 million<sup>32</sup> Federal share) higher than the actual CPEs of \$1.5 billion<sup>33</sup> that the State agency calculated. However, the State agency never refunded the overpayment of \$337.5 million to the Federal Government as required by the waiver. In addition, the actual CPEs of \$1.5 billion that the State agency calculated included unallowable costs of \$609.4 million<sup>34</sup> as follows:

- \$522,301,135 (\$370,119,499 Federal share) of net costs for caring for uninsured IMD patients for which the State agency had no detailed supporting documentation;
- \$53,629,631 (\$37,873,870 Federal share) of net costs for caring for TennCare IMD patients between the ages of 21 and 64 for whom Federal funding was not allowable and costs were expressly prohibited by the waiver; and
- \$33,477,410 (\$21,985,082 Federal share) in costs that were overstated because the State agency incorrectly calculated inpatient routine costs for IMDs.

(See Appendix C for a summary of these findings by year and in total.)

The State agency did not adjust CPE estimates to actual CPEs because it did not have policies and procedures in place to ensure that it did so. The State agency claimed costs for uninsured IMD patients for which it had no patient-level detailed support because it neither had policies and procedures nor actual practices in place for collecting patient-level detail data for uninsured IMD patients. The State agency claimed the costs of caring for TennCare enrollees who were IMD patients between the ages of 21 and 64 because it believed that the costs for those patients were allowable and thus had no policies and procedures to identify and exclude those costs. Finally, the State agency also overstated actual CPEs that it calculated for IMDs

---

<sup>28</sup> The allowable amount claimed was \$909,448,894.

<sup>29</sup> The remaining amount claimed was \$1,091,545,116.

<sup>30</sup> The Federal share was \$767,461,115.

<sup>31</sup> The total amount was \$482,136,940.

<sup>32</sup> The total Federal share was \$337,482,664.

<sup>33</sup> The total actual CPEs calculated by the State agency were \$1,518,857,070.

<sup>34</sup> The total of unallowable costs was \$609,408,176.

because it did not have a review process in place that would identify errors in the calculations that its contractor made.

As a result, over a 6-year period the State agency received overpayments of \$397.4 million<sup>35</sup> from the Federal Government and may have received additional overpayments of \$370.1 million<sup>36</sup> for unsupported costs.

### **THE STATE AGENCY DID NOT RETURN FEDERAL OVERPAYMENTS OF CERTIFIED PUBLIC EXPENDITURES IDENTIFIED THROUGH RECONCILIATION**

Within 12 months of the end of each SFY, the waiver requires the State agency to reconcile “actual CPEs” with “CPE estimates” and revise its FFP claim for CPEs on its CMS-64s. The State agency must calculate actual CPEs using the protocol in Attachment F of the STCs.<sup>37</sup> If the State agency identifies that a hospital received an overpayment, the State agency should credit the Federal Government, and if it identifies that a hospital has been underpaid, the State agency can claim additional reimbursement for the underpayment. Upon finalization of the hospitals’ Medicare cost reports, the State agency must perform a final reconciliation based on the finalized Medicare cost reports.<sup>38</sup>

The State agency calculated the actual CPEs and determined that for the audit period the estimated CPEs claimed on the CMS-64s exceeded actual CPEs in the aggregate (i.e., hospitals had been overpaid). However, it did not adjust its estimated claims for CPEs to reflect this overpayment, as required, or return the Federal share of overpayments. The State agency originally claimed estimated CPEs totaling \$2 billion. The State agency calculated actual CPEs of only approximately \$1.5 billion—a difference of about \$482.1 million. Because it did not adjust the estimated CPEs claimed to the actual CPEs that it calculated, the State agency received an overpayment of \$337.5 million from the Federal Government.

### **THE STATE AGENCY’S CALCULATED ACTUAL CERTIFIED PUBLIC EXPENDITURES INCLUDED UNSUPPORTED COSTS FOR UNINSURED PATIENTS WHO RECEIVED SERVICES FROM INSTITUTIONS FOR MENTAL DISEASES**

When defining CPEs, the STCs only allow the actual costs incurred by Government-operated hospitals for the provision of inpatient and outpatient TennCare services for TennCare enrollees and uninsured patients. In addition, the STCs require that the State be able to document that

---

<sup>35</sup> The total overpayment was \$397,341,616. We rounded this amount up to \$397.4 million so that the rounded overpayments (\$397.4 million and \$370.1 million) correctly total \$767.5 million.

<sup>36</sup> The total additional overpayment was \$370,119,499.

<sup>37</sup> STC-a, paragraph 54(h), STC-b, paragraph 57(h), and STC-c, paragraph 55(h).

<sup>38</sup> STCs, Attachment F, sections III and IV.

the hospitals had actual unreimbursed costs for providing those services, which exceeded the amounts paid to the hospital (STC-a, paragraph 54(h), STC-b, paragraph 57(h), and STC-c, paragraph 55(h)). When calculating uninsured costs, the State may use data for services furnished to uninsured patients during the payment year to the extent that the data can be verified to be complete and accurate (STCs, Attachment F, section I). The STCs also require the State to calculate costs by multiplying inpatient routine costs per day and ancillary cost-to-charge ratios, as derived from the Medicare cost report, by low-income patient days and ancillary charges, respectively (STCs, Attachment F, section I).

Furthermore, the Act does not allow FFP for IMD costs for patients between the ages of 21 and 64 (the Act, sections 1905(a)(14),(16), and (30)(B)). In addition, the STCs expressly prohibit claiming FFP for expenditures for TennCare enrollees who are IMD patients between the ages of 21 and 64 (STCs a and c, paragraph 31, and STC-b, paragraph 33), and the costs of such services for uninsured patients are not eligible as CPE.<sup>39</sup>

During the audit period, the State agency included in its calculation of actual CPEs the costs for five State-owned IMDs. The actual CPEs calculated by the State agency included \$522.3 million (\$370.1 million Federal share) in net costs (i.e., costs net of payments) for caring for uninsured IMD patients for which the State agency provided no supporting patient-level detail. If supporting patient-level detail for the costs showed that the State agency's claim did not comply with Federal requirements (e.g., some costs related to patients between the ages of 21 and 64, some costs included amounts for insured patients, some payments were not netted against costs, or some overstated patient days and ancillary charges were used in calculating costs), then the State agency may have received an overpayment of \$370.1 million from the Federal Government.

