TENNESSEE COMPTROLLER OF THE TREASURY

TennCare Examination

Joseph Howard Rupard, MD
Shelbyville, Tennessee

Cost Report

August 22, 2016, Through August 31, 2017

TennCare Visits and Payments

August 22, 2016, Through June 30, 2019

Jason E. Mumpower
Comptroller of the Treasury

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TENNESSEE COMPTROLLER OF THE TREASURY

JASON E. MUMPOWER
Comptroller

December 16, 2021

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 rural health clinics participating in the Tennessee Medical Assistance Program under Title XIX of the Social Security Act (Medicaid).

Submitted herewith is the report of the examination of the rural health clinic cost report of Joseph Howard Rupard, MD, in Shelbyville, Tennessee, for the period August 22, 2016, through August 31, 2017; and TennCare visits and payments for the period August 22, 2016, through June 30, 2019.

Sincerely,

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

KJS/pn
20/030

State of Tennessee

Examination Highlights

Comptroller of the Treasury Division of State Audit

TennCare Report
Joseph Howard Rupard, MD
Shelbyville, Tennessee
Cost Report for the Period
August 22, 2016, Through August 31, 2017;
and TennCare Visits and Payments for the Period
August 22, 2016, Through June 30, 2019

FINDINGS RECOMMENDING MONETARY REFUNDS

Failure to Accurately Report TennCare Visits and Payments

Joseph Howard Rupard, MD failed to accurately report TennCare visits and payments submitted to the State of Tennessee. The clinic overreported 2,532 visits and overreported $174,688.04 in payments received from managed care organizations (MCOs), third parties, and patients for the period August 22, 2016, through June 30, 2019. These overreported visits included visits for the Shelbyville Medical Group and the Lynchburg Family Medicine and Minor Emergency Clinic (non-rural health clinics also owned by Dr. Rupard), claims that did not meet the Centers for Medicare and Medicaid Services' (CMS) definitions of a visit, Medicare/Medicaid dual-eligible visits, and visits that could not be identified as TennCare visits.

Of the 2,532 overreported TennCare visits, Joseph Howard Rupard, MD requested settlement for 1,381 visits not rendered at the RHC, but at Shelbyville Medical Group and 772 that were rendered at Lynchburg Family Medical and Minor Emergency Clinic. Also, Shelbyville Medical Group did not have a contract with one of the TennCare MCOs during the period and was improperly billing TennCare claims for patients seen at that clinic under the RHC's credentials, then including those visits on the quarterly invoices for settlement.

As a result of these adjustments and adjustments made to the Prospective Payment System (PPS) rate, the Division of TennCare made overpayments of $292,780.48 to the clinic for the period August 22, 2016, through June 30, 2019 (page 5).

Nonallowable Expenses Included on the Cost Report

Joseph Howard Rupard, MD improperly reported $424,785.46 of expenses for the period August 22, 2016, to August 31, 2017. The nonallowable amounts consisted of expenses that were incurred by other clinics owned by Dr. Rupard; unsupported expenses; prior-period expenses; and personal expenses. The adjustment to the PPS rate is incorporated in the overpayment calculation in the failure to accurately report TennCare visits and payments finding (Finding 1) (page 9).

Failure to Accurately Report Total Visits on the Cost Report

Joseph Howard Rupard, MD failed to accurately report total visits on the cost report for the period August 22, 2016, through August 31, 2017. The clinic underreported 198 total visits. The adjustment to total visits is incorporated in the PPS rate change in the nonallowable expenses finding (Finding 2) (page 13).

Joseph Howard Rupard, MD
Shelbyville, Tennessee
Cost Report for the Period
August 22, 2016, Through August 31, 2017;
and TennCare Visits and Payments for the Period
August 22, 2016, Through June 30, 2019

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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 rural health clinics that participate in the Tennessee Medicaid Prospective Payment System.

Under their agreements with the state and as stated on cost reports submitted to the state, participating rural health clinics 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 the rural health clinic's assertions that it is in compliance with such requirements.