For SFYs 2012–14, the State agency calculated actual CPEs for the IMDs using the STC-prescribed methodology. However, the State agency did not provide patient-level details to support the uninsured patient days that it used in its calculations.

For SFYs 2009–11, in addition to not having patient-level details, the State agency did not calculate the IMD net uninsured costs using the methodology prescribed in the STCs, Attachment F, section I. (See “Hospital Cost Portion of Calculations” in the background section of this report.) Instead, for those 3 years the State agency derived a cost-to-charge ratio from

---

<sup>39</sup> The STCs allow Government-operated hospitals to certify as public expenditures eligible for FFP the actual unreimbursed costs incurred for the provision of TennCare-covered services for TennCare enrollees and uninsured patients. Because services provided to IMD patients who are between the ages of 21 and 64 are not TennCare-covered services, costs incurred for providing such services to TennCare enrollees and uninsured patients are not eligible as CPE.

the Joint Annual Reports (JARs)<sup>40</sup> for the IMDs and multiplied that ratio by the charity charges from the JARs to determine the net uninsured costs.

Without supporting patient-level details, we were unable to verify the summary totals of uninsured patient days and payments used in the UCC calculations. Additionally, we were unable to determine whether the patients being served were between the ages of 21 and 64—an age range for which Federal funding is not available. Moreover, 85.4 percent of the IMD costs for TennCare enrollees was for services to patients who were between the ages of 21 and 64. (See the next section of this report.) Therefore, it is likely that a large portion of the uninsured costs was also for patients in this age range.

#### **THE STATE AGENCY’S CALCULATED ACTUAL CERTIFIED PUBLIC EXPENDITURES INCLUDED INSTITUTIONS FOR MENTAL DISEASES COSTS FOR TENNCARE ENROLLEES AGED 21 TO 64**

The Act does not allow FFP for IMD costs for patients between the ages of 21 and 64 (the Act, sections 1905(a)(14),(16), and (30)(B)). In addition, the STCs expressly prohibit claiming FFP for expenditures for TennCare enrollees who are IMD patients between the ages of 21 and 64 (STCs a and c, paragraph 31, and STC-b, paragraph 33).

The actual CPEs calculated by the State agency inappropriately included \$53.6 million (\$37.9 million Federal share) in CPEs for net IMD costs of caring for TennCare enrollees between the ages of 21 and 64,<sup>41</sup> representing about 85.4 percent of the total net costs of caring for TennCare enrollees for its 5 State-owned IMDs for the audit period. Because the State agency inappropriately included IMD costs related to TennCare enrollees between the ages of 21 and 64 in its calculation of actual CPEs, it received an overpayment of \$37.9 million from the Federal Government.

#### **THE STATE AGENCY’S CALCULATED ACTUAL CERTIFIED PUBLIC EXPENDITURES INCLUDED INCORRECTLY CALCULATED INSTITUTIONS FOR MENTAL DISEASES INPATIENT ROUTINE COSTS**

The CPE protocol in Attachment F of the STCs provides for inpatient routine costs to be calculated by multiplying patient days from various low-income categories by costs per day for

---

<sup>40</sup> The JAR is a report that the Tennessee Department of Health requires all licensed hospitals in the State to complete. It contains various financial data including charges, expenses, bad debts, assets, liabilities, and charity care that a hospital provides.

<sup>41</sup> Although the State agency did not have patient-level detail supporting documentation for the IMD patients that were uninsured, it did have detail for TennCare enrollees.



the applicable inpatient routine cost center, as derived from the Medicare cost report (STCs, Attachment F, section I).

The State agency included in its calculation of actual CPEs a total of \$33.5 million (\$22 million Federal share) in overstated costs that resulted from errors in its formulas and the incorrect allocation of patient days for four out of its five State-owned IMDs.

### **Errors Resulting in Incorrect Costs Per Day**

The State agency's contractor that prepared the cost calculations for the IMDs made errors in its calculations of the inpatient routine costs for SFY 2014 resulting in an overstatement of costs totaling approximately \$18 million<sup>42</sup> (\$11.8 million<sup>43</sup> Federal share). The contractor allocated patient days to the various inpatient routine cost centers. However, instead of multiplying the patient days that it assigned to each inpatient routine cost center by the costs per day for that specific cost center, the contractor multiplied all of the patient days by the costs per day of the adults and pediatrics cost center. As a result of this error in its calculation of actual CPEs, the State agency received an overpayment of \$11.8 million from the Federal Government.

### **Allocation of Patient Days Did Not Match Supporting Documentation**

In addition to the errors for SFY 2014, the allocation of patient days to various inpatient routine cost centers for four of the five State-owned IMD facilities for the other years in the audit period did not match what the allocation should have been according to either the detail of patient data for the TennCare enrollees or the summary of patient data for the uninsured. Consequently, the State agency in some cases multiplied patient days by the wrong costs per day, causing the calculated actual CPE amounts to be overstated by \$15.5 million<sup>44</sup> (\$10.2 million<sup>45</sup> Federal share). As a result of the improper allocation of patient days in its calculation of actual CPEs, the State agency received an overpayment from the Federal Government of \$10.2 million.

---

<sup>42</sup> The total overstatement was \$18,021,465.

<sup>43</sup> The total Federal share was \$11,804,060.

<sup>44</sup> The total overstatement was \$15,455,945.

<sup>45</sup> The total Federal share was \$10,181,022.

## THE STATE AGENCY DID NOT HAVE ADEQUATE INTERNAL CONTROLS IN PLACE

The State agency did not comply with Federal requirements for claiming CPEs for public hospital unreimbursed costs because it did not have adequate internal controls<sup>46</sup> in place. Specifically, the State agency did not have policies and procedures for:

- adjusting its CPE estimates to the actual CPEs that it calculated,
- collecting supporting patient-level detail for the data for uninsured IMD patients used in calculating actual CPEs, or
- identifying and excluding the costs of caring for IMD patients between the ages of 21 and 64.