BACKGROUND

Tennessee's Medicaid Prospective Payment System (PPS) for rural health clinics is described in attachment 4.19-B of the Tennessee State Plan under Title XIX of the Social Security Act Medical Assistance Program. A clinic's initial PPS rate is established using the allowable costs and visits as reported on the rural health clinic cost report. After the initial rate is determined, the PPS rate increases at the beginning of the state's fiscal year (July 1) based on the current change in the Medicare Economic Index.

The clinic contracts with the TennCare managed care organizations (MCOs) and files claims with the MCOs for services provided to TennCare enrollees. Within 60 days after the end of each quarter, the clinic reports to the state the paid TennCare visits and the monies received for TennCare services from the MCOs, third parties, and patients. The state then makes quarterly payments to the clinic for the difference between the reimbursable costs (PPS rate multiplied by paid TennCare visits) and the amount of MCO reimbursements received for TennCare enrollee claims. Rural health clinic visits are medically necessary, face-to-face medical or mental health visits or qualified preventive visits between the patient and a physician, nurse practitioner, physician assistant, clinical nurse midwife, clinical psychologist, or clinical social worker during which a qualified rural health clinic service is furnished.

Joseph Howard Rupard, MD, in Shelbyville, Tennessee, provides rural health clinic services and participates in Tennessee's Medicaid Prospective Payment System. The clinic is owned and operated by Dr. Joseph H. Rupard, MD. Dr. Rupard also owns Celebration Family Health Clinic, a rural health clinic in Lewisburg, Tennessee, Lynchburg Family Medical and Minor Emergency Clinic and Shelbyville Medical Group, which are not rural health clinics.

During the cost reporting period August 22, 2016, through August 31, 2017, the clinic reported 5,675 visits; $1,284,406 in trial balance expenses; and net expenses of $1,256,610 after provider adjustments. Interim rates in effect during the examination were based on the trial balance expenses reported on the cost report for the period August 22, 2016, to August 31, 2017. During the examination period, auditors evaluated provider adjustments to determine if they were allowable for inclusion in the final rate.

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

Period	Interim Prospective Payment System (PPS) Rate (044-8967)
August 22, 2016, through June 30, 2017	$152.27
July 1, 2017, through June 30, 2018	$154.10
July 1, 2018, through June 30, 2019	$156.26
July 1, 2019, through June 30, 2020	$158.60

Joseph Howard Rupard, MD filed a cost repot effective August 22, 2016, for resubmission into the rural health clinic program. Prior to this application, the Joseph Howard Rupard, MD facility had been certified as an RHC at the same location on April 17, 2002, with an original PPS rate of $65.42, but subsequently left the program on April 1, 2014, with an ending PPS rate of $84.86.

PRIOR EXAMINATION FINDINGS

This is the first examination of this clinic.

SCOPE OF THE EXAMINATION

Our examination covers certain financial-related requirements of Tennessee's Medicaid Prospective Payment System for rural health clinics. The requirements covered are referred to under management's assertions specified later in the Independent Accountant's Report. Our examination does not cover quality of care or clinical or medical provisions.

TENNESSEE COMPTROLLER OF THE TREASURY

JUSTIN P. WILSON
Comptroller

JASON E. MUMPOWER
Deputy Comptroller

Independent Accountant's Report

April 29, 2020

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:

We have examined management's assertions, included in its representation letter dated April 29, 2020, that Joseph Howard Rupard, MD complied with the following requirements:

- Expenses reported on the rural health clinic cost report for the period August 22, 2016, through August 31, 2017, were reasonable, allowable, and in accordance with state and federal rules, regulations, and reimbursement principles.
- Total patient visits on the rural health clinic cost report for the period August 22, 2016, through August 31, 2017, have been appropriately counted.
- TennCare patient visits and monies received for all TennCare services for the period August 22, 2016, through June 30, 2019, were reported in accordance with the State Plan Amendment for Rural Health Clinics.