The State agency did not have policies and procedures for collecting supporting patient-level detail for uninsured IMD patients or for identifying and excluding the costs of caring for IMD patients between the ages of 21 and 64 because it erroneously believed that the costs of caring for both uninsured patients and TennCare enrollees in IMDs were allowable as charity regardless of the ages of the patients.<sup>47</sup>

Additionally, the State agency did not monitor its contractor but instead relied solely on the contractor to perform the calculations of actual CPEs, and the State had no review process in place to identify errors the contractor might have made.

Because of these deficiencies in its internal controls, during a 6-year period the State agency received overpayments of \$397.4 million from the Federal Government and may have received additional overpayments of \$370.1 million for unsupported costs.

---

<sup>46</sup> Control activities are the actions management establishes through policies and procedures to achieve objectives and respond to risks in the internal control system (GAO-14-704G Federal Internal Control Standards).

<sup>47</sup> Additionally, State agency officials said that they elected not to burden non-DSHs with collecting supporting patient-level detail for uninsured patients because those hospitals did not receive DSH payments (all five IMDs were non-DSHs during the audit period).

## RECOMMENDATIONS

We recommend that the Tennessee State Medicaid Agency:

- refund to the Federal Government \$397,341,616 in overpayments representing the Federal share of CPEs that the State agency claimed in excess of the allowable amount;
- provide support for or refund to the Federal Government \$370,119,499 for the net costs of caring for uninsured IMD patients for which the State agency did not provide detailed supporting documentation; and
- establish additional policies and procedures to ensure compliance with the STCs including policies and procedures for:
  - adjusting the CPE estimates to actual costs on the CMS-64s upon determining that hospitals have been overpaid or underpaid,
  - collecting and maintaining patient-level detail data for the uninsured population for the IMDs,
  - ensuring that the State agency identifies and excludes from its actual CPE calculations the net costs of caring for IMD patients between the ages of 21 and 64, and
  - reviewing the actual CPE calculations of its contractor.

### STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not concur with our first two recommendations and partially concurred with our third recommendation. The State agency's comments are summarized below.

After reviewing the State agency's comments, we maintain that our recommendations are valid for the reasons detailed below.

The State agency's comments are included in their entirety as Appendix D.

## **RECOMMENDATION TO REFUND \$397.4 MILLION IN OVERPAYMENTS**

### **State Agency Comments**

The State agency disagreed with our recommendation to refund \$397.4 million in overpayments for two reasons.

First, the State agency said that it was unreasonable for us to audit a period that reached back more than a decade and concluded more than 7 years ago. The State agency contended that this made it difficult for it to address the allegations of overclaiming. It stated that much of the information we requested was no longer available, per standard data retention policies. The State agency also stated that employee turnover in the intervening years made it difficult to provide the information that we had requested. The State agency added that we had “inexplicably and seemingly arbitrarily failed to include 2015—a year in which the State undercollected—when the State provided that data to the auditors.”

Second, the State agency specifically disagreed with \$37.9 million of the refund recommendation that related to the costs of caring for IMD patients who were TennCare enrollees between the ages of 21 and 64. The foundation of the State agency’s argument is its statement that “in determining allowable costs, the Disproportionate Share Hospital (DSH) Payments Rule is followed when defining unreimbursed costs.” The State agency cited various criteria that demonstrated that, for purposes of determining uncompensated care for Medicaid DSH calculations, States may include the costs of caring for IMD patients between the ages of 21 and 64.

Furthermore, the State agency contended that we misapplied the language of the STCs regarding IMD patients between the ages of 21 and 64. The State agency said that in 1994 TennCare’s waiver authorized the payment of Medicaid claims for IMD patients between the ages of 21 and 64 but that this authority was eventually phased out. It said that the STC language prohibiting these costs was included to make it clear that TennCare was no longer allowed to pay these claims but that the STC language does not prohibit the State agency from claiming the costs as uncompensated care. It said that the STC language we cited was intended neither to govern uncompensated care policy nor to result in Tennessee surrendering its right to classify these costs as uncompensated care. Finally, the State agency said that if CMS had intended the STCs to prohibit the claiming of the costs in question it would have said so in the section addressing supplemental pool payments rather than the sections containing provisions related to IMDs, which the State agency thought we had taken out of context.

### **Office of Inspector General Response**

We disagree with the State agency’s contention that our audit period was unreasonable. When the audit started on May 13, 2019, SFY 2014 was the most recent year for which the State agency had completed its calculations of actual CPEs. Our audit period excluded SFY 2015

because the state had not yet completed its calculations for that year. The State agency did not provide us with its SFY 2015 actual CPE calculations until January 2020, more than 8 months after the audit started.

The State agency asserted that our audit period was unreasonable because the information we requested for this time was no longer available. However, our audit found that the State agency had the necessary documentation to calculate and had calculated the actual CPEs for SFYs 2009–14. Most of the report findings are not based on missing or incomplete documentation. The only finding in this report that is based on missing or incomplete documentation is related to patient-level detail for uninsured IMD patients, which the State agency said it has never required of the IMDs and is discussed in our response to State agency comments on our second recommendation.

The State agency provided an additional argument for \$37.9 million of the \$397.4 million overpayment.<sup>48</sup> The State agency offered no additional argument concerning why it should not refund the \$337.5 million by which the CPEs claimed on the CMS-64s exceeded actual CPEs. Furthermore, the State agency agreed that its contractor made miscalculations regarding IMD inpatient routine costs that resulted in a \$22 million overpayment, although it stated that it had already corrected the errors.

Neither the STCs nor any of the Medicaid DSH regulations cited by the State agency support the point that allowable costs for CPEs may be determined by following the Medicaid DSH rule. These criteria are not relevant to TennCare’s CPE costs. Furthermore, it does not follow that because these costs may have been allowable in the Medicaid DSH calculations they are allowable for the claiming of CPEs. The State agency agreed to different rules for the allowable costs for CPEs in the STCs.

Additionally, the State agency argued that the STC sections with IMD provisions prohibit the State from claiming FFP for Medicaid claims payments for IMD services provided to patients between the ages of 21 and 64 but do not prohibit claiming those costs as uncompensated care. The relevant STC sections say only that “[e]xpenditures for services rendered to TennCare . . . enrollees between the ages of 21 and 64 who are patients in IMDs are not eligible for FFP.” CPEs that the State agency claimed are expenditures. Thus, by including in its CPEs the costs of caring for IMD patients who are TennCare enrollees between the ages of 21 and 64, the State agency claimed expenditures in violation of those STC sections.