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

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Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether management's assertions are fairly stated, in all material respects. An examination involves performing procedures to obtain evidence about management's assertions. The nature, timing, and extent of the procedures selected depend on our judgment, including an assessment of the risks of material misstatement of management's assertions, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our adverse opinion. Our examination does not provide a legal determination on the entity's compliance with specified requirements.

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

- failure to accurately report TennCare visits and payments;
- nonallowable expenses included on the cost report; and
- failure to accurately report total visits on the cost report.

In our opinion, because of the significance of the matter described above, management's assertions that Joseph Howard Rupard, MD complied with the aforementioned requirements for expenses reported on the rural health clinic cost report for the period August 22, 2016, through August 31, 2017; and for TennCare patient visits and payments for the period August 22, 2016, through June 30, 2019, are not fairly stated in accordance with the criteria, in all material respects.

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,

Deborah V. Loveless

Deborah V. Loveless, CPA
Director

DVL/pn

FINDINGS AND RECOMMENDATIONS

1. Failure to Accurately Report TennCare Visits and Payments

Finding

Joseph Howard Rupard, MD failed to accurately report visits and payments on the quarterly invoices submitted to the State of Tennessee. During the examination period August 22, 2016, through June 30, 2019, auditors determined that the paid TennCare visits totaled 7,578, while the clinic reported 10,110, thus overreporting 2,532 visits. The visits variance is the result of the facility including visits for Shelbyville Medical Group and Lynchburg Family Medicine and Minor Emergency Clinic (non-rural health clinics owned by Dr. Rupard), claims that did not meet the Centers for Medicare and Medicaid Services' (CMS) definition of a visit, Medicare/Medicaid dual-eligible visits, and visits that could not be identified as TennCare visits.

	A	B	C
Quarter Ended	**TennCare Visits as Reported by Clinic**	**TennCare Visits per TennCare Claims Data**	**Visits Variance (A-B)**
9/30/2016	372	243	129
12/31/2016	965	594	371
3/31/2017	1,043	605	438
6/30/2017	1,037	619	418
9/30/2017	909	613	296
12/31/2017	840	717	123
3/31/2018	970	781	189
6/30/2018	1,000	809	191
9/30/2018	949	777	172
12/31/2018	836	677	159
3/31/2019	616	643	(27)
6/30/2019	573	500	73
	10,110	7,578	2,532

Of the 2,532 overreported TennCare visits noted above, Joseph Howard Rupard, MD requested settlement for 1,381 visits not rendered at the RHC but at Shelbyville Medical Group, and 772 visits not rendered at the RHC but at Lynchburg Family Medical and Minor Emergency Clinic. The State of Tennessee only settles on paid TennCare visits rendered at the RHC. Additionally, Shelbyville Medical Group did not have a contract with one of the TennCare MCOs during the period and was improperly billing TennCare claims for patients seen at that clinic under the RHC's credentials and was including those visits on the quarterly invoices for settlement.

During the examination for the period August 22, 2016, through June 30, 2019, auditors determined that Managed Care Organization (MCO), third-party liability (TPL), and patient

payments totaled $476,162.96, while the clinic reported $650,851.00 in payments. The facility overreported $174,688.04 in payments received from MCOs, third parties, and patients for the period tested.

	A	B	C
Quarter Ended	**MCO & TPL Payments Reported by Clinic**	**Amount Paid by MCOs & TPL per Claims Data**	**Variance in Payments (A-B)**
9/30/2016	$ 24,147.00	$ 15,707.75	$ 8,439.25
12/31/2016	63,863.00	38,483.81	25,379.19
3/31/2017	66,937.00	38,780.38	28,156.62
6/30/2017	65,876.00	38,437.42	27,438.58
9/30/2017	56,193.00	35,597.61	20,595.39
12/31/2017	56,343.00	46,191.83	10,151.17
3/31/2018	61,377.00	47,432.48	13,944.52
6/30/2018	62,346.00	48,231.98	14,114.02
9/30/2018	59,417.00	48,765.36	10,651.64
12/31/2018	54,177.00	43,791.33	10,385.67
3/31/2019	41,998.00	41,151.07	846.93
6/30/2019	38,177.00	33,591.94	4,585.06
	$ 650,851.00	$ 476,162.96	$ 174,688.04

Title 42, *United States Code*, 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 Title 31, *United States Code*, Section 3729(b)(3). The False Claims Act subjects a provider to a fine and treble damages if the provider knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay money to the federal government.