Finally, in regard to the State agency’s assertion that the section of the STCs governing supplemental pools (STC-a, paragraph 54(h), STC-b, paragraph 57(h), and STC-c, paragraph 55(h) for public hospital CPEs) would have addressed the costs in question had CMS intended for them to be unallowable, we would point out that the section states that the State agency

---

<sup>48</sup> The \$397.4 million overpayment consists of three different amounts that we identified in Appendix C: (1) \$337.5 million – Overpayments of CPEs Not Returned, (2) \$37.9 million – IMD Costs for Medicaid Patients Aged 21 to 64, and (3) \$22 million – Incorrectly Calculated IMD Inpatient Routine Costs.

may claim only unreimbursed costs for providing TennCare covered hospital inpatient and outpatient services for TennCare enrollees and the uninsured. As previously explained, the earlier sections of the STCs clearly stated that expenditures for IMD services provided to TennCare enrollees between the ages of 21 and 64 are not eligible for FFP, and those services are not listed as TennCare benefits under the waiver. Accordingly, those costs are not TennCare-covered services, and the State agency may not include those costs in its CPE calculations.

We maintain that the State agency should refund the entire \$397.4 million overpayment.

## **RECOMMENDATION TO PROVIDE SUPPORT FOR OR REFUND \$370.1 MILLION IN INSTITUTIONS FOR MENTAL DISEASES COSTS FOR UNINSURED PATIENTS**

### **State Agency Comments**

The State agency disagreed with our recommendation that it provide support for or refund to the Federal Government \$370.1 million for the net costs of caring for uninsured IMD patients. The State agency said that, in addition to its disagreement with our interpretation of Federal requirements, it had provided sufficient data to support the claims. Furthermore, the State agency said that the recommendation to disallow the entire cost of uninsured IMD patients over the dispute regarding supporting documentation is extreme and inappropriate. The State agency contended that the summary supporting documentation that it provided to support the costs of caring for uninsured IMD patients was sufficient. The State agency claimed that for many years it required each hospital to submit revenue-code-level details (as opposed to patient-level details) along with an attestation from the hospital that the data were accurate representations of incurred costs. The State agency argued that the documentation produced to support this requirement was consistent with what the waiver required and that it provided us with auditable documentation. The State agency also noted that it provided patient-level details for the IMD costs related to TennCare enrollees.

Also, the State agency argued that the Medicaid Financial Accountability Rule (MFAR) that CMS proposed in late 2019 included a new requirement that each State have claim data for uninsured costs in its Medicaid Management Information System (MMIS).<sup>49</sup> The State agency concluded that because CMS withdrew the proposed MFAR rule, having patient-level details to claim FFP is not a requirement. The State agency contended that to require such details the Federal Government should go through the appropriate rulemaking process.

Finally, the State agency contended that we had taken “the unreasonable position that the IMDs had absolutely no uninsured-related uncompensated care costs for the 6-year period covered by the audit.”

---

<sup>49</sup> The MMIS is a mechanized claims processing and information retrieval system that a State Medicaid program must have to be eligible for Federal funding.

## **Office of Inspector General Response**

We maintain that the State agency should either provide patient-level details supporting the \$370.1 million that it claimed for the costs of caring for uninsured IMD patients or refund that amount. We disagree with the State agency's contention that revenue code-level details constituted auditable documentation to support its claim for the cost of caring for uninsured IMD patients. The STCs allow the claiming of FFP only for actual unreimbursed costs of providing TennCare-covered services, which do not include services rendered to IMD patients between the ages of 21 and 64. Therefore, to properly audit the costs of caring for uninsured IMD patients that the State agency included in its CPEs, patient-level details are required to verify the summary totals of uninsured patient days and payments used in the UCC calculations and to identify the ages of uninsured patients. The State agency correctly noted that it provided patient-level details for TennCare enrollees; however, those details do not help us evaluate the IMD costs for uninsured patients.

CMS's withdrawal of its 2019 proposed MFAR rule, including its requirement regarding Medicaid MMIS data, is not relevant to our request for patient-level details to support IMD costs for uninsured patients. The State agency provided patient-level details for both TennCare enrollees and uninsured patients for the DSHs that we tested, as well as patient-level details for TennCare enrollees for the IMDs. We asked only that the State agency similarly provide us with auditable patient-level details to support uninsured IMD costs. Without supporting patient-level details to enable us to verify the summary totals of uninsured patient days and payments used in the UCC calculations and to determine the patients' ages, we cannot evaluate whether the claim for the cost of caring for uninsured IMD patients is compliant with the STCs.

Finally, the State agency was incorrect in claiming that we assumed that the IMDs had absolutely no uninsured-related uncompensated care costs for the 6-year period covered by the audit. Rather, we made a reasonable request that the State agency either provide auditable patient-level details to support the costs as it did for the TennCare enrollee IMD patients or refund the costs that it claimed. As we noted in this report, 85.4 percent of the IMD costs for TennCare enrollees was for patients who were between the ages of 21 and 64.

We maintain that the State agency should provide support for or refund \$370.1 million that it claimed for the costs of caring for uninsured IMD patients.

### **RECOMMENDATION TO ESTABLISH ADDITIONAL POLICIES AND PROCEDURES TO ENSURE COMPLIANCE WITH THE SPECIAL TERMS AND CONDITIONS**

#### **State Agency Comments**

The State agency said that it would implement further written procedures for adjusting the CPE estimates to actual costs on the CMS-64s and written policies regarding how the Federal share of any CPE claim in excess of allowable amounts should be returned. In response to our

recommendation to establish additional policies and procedures for reviewing the actual CPE calculations of its contractor, the State agency said that it had corrected the issue of its contractor incorrectly calculating inpatient routine costs several years earlier. Furthermore, the State agency indicated that it is now requesting that IMDs submit patient-level details for their uninsured patients. However, it said that it did not concur with our recommendation that the State stop claiming CPEs for IMD patients between the ages of 21 and 64 because it believed our interpretation of the applicable law and CMS guidance was incorrect.

### **Office of Inspector General Response**

We maintain that, in accordance with the STCs, the State should identify and exclude from its CPE claim the costs of caring for IMD patients between the ages of 21 and 64.

Although the State agency may have corrected the specific error that we identified in this report, we maintain that the State agency should establish policies and procedures for reviewing all of its contractor's CPE calculations, not just those related to the error we identified in this report.



## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered CPEs that the State agency claimed for SFYs 2009–14 (audit period).<sup>50</sup> For this period, the State agency claimed CPEs totaling \$2 billion.

We conducted our audit from May 2019 to April 2021. In planning and performing our audit, we limited our review of the State agency’s internal controls to those controls related to verifying that the CPEs it claimed complied with Federal requirements.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable laws and regulations;
- reviewed the waiver’s STCs, which contained the governing guidance for the CPE program;
- reviewed the CMS-64s for the quarters ended September 30, 2008, through June 30, 2021,<sup>51</sup> to identify CPEs that TennCare claimed for the audit period;
- identified from the CMS DSH audit files the UCC for all Tennessee public DSHs for all SFYs in the audit period;
- reviewed for each SFY in the audit period the State agency’s interim reconciliation files that contained summary calculations of actual CPEs for all Tennessee public hospitals;
- reconciled the actual CPEs from the State agency’s interim reconciliation files with the CMS DSH audit files for all Tennessee public DSHs for all SFYs in the audit period and summarized the results;
- calculated the difference between the CPEs claimed by TennCare for the audit period and the actual CPEs as reflected in TennCare’s interim reconciliation files; and

---

<sup>50</sup> SFY 2009 was the first SFY for which State officials indicated that they had not adjusted the CPE estimates to correct overpayments. SFY 2014 was the most recent year for which the State agency had completed its calculations of actual CPEs when we began our audit.

<sup>51</sup> Because States can make adjustments on CMS-64s that apply to prior periods, we looked at all of TennCare’s CMS-64s after our audit period.

- selected for testing 10 providers that accounted for 80 percent of the total cost of caring for low-income patients included in the State’s interim reconciliation files, including the 5 publicly owned DSHs with the highest cost of caring for low-income patients and all 5 State-owned IMDs;

For the five DSHs selected for testing and for all SFYs in our audit period, we:

- reconciled the DSH survey file UCC calculations to the CMS DSH audit file and summarized the results;
- recalculated the total hospital costs per day for inpatient routine cost centers and cost-to-charge ratios for ancillary cost centers used in the CPE calculations, using finalized cost reports where available;<sup>52</sup>
- recalculated the low-income costs by multiplying our calculation of inpatient routine costs per day and ancillary cost-to-charge ratios times low-income patient days and ancillary charges, respectively; and
- compared the low-income costs that we calculated to the low-income costs used by the State agency in calculating actual CPEs.

For the five DSHs selected for testing and one SFY in our audit period, we tied to the patient-level detail totals for TennCare enrollees and uninsured patients, without material variance, the summary low-income patient days, ancillary charges, and payments that were used in the CPE calculations.

For the five State-owned IMDs selected for testing and all SFYs in our audit period, we:

- recalculated the total hospital costs per day for inpatient routine cost centers, using the finalized Medicare cost reports when available;
- reviewed and adjusted as necessary the State agency’s allocation of low-income patient days to the various inpatient routine cost centers;
- recalculated the low-income costs by multiplying our calculation of inpatient routine costs per day for each inpatient routine cost center times that cost center’s low-income patient days;

---

<sup>52</sup> We tested a total of 58 cost-report years (9 facilities including 5 DSHs and 4 IMDs for 6 cost-report years each plus 1 IMD for only 4 cost-report years because it closed in SFY 2012). Of the 58 cost-report years tested, we were able to use the finalized Medicare cost reports for 43 cost-report years, or about 74 percent. For those cost-report years for which we had access to the finalized Medicare cost reports, there were only immaterial changes to low-income costs (i.e., costs of caring for low-income patients) attributable to the different cost-report versions.

- compared the TennCare enrollee patient days and payment summary figures used in the CPE calculations with the patient-level detail for TennCare enrollees, identifying any differences;
- identified the patient data for TennCare enrollees between the ages of 21 and 64 and determined the effect of that data on the State agency's actual CPE calculations; and
- identified the net uncompensated costs (i.e., costs net of payments) for uninsured patients included in the actual CPEs calculated by the State agency because the State agency could not provide patient-level detail.

Also, we discussed the results of our audit with State agency officials.

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

## APPENDIX B: FEDERAL REQUIREMENTS

### SOCIAL SECURITY ACT

#### Social Security Act § 1905(a)

According to section 1905(a), IMD costs for patients under the age of 21 and for patients 65 years of age and older are allowable medical assistance costs for Medicaid. Section 1905(a)(14) states that medical assistance costs incurred in an IMD are allowable for patients 65 years of age or over. Section 1905(a)(16) says that, as of January 1, 1973, inpatient psychiatric hospital services for individuals under the age of 21 are allowable medical assistance costs. Section 1905(a)(30)(B)<sup>53</sup> says that, except as provided in section 1905(a)(16) (i.e., that IMD costs are allowed for persons under the age of 21), IMD costs for persons under the age of 65 are not allowable.

#### Social Security Act § 1905(h)(1)(A)

Section 1905(h)(1)(A) of the Act further clarifies that the services for individuals under age 21 must be provided “in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1861(f) or in another inpatient setting that the Secretary has specified in regulations.”

#### Social Security Act § 1905(i)

Section 1905(i) of the Act defines an IMD as “a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.”

### CMS SPECIAL TERMS AND CONDITIONS FOR THE WAIVER

#### STC-a and STC-c, Paragraph 31, and STC-b, Paragraph 33

“Expenditures for services rendered to TennCare . . . enrollees between the ages of 21 and 64 who are patients in IMDs are not eligible for FFP.”

---

<sup>53</sup> During our audit period, the applicable requirement was at section 1905(a)(29)(B) of the Act. Public Law No. 115-271, § 1006(b) (Oct. 24, 2018) redesignated paragraph (29) as paragraph (30).

**STC-a, Paragraph 54(h), STC-b, Paragraph 57(h), STC-c, Paragraph 55(h)**

Actual costs incurred by government operated hospitals for the provision of inpatient and outpatient TennCare services for TennCare enrollees and uninsured patients are eligible as CPE. The State must be able to document that the applicable hospitals had actual unreimbursed costs for providing those TennCare covered hospital inpatient and outpatient services, which exceeded the amounts paid to the hospital . . . .