Chapter 13, Section 40.1, of the *Medicare Benefit Policy Manual* states, "RHC [rural health clinic] or FQHC [federally qualified health center] visits may take place in the RHC or FQHC, the patient's residence (including an assisted living facility), a Medicare-covered Part A SNF (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 20.1.1), or the scene of an accident."

As a result of the adjustments to TennCare visits and payments, as well as the adjustments found in Findings 2 and 3, the clinic received overpayments totaling $292,780.48 for the examination period August 22, 2016, through June 30, 2019.

Recommendation

Joseph Howard Rupard, MD should establish procedures to ensure that it submits accurate quarterly invoices to the State of Tennessee. The invoices should reflect the actual paid TennCare visits, and all monies received for TennCare services for each quarter reported. It should only include visits that were performed by Joseph Howard Rupard, MD, the registered rural health clinic.

As a result of the adjustments to TennCare visits and payments, and the Prospective Payment System rate, quarterly settlements starting with the quarter ended September 30, 2016, will be reprocessed. Upon the Division of TennCare's approval, State Audit will reprocess all quarterly settlements and transmit to TennCare for recoupment of the overpayment.

Management's Comment

Although the auditors provided—at Dr. Rupard's request—a list of the TennCare claims it alleges were "overreported," TennCare did not provide adequate documentation delineating which of these claims that were characterized as "claims that did not meet the Centers for Medicare and Medicaid Services' (CMS) definition of a visit," "Medicare/Medicaid dual-eligible visits," or "visits that could not be identified as TennCare visits."

The visits included in the above categories could very well be properly classified as TennCare visits, but the auditors evidently could not determine whether they were identified as such or what visits constituted those that did not meet CMS' definition of a visit. These distinctions are critical—without this information, Dr. Rupard cannot determine why any of the visits at issue were denied. The generic assertion that all of these claims were invalid and should be charged against Dr. Rupard defies understanding and should be properly presented and documented so that Dr. Rupard can further research and respond to these allegations.

The auditors (improperly) denied the 932 visits conducted by Physician Assistant [PA] Byron Bloom at the RHC during the period ending on August 31, 2017. The total visits for Bloom during that period totaled 967, of which only 35 were non-RHC visits. The visits reported by Dr. Rupard within the same time period totaled 1,352 (RHC), and Nurse Practitioner McBay's visits totaled 3,391. In all, 5,675 visits were reported for the RHC for the period ending on August 31, 2017. Mr. Bloom's employment agreement clearly requires him to see patients at the RHC, and his declaration confirms that he does just that. As such, Mr. Bloom's RHC-related compensation is an allowable expense for the RHC, and neither this compensation nor Mr. Bloom's visits should be excluded by TennCare. Those visits must be added back to the total RHC visits, and his salary costs attributable to the services he provided at the RHC must be included, as well.

In an effort to ensure that the RHC was in compliance with the applicable rules and regulations, Dr. Rupard engaged professionals to assist with the administration of the RHC, at great expense, in terms of both time and money. While Dr. Rupard is well educated from a clinical standpoint, he has never received any formal business training and, as such, he has relied on these professionals and their guidance with respect to the billing and preparation of all schedules, the

Medicare Cost Report, and the periodic reports required by TennCare. In Dr. Rupard's view, the outsourcing of these functions to other professionals was entirely appropriate and advisable, and it allowed him to focus on serving his patients in Bedford County. There has never been any intent on the part of Dr. Rupard to misreport visits or costs, despite TennCare's (entirely unfounded) insinuations to the contrary.