Within 12 months of the end of each fiscal year, the State agency is required to revise its FFP claim for CPEs to reconcile on an interim basis actual CPEs with the estimated CPEs that it claimed on the CMS-64s. (This is referred to as the interim reconciliation in Attachment F.)

**Attachment F**

If during the interim reconciliation process the State agency identifies that a hospital received an overpayment, the State agency should credit the Federal Government. If the State agency identifies that a hospital has been underpaid, the State agency can claim additional reimbursement for the underpayment. Upon finalization of hospitals' Medicare cost reports, the State agency must perform a final reconciliation based on the finalized Medicare cost reports.

“Actual uninsured data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate.”

Inpatient routine costs for each category of low-income patients should be calculated by determining the overall hospital costs per day for each inpatient routine cost center and multiplying it by the low-income patient days for the cost center.

All TennCare supplemental pool payments must be offset against costs in calculating CPEs.

**APPENDIX C: UNALLOWABLE COSTS CLAIMED AS CERTIFIED PUBLIC EXPENDITURES**

<b>Types of Unallowable Costs</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>Total</b>
Overpayments of CPEs Not Returned	\$118,745,690	\$40,664,851	\$111,586,490	\$122,509,599	\$160,992,212	(\$72,361,902)	<b>\$482,136,940</b>
Unsupported IMD Uninsured Costs	107,736,490	125,289,170	110,482,137	81,588,413	48,361,257	48,843,668	<b>522,301,135</b>
IMD Costs for Medicaid Patients Aged 21 to 64	15,201,172	10,435,749	10,130,121	1,274,404	8,173,255	8,414,930	<b>53,629,631</b>
Incorrectly Calculated IMD Inpatient Routine Costs	(631,483)	(59,305)	(161,580)	(947,238)	17,255,551	18,021,465	<b>33,477,410</b>
<b>Total Unallowable Costs Claimed by the State Agency</b>	<b>\$241,051,869</b>	<b>\$176,330,465</b>	<b>\$232,037,168</b>	<b>\$204,425,178</b>	<b>\$234,782,275</b>	<b>\$2,918,161</b>	<b>\$1,091,545,116</b>

<b>Types of Unallowable Costs (Federal Share)</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>Total</b>
FMAP RATES	71.11%	75.09%	73.67%	66.23%	66.19%	65.50%	
Overpayments of CPEs Not Returned	\$84,440,060	\$30,533,203	\$82,208,557	\$81,141,170	\$106,556,720	(\$47,397,046)	<b>\$337,482,664</b>
Unsupported IMD Uninsured Costs	76,611,418	94,073,373	81,394,952	54,038,046	32,009,107	31,992,603	<b>370,119,499</b>
IMD Costs for Medicaid Patients Aged 21 to 64	10,809,553	7,835,682	7,463,113	844,070	5,409,673	5,511,779	<b>37,873,870</b>
Incorrectly Calculated IMD Inpatient Routine Costs	(449,048)	(44,529)	(119,040)	(627,379)	11,421,018	11,804,060	<b>21,985,082</b>
<b>Total Unallowable Costs Claimed by the State Agency</b>	<b>\$171,411,983</b>	<b>\$132,397,729</b>	<b>\$170,947,582</b>	<b>\$135,395,907</b>	<b>\$155,396,518</b>	<b>\$1,911,396</b>	<b>\$767,461,115</b>

## APPENDIX D: STATE AGENCY COMMENTS



### STATE OF TENNESSEE DIVISION OF TENNCARE

310 Great Circle Road  
NASHVILLE, TENNESSEE 37243

**BILL LEE**  
GOVERNOR

**STEPHEN SMITH**  
DIRECTOR

July 9, 2021

Lori S. Pilcher  
Regional Inspector General for Audit Services  
Department of Health and Human Services Office of Inspector General  
Office of Audit Services, Region IV  
61 Forsyth Street, SW, Suite 3T41  
Atlanta, GA 30303

Dear Ms. Pilcher:

The State of Tennessee's Medicaid program, TennCare, does not concur with the federal Department of Health and Human Services Office of Inspector General's (OIG's) recommendations related to its audit of the State's claiming for certified public expenditures (CPE) for public hospital unreimbursed costs. Furthermore, the State strongly objects to the approach taken in this audit. The audited years (2009 to 2014) are based on findings that date back more than a decade and place the State of Tennessee in an untenable and unreasonable position of having to 1) piece together communications and understandings, both verbal and written, formal and informal, among state and federal officials no longer employed or associated with the respective agencies; and/or 2) locate and provide individual claiming data that is not required by generally accepted auditing standards and for which hospital providers had no reason to anticipate the federal government's future demand.

Furthermore, the recommendations are based on faulty reasoning, as described below, and would have a detrimental impact on the more than 1.5 million Tennesseans who rely on Medicaid for benefits and services, as every dollar of the funds in question was utilized to serve Tennessee Medicaid members as part of the operation and delivery of the TennCare program.

#### **OIG Recommendation #1:**

Tennessee refund \$397.4 million in overpayments to the Federal Government for CPEs that it claimed in excess of the allowable amount.

#### **State Response:**

The State does not concur with this recommendation. The recommendation is inappropriate and unreasonable, and OIG's interpretation of federal requirements governing costs related to patients aged 21 to 64 in Institutions for mental disease (IMDs) is flawed.

This audit, released in 2021, began as an examination of the State's entire supplemental pool program and was ultimately narrowed to CPE for public hospital unreimbursed costs in state fiscal years 2009-2014. The result is an audit that reaches back more than a decade into the past, to two prior state executive administrations, and beyond any reasonable audit standard. This approach of releasing audit findings 12 years after the activity in question takes place shines a light on a flawed structure for federal audits that places states, their citizens, and taxpayers at a serious disadvantage and risk.