Dr. Rupard acknowledges that Chad Graham, his former office manager who was responsible for the management and oversight of the RHC (among other things) may have misreported TennCare visits at the Lynchburg clinic as RHC visits. The reason for this decision is not entirely clear to Dr. Rupard, but it may be due to the fact that the Lynchburg and RHC clinics shared a tax identification number (although each clinic kept separate books). Mr. Graham assured Dr. Rupard on multiple occasions that he was fully capable of handling all aspects of the RHC's business and he attended at least three RHC-specific trainings (paid for by Dr. Rupard). As Dr. Rupard understood it, Mr. Graham worked closely with Mark Lynn, an RHC consultant and specialist, on the annual cost reports and other reporting for the RHC, as well. There was never any attempt to defraud TennCare or to achieve reimbursement that was not deserved—rather, the misclassification of the Lynchburg visits was simply an administrative error that has since been corrected following Mr. Graham's departure. It was Mr. Graham's misunderstanding of the cost reporting process, despite his training to the contrary, that led to the misclassification of visits to Lynchburg.

When we met with the auditors in Nashville, they indicated that its determination of which visits did and did not occur at the RHC was based on their manual review of Dr. Rupard's patient charts and patient sign-in sheets. As an initial matter, one cannot determine where a patient was seen simply by looking at his or her medical chart. Furthermore, while the patient sign-in sheets may have *seemed* like a viable way of determining which patients were seen at the RHC and elsewhere, the auditors' reliance on these sign-in sheets was, as explained below, misplaced, and likely led to skewed and inaccurate results.

As discussed above, certain RHC visits that the auditors concluded were not RHC visits are incorrect when all facts are considered. PA Bloom's visits were not included, and they represented 932 of the total RHC visits. PA Bloom's employment contract clearly requires him to spend a significant portion of his time at the RHC. PA Bloom has also signed a declaration under penalty of perjury that confirms not only that he spent a significant portion of his time at the RHC, but also that the sign-in sheets at the RHC and non-RHC clinic in Shelbyville (SMG) where he spends the balance of his time are not reliable indicators of which patients were seen at either clinic on a given day. For this reason, the auditors' decision to disallow visits by TennCare patients whose names appeared on an SMG sign-in sheet is a material error that needs to be corrected. These patients, as PA Bloom's declaration makes clear, were seen at the RHC only if they were RHC (read: TennCare) patients. Conversely, TennCare patients were not seen at the SMG, and these patients would, as a matter of course, be sent to the RHC clinic because all providers and staff knew a TennCare patient visit would not be reimbursed if they were seen at the SMG. Thus, TennCare patients were only seen at the RHC. These facts have been attested to by PA Bloom.

Auditor's Comment

Auditors provided examples of claims that did not meet the Centers for Medicare and Medicaid Services definition of a visit, dual-eligible visits, and visits that could not be identified as TennCare visits to the facility.

Regarding the location where services were rendered, the auditors reviewed electronic and paper medical records to determine the location and arrived at the 1,381 visits that occurred at the Shelbyville, non-RHC clinic. The electronic medical records indicated the place of service where the visit occurred. In addition, Ms. Kelli Smith, Administrator, informed the auditor of the service location on the paper claims the auditors reviewed.

2. Nonallowable Expenses Included on the Cost Report

Finding

Joseph Howard Rupard, MD included $424,785.46 of nonallowable expenses on the cost report for the period August 22, 2016, through August 31, 2017. The nonallowable expenses consisted of $382,326.50 in expenses that were incurred by other clinics owned by Dr. Rupard; $39,613.71 in unsupported expenses; $2,803.25 in prior-period expenses; and $42.00 in personal expenses.

Visits that occurred at Shelbyville Medical Group and Lynchburg Family Medicine and Minor Emergency Clinic were billed and settled through Joseph Howard Rupard, MD. A total of $243,702.46 of administrative and support service salaries and $148,910.00 of contracted billing services expense were reported in full on the Joseph Howard Rupard, MD cost report. The auditors allocated amounts included on the cost report based on weighted total visits, thus resulting in $133,467.09 of nonallowable salary expense and $83,666.29 nonallowable contracted billing services. Expenses incurred by other clinics also included $134,132.85 Physician Assistant salary for services rendered at Shelbyville Medical Group and $31,060.27 other expenses which included legal fees, accounting fees, loan interest, medical supplies, office supplies, property insurance, utilities and repairs, and maintenance contract services. These other expenses were incurred by other clinics owned by Dr. Rupard and not Joseph Howard Rupard, MD.

The allowability of costs is governed by applicable Medicare principles of reimbursement for provider costs as set forth in the *Code of Federal Regulations* and the *Provider Reimbursement Manual*.

Title 42, *Code of Federal Regulations* (CFR), Part 413, Section 24, states that "providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors."

Title 42, *CFR*, Part 413, Section 9, states that "operating costs . . . not related to patient care, specifically not reimbursable under the program or flowing from the provision of luxury items or services . . . will not be allowable."

As a result of the above adjustments to allowable expenses and the adjustments to total visits in Finding 3, the clinic's Medicaid reimbursable rates were decreased as follows:

Period	Interim Rate	Final Rate	Difference
August 22, 2016, through June 30, 2017	$152.27	$141.64	($10.63)
July 1, 2017, through June 30, 2018	$154.10	$143.76	($10.34)
July 1, 2018, through June 30, 2019	$156.26	$145.92	($10.34)
July 1, 2019, through June 30, 2020	$158.60	$148.11	($10.49)

As a result of the rate decrease, as well as the adjustments in Finding 1, the clinic received overpayments of $292,780.48 for the period August 22, 2016, through June 30, 2019.

Amount Due to TennCare: Overreported TennCare Visits	$ (361,939.92)
Amount Due to the RHC: Overreported Payments	174,688.04
Amount Due to TennCare: Rate Change	(105,528.60)
Total Amount Due to TennCare	$ (292,780.48)

Recommendation

Joseph Howard Rupard, MD should only include allowable expenses on the cost report. All reported expenses should be adequately supported, for covered services, related to patient care, related only to the facility named on the cost report, and in compliance with other applicable regulations. Implementation of the audited rates is the decision of the Division of TennCare.

Management's Comment

The balance of costs—"Allocation of Billing Expense and Salaries"—apparently has been disallowed based on a per visit calculation. The disallowance of costs based on visits alone does not accurately reflect the actual costs, nor the significant investment of time by Dr. Rupard and others into the RHC. This somewhat arbitrary calculation ignores the additional time required to properly operate and manage a RHC, which well exceeds the time and other resources needed to run a traditional, non-RHC clinic. The additional paperwork alone is much more substantial than a normal medical practice, and the costs associated must be allocated based on a more appropriate methodology.

The actual costs, which have now been substantiated by Dr. Rupard and the RHC, total $73,750.09 and should be incorporated into the PPS rate changes calculated by auditors. The

originally disallowed amount of $210,466.79 differs from the costs reported by auditors ($462,898.17) by $252,431.38. Of the amount scheduled by auditors, Dr. Rupard has since been able to substantiate $73,750.09 of those costs, which should reduce the disallowed cost amount, prior to any further adjustments based on the information presented herein. The PPS rate should be modified by the substantiated costs and adjusted for the costs previously disallowed but not reflected on the auditors' schedule of disallowed costs.

The salaries of Dr. Rupard, Ms. Butts, Ms. Brown, Mr. Graham, and PA Bloom should also reflect the substantial additional effort required to oversee, manage, and operate the RHC. These costs must be adjusted, along with billing expenses, custodial/housekeeping services, and related costs, all of which have been unfairly and inequitably allocated against the RHC in a manner that, again, fails to consider the additional costs and effort required to operate a RHC. Auditors have disallowed $254,780.34 of costs based on the number of visits alone. The billing expenses for an RHC are, without a doubt, greater than those of a non-RHC practice because of the RHC-specific documentation and follow-up requirements, yet these factors have been ignored, at the expense of Dr. Rupard. Finally, the rate per visit for Dr. Rupard's efforts do not do justice to the needs and maintenance of an RHC.