The fact this audit dates back 12 years and concludes with a year 7 years in the past presented extreme difficulty to the State in addressing allegations of overclaiming. Much of the relevant information is no longer available per standard data retention policies. And none of the relevant employees from Tennessee or CMS involved in the activities under review remain employed at the respective agencies. While the State has provided all materials that have been preserved and are able to be located, there are, of course, many other pieces of documentation and communication that have been lost to time, including communications and documents from CMS regarding the State's claiming methodology. We believe some of this documentation could have been relevant to mitigating if not outright refuting the concerns presented by OIG had the audit been conducted within a reasonable time period. If OIG had audited a more reasonable time period, the result of this audit would have looked very different. In addition, OIG inexplicably and seemingly arbitrarily failed to include 2015 – a year in which the State undercollected - when the State provided that data to the auditors.

It's also important to note that OIG's approach of examining years as far back into the past as it has highlights a major flaw in the system that should be examined. How far is too far? Is there any point in time that OIG would position as too far? For example, at one point during the audit examination, OIG auditors requested information from 2003 – nearly 20 years ago. No standard of reasonableness could result in an expectation that a state be able to provide any meaningful or relevant documentation from nearly 20 years ago.

With the preceding comments establishing the extreme difficulty in which the State had to operate to counter OIG allegations and findings, the State did work diligently to locate documentation and piece together communications from more than a decade ago among individuals who are no longer with TennCare or CMS. This documentation, at a minimum, revealed uncertainty around the applicable CPE protocol during the audit period. For example, documentation shows that, in accordance with the demonstration terms and conditions then in effect, the State submitted a CPE protocol for CMS review and approval on June 26, 2008. On August 20, 2008, CMS responded committing to an "expedient" review of the protocol; however, based on best available records, it appears CMS failed to do so. This, along with the fact CMS promulgated a CPE rule on May 24, 2007, that was later vacated by a federal court [*Alameda Cty. Med. Ctr. v. Leavitt*, 559 F. Supp. 2d 1 (D.D.C. 2008)], contributed to an environment of uncertainty and, at the very least, calls into question an audit recommendation seeking the repayment of hundreds of millions of dollars.

In addition, the State strongly objects to the portion of the recommendation related to IMDs. The OIG identifies a \$37,873,870 overpayment because it believes the State cannot claim CPE on any persons aged 21-64 that receive services in IMDs. (*Note: In Recommendation #2, OIG also asserts the portion of these dollars related to services for this age group are also unallowable.*) The OIG's interpretation of this issue represents a fundamental misunderstanding of basic federal policy. In summary, federal policy clearly allows unreimbursed costs for Medicaid enrollees aged 21-64 at IMDs to be treated as uncompensated care costs and factored into hospital supplemental pools. Tennessee's approach has been consistent with this federal guidance.



In determining allowable costs, the Disproportionate Share Hospital (DSH) Payments Rule is followed when defining unreimbursed costs. Under the DSH rule, states may make DSH payments to IMDs, which are defined by the Social Security Act (the Act) as hospitals, nursing facilities, or other institutions of more than 16 beds that primarily serve individuals with mental diseases (§ 1905(i) of the Act). Because IMDs cannot receive Medicaid payment for individuals age 21–64 (§ 1905(a)(B) of the Act), IMD services provided to Medicaid enrollees in this age range are classified as unpaid costs of care for the uninsured, a type of uncompensated care that is eligible for DSH funding, and thus allowed for FFP claiming.

42 CFR Parts 447 and 455 Medicaid Program; Disproportionate Share Hospital Payments; Final Rule, Page 77929, #15 states:

*For Medicaid eligible individuals under age 21 or over age 65, uncompensated care costs for those eligible individuals would be reported as uncompensated costs for the Medicaid population. For the costs of services provided to those patients between the ages of 22 and 64 who are otherwise eligible for Medicaid, the treatment for the hospital-specific limit may vary based on State practices. Many States remove these individuals from eligibility rolls for administrative convenience (and must reinstate them if they are discharged from the IMD); if so, the costs should be reported as uncompensated care for the uninsured. States that do not remove the individuals from the Medicaid eligibility rolls should report the costs as uncompensated care for the Medicaid population.*

CMS Additional Information on the DSH Reporting and Audit Requirements, Question 28 states:

*For the costs of services provided to those patients between the ages of 22 and 64 who are otherwise eligible for Medicaid, the treatment of the service costs in the hospital-specific limit may vary based on State practice. Many States remove these individuals from eligibility rolls for administrative convenience (and must reinstate them if they are discharged from the IMD); if so, the costs should be reported as uncompensated care for the uninsured. States that do not remove the individuals from the Medicaid eligibility rolls should report the costs as uncompensated care for the Medicaid population. Therefore, the costs of services provided in an IMD to an individual who is 22-64 and who is otherwise Medicaid eligible, can be included either as uninsured uncompensated or Medicaid uncompensated in the UCC, depending on the eligibility status (as determined by the State) of the individual while in the IMD.*

Also, a MACPAC report to Congress issued in March 2016 titled “Overview of Medicaid Policy on Disproportionate Share Hospital Payments,” page 6, Box 1-2 states, “Because IMDs cannot receive Medicaid payment for individuals age 21–64 (§ 1905(a)(B) of the Act), IMD services provided to Medicaid enrollees in this age range are classified as unpaid costs of care for the uninsured, a type of uncompensated care that is eligible for DSH funding.”

While Tennessee is not allowed to claim FFP for claims payments for Medicaid enrollees aged 21-64 at IMDs, the clear intent of this federal language is that those costs then become allowable uncompensated care. Tennessee has consistently held to this position and provided sufficient documentation to OIG to support it. OIG’s response has been to cite STCs a and c, paragraph 31, and STC-b, paragraph 33 from TennCare’s Section 1115 waiver agreement with CMS to claim that the State cannot claim FFP for these costs on CPEs. OIG is misapplying this language outside of its intended scope. The intent of these STCs was to prevent TennCare from claiming FFP for managed care claims payments to IMDs for enrollees aged 21-64. For additional context, when the original TennCare demonstration was established in 1994, Tennessee had authority in its 1115 waiver to pay Medicaid claims for IMD services for enrollees aged 21-64. This authority was temporary and eventually phased out. The STCs that OIG references were added into the TennCare waiver to make it clear that, while TennCare had

once been allowed to pay these Medicaid claims, it was no longer allowed to do so. This STC was intended to codify a change in TennCare covered benefits. It was not intended to govern uncompensated care policy. Nor was the intent of this language to result in Tennessee surrendering its right to classify these costs as uncompensated care, a right that CMS has expressly granted to every single state as demonstrated in the above guidance. OIG's assertion represents a fundamental lack of understanding about the interplay between the STCs and supplemental pools. If CMS had actually intended these STCs to also prohibit Tennessee from experiencing the same benefit that every other state experiences, it would certainly have stated so in the lengthy and detailed STC that governs hospital supplemental pool payments, STC 57. Instead, the language OIG is relying on for this novel interpretation is at STCs 31 and 33, 36 pages away from and out of the context of the language governing supplemental pools.