The combination of the disallowed expenses on Exhibit 1 ($254,780.34), plus the $210,466.79 in disallowed expenses on the Disallowed Expense Revision (Exhibit 2) do not total the amount referenced in the TennCare report. The total in the TennCare report is $462,898.17, while the total of the two exhibits is $465,247.13. This inconsistency is concerning and raises several important questions, including: (1) the exact amount that is at issue; (2) the accuracy of the disallowed expense calculation; and relatedly, (3) whether there are other costs that were—but should not have been—disallowed. Based on the information provided to date, it is impossible for Dr. Rupard to make that determination, but principles of fairness require that these questions be addressed and that the foregoing inconsistency be resolved.

Dr. Rupard provided the auditors (via Exhibit 8) with all of the supporting documentation for the additional substantiated costs reported above ($73,750.09) for the RHC. The auditors have disallowed almost 100% of the expenditures related to the RHC that were supported with invoices and checks. Dr. Rupard's staff went to great lengths to gather the invoices produced to the auditors and virtually all of these expenses were still disallowed for various technicalities. The fact that an invoice is mailed to another clinic address does not mean that the expense reflected on the invoice does not relate to the RHC. The general ledger produced by Dr. Rupard that reflects the RHC expenditures was compiled and maintained by an independent accountant outside of the clinic. We struggle to understand why the auditors nonetheless insisted on obtaining bank statements in addition to the documentation (e.g., copies of checks that were obtained from the bank) already provided to support these expenditures. It is difficult to imagine how these check copies were obtained by the bank if these checks were not, in fact, cashed and if the funds had not cleared. Therefore, we dispute the allocation made based solely on visits as well as those costs which were disallowed but are now supported with documentation. The other expenses must be properly allocated to determine any disallowed costs, and the disallowed costs must be properly reconciled before that determination may be made. Despite the auditors' stated willingness to review additional documentation for these expenditures following our last meeting in Nashville, their

refusal to meaningfully revisit its initial findings with respect to these leaves Dr. Rupard and the RHC in tenuous positions.

Dr. Rupard also takes issue with the auditors' disallowance of supply costs based on the delivery location. When ordering supplies of any type, it is more cost effective to order with a greater volume to achieve cost savings. Where that package is delivered is irrelevant. Yet, the auditors have taken the position that supply costs are not includible unless the shipment goes directly to Dr. Rupard's RHC, regardless of whether the supplies in question were used for the benefit of RHC patients.

CMS rules related to adequate cost data (Title 42, *CFR*, Part 413, Section 24) do not require or reference anything beyond using a provider's "financial and statistical records which must be capable of verification. . ." Dr. Rupard and his staff have provided the auditors with the cost report itself, which was accompanied by additional detail, including a detailed general ledger reflecting all revenues and expenditures for the cost report period, invoices, checks, and detailed explanations of costs, thereby satisfying the applicable cost report standards for accuracy and verification. Nevertheless, the auditors refused to properly allocate the costs included in the cost report and demanded even more information, including bank statements, before it would even consider making changes. The information provided to the auditors to date is more than sufficient and exceeds what other entities provide to CMS cost report auditors. Further, the auditors' position that all costs must relate directly to patient care runs contrary to applicable CMS guidance, which allows reasonable indirect costs where appropriate. This guidance also recognizes that, in order to take care of patients and incur costs related to patient care, a clinic must have and incur overhead, including staff costs, insurance, professional assistance, administrative costs, taxes, and other expenses. Cost reports routinely include clinical and non-clinical costs, so the auditors' refusal to revisit their position on Dr. Rupard's reports is baffling, to say the least.

As the auditors are likely aware, CMS' reference form 222-17 permits home office costs, administration costs, malpractice premiums, malpractice paid losses, bad debts, all costs other than salaries from the RHC's books and records, transportation, GME costs and other overhead costs (lines 40-48), and finally all administration and management expenses (lines 60-68).