A smaller part of this alleged overpayment is related to miscalculations on IMD inpatient routine costs. This amount is \$21,985,082 over the course of the audit period. The State recognizes that this was indeed a miscalculation, though as OIG recognizes, for four out of the six years in the audit period, this miscalculation actually resulted in the State claiming less federal CPE than it was entitled to. Furthermore, this calculation issue was already corrected many years ago, and OIG is only now identifying and enforcing it in 2021.

#### **OIG Recommendation #2:**

Tennessee provide support or refund to the Federal Government \$370.1 million for the net costs of caring for uninsured IMD patients for which it did not provide detailed supporting documentation.

#### **State Response:**

The State does not concur with this recommendation. The State provided completely sufficient data to support the claims and therefore this recommendation and any refund is unwarranted. Furthermore, the recommendation to disallow the entire cost of uninsured IMD patients over the dispute regarding supporting documentation is particularly extreme and inappropriate. No rational basis exists to suggest IMDs had zero costs associated with caring for uninsured during the relevant time period.

Tennessee's approved CPE protocol allows the State to claim CPE on Medicaid shortfall and also on charity care for uninsured patients. In order to claim the CPE that is authorized by the 1115 demonstration for uninsured uncompensated care, Tennessee for many years had the hospitals submit detailed revenue code level data, along with an attestation from the hospitals that the data was an accurate representation of incurred costs. This standard is both consistent with the requirements of the 1115 demonstration and also provided OIG with auditable information. Furthermore, the State provided all patient-level detailed data requested by OIG for all Medicaid enrollees, which is the patient population for which Medicaid program maintains individual-level data. For the uninsured, the State also provided detailed revenue code level data and attestations for the uninsured patient data when requested by OIG.

Instead of accepting the provided data, OIG took the extreme approach of determining, without any support from CMS or the terms of the demonstration, that granular patient-level data regarding individuals outside the Medicaid program from more than a decade ago was the *only* acceptable source of documentation, even though that data is not specifically required by either CMS or the 1115 demonstration.

It is critical to note that when CMS proposed the Medicaid Financial Accountability Rule (MFAR) in late 2019, CMS included a new requirement that in order for states to claim FFP on uninsured costs, they must possess all related claims in their MMIS systems [see MFAR – proposed 42 CFR § 447.206(c)(1)]. CMS received many comments from multiple states objecting to this new requirement. At the end of 2020, CMS withdrew the MFAR. The clear conclusion is that having access to patient-level detailed data in order to claim FFP is not currently and has never been a requirement. If the federal government wishes it to be a requirement, then it should go through the appropriate rulemaking process to establish it as a requirement. It is inappropriate to enforce a standard from a proposed rule that CMS has withdrawn. The federal government has no legal basis to arbitrarily hold Tennessee to this unpromulgated rule.

Furthermore, by completely disallowing all IMD costs because of a lack of patient-level data, OIG is essentially taking the unreasonable position that the IMDs had absolutely no uninsured-related uncompensated care costs for the six-year period covered by the audit. Such a position is not based in reality or logic. The IMDs did have uninsured-related uncompensated care costs during this period (as they do in any given year), the State is allowed to claim those costs as CPE per the terms of Tennessee's demonstration, and the attested revenue code-level detailed data represents the most accurate picture of what occurred in 2009-2014. Again, Tennessee has provided all of this data to OIG for review and examination, and yet OIG is still disallowing the entire amount, resulting in a potential \$370 million overpayment determination. It is unreasonable to suggest the State pay back hundreds of millions of dollars from as far back as 12 years ago based on an allegation that the costs do not exist when it is abundantly clear these costs did exist and are supported by revenue code-level data. For OIG to recommend a position that it knows does not accurately reflect the reality of what occurred is simply inappropriate.

**OIG Recommendation #3:**

Tennessee establish additional policies and procedures to ensure compliance with Federal requirements.

**State Response:**

The State concurs in part and does not concur in part. While the State will implement written internal policies regarding how the federal share of any CPE claim in excess of allowable amounts will be returned, the State disagrees with some of the OIG's interpretation of requirements around IMD claiming.

OIG has recommended that the state Medicaid agency establish internal procedures for reconciling CPEs. While the State already has the CPE protocol in place, the State will write and implement further procedures.

OIG has also recommended that the State review its contractor's CPE calculations related to the inpatient routine costs. As mentioned earlier in the comments, this issue was corrected several years ago.

OIG has also recommended that the State collect patient-level detail data related to the uninsured population at IMDs. The State maintains that, for patient-level detailed data to be required, this should be specified in the state's demonstration or in a statute or rule. Nevertheless, the State has already begun requesting that IMDs submit patient-level detail data for their uninsured patients.

OIG has also recommended that the State claim no CPE for IMD patients aged 21-64. As discussed above, the State does not concur and believes OIG's interpretation of this issue is incorrect under applicable law and CMS guidance.

**Conclusion:**

The State reiterates its strong non-concurrence with the recommendations of this audit. An audit process that dates back 12 years is fundamentally flawed and places the State in the impossible position of having to refute findings without key documents or historical knowledge of key agreements – both formal and informal - from individuals responsible for decisions and actions from both the state agency and the federal government.

Furthermore, despite the unreasonable timeframe, for more than half of the total dollars reflected in the OIG recommendations – those related to IMDs – the State has provided completely acceptable and auditable documentation and provided federal guidance and rules to confirm Tennessee rightly claimed expenses for uncompensated care. If OIG applied this clear federal guidance and the language of the demonstration as intended by CMS, the total findings would immediately be reduced by more than half.

The State looks forward to future discussions with CMS and is confident in its ability to counter OIG's findings and recommendations.

Sincerely,

*Stephen Smith*

Stephen Smith

Director