Based on the foregoing, Dr. Rupard maintains that the auditors should adjust the disallowed cost report expenses based on the allocation provided by him and the revised rates should also be adjusted to give Dr. Rupard credit for the visits disallowed by auditors without supporting documentation, as described above. Neither the auditors nor TennCare has provided any training, education, or timely reviews of Dr. Rupard's cost reports, leaving Dr. Rupard with no recourse but to rely on the professionals he hired to prepare and submit these reports. We take strong exception to the auditors' position on these matters and respectfully request adjustments in favor of Dr. Rupard.

Auditor's Comment

The auditors reviewed information submitted and allowed an additional $37,646.96 salary expense for the increased responsibilities at the RHC. Dr. Rupard's salary was not disallowed.

Mr. Bryan Bloom signed a questionnaire stating that he worked one day a week at Joseph Howard Rupard, MD. Based on this questionnaire, the auditors allowed $42,900.39 of his salary.

Based on the review of the additional information submitted to substantiate costs totaling $73,750.09, auditors allowed $465.75 of additional expense. Indirect costs noted in management's comment would be deemed allowable, assuming those costs were reasonable and adequately supported by invoice and proof of payment. However, the majority of the additional support provided for those expenses was either missing an invoice or proof of payment or was directly related to another facility owned by Dr. Rupard.

Auditors supplied the provider with documentation for all disallowed amounts and evidence that the total on the two exhibits did in fact total $462,898.17, the amount noted in the finding.

3. Failure to Accurately Report Total Visits on the Cost Report

Finding

Joseph Howard Rupard, MD failed to accurately report total visits on the cost report for the period August 22, 2016, through August 31, 2017. The examination disclosed a total of 5,873 visits, while only 5,675 total visits were reported on the cost report for the period; thus, the clinic underreported 198 total visits.

According to 42 CFR 413.24, providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial statistical records, which qualified auditors must be able to verify.

The adjustment to total visits is incorporated in the Prospective Payment System rate change in the nonallowable expense finding (Finding 2).

Recommendation

Joseph Howard Rupard, MD should establish procedures to ensure that it reports accurate total visits on the cost report.

Management's Comment

TennCare has provided little to no guidance or training to rural health clinics with respect to the calculation of visits or preparation and submission of cost reports. Once a cost report is submitted, providers like Dr. Rupard also have no meaningful way to access or review TennCare's visit data to determine whether the number of visits listed in their cost reports is consistent with TennCare's visit data. And yet, TennCare and its auditors seemingly expect perfection from

providers and impose stiff penalties on those who fail to correctly ascertain, interpret, or apply TennCare's prolix and intricate reporting requirements.

In an attempt to comply with all applicable regulations, Dr. Rupard engaged and relied on several professionals to manage the billing and other aspects of his practice (including the RHC) and to prepare, review, and submit the visit data and cost reports at issue. While Dr. Rupard acknowledges the auditors' position that some of the visit calculations in the cost reports were inaccurate, the fact that reasonable minds can and do differ with respect to the appropriate methodology for calculating the RHC visits at issue, coupled with the auditors' findings that Dr. Rupard both underreported total visits between August 2016-2017 and overreported visits in other quarters of the examination period effectively negates a finding of a fraudulent scheme or intent on the part of Dr. Rupard. Dr. Rupard's intent has always been to accurately calculate and report visit data and if visits were underreported, then Dr. Rupard will accept credit for those visits.

Jospeh Howard Rupard Clinic
Settlement Calculation
Dates of Service 8/22/16-6/30/19

	A	B	C	D	E	F	G	H	I
Quarter Ended	**TennCare Visits as Reported by Clinic**	**MCO & TPL Payments Reported by Clinic**	**TennCare Visits per TennCare Claims Data**	**PPS Rate**	**Reimbursable Cost (C*D)**	**Amount Paid by MCOs & TPL per Claims Data**	**Tentative Settlements Paid by TennCare**	**Total Paid (F+G)**	**Amount Due from/(to) State (E-H)**
9/30/2016	372	$ 24,147.00	243	$141.64	$ 34,418.52	$ 15,707.75	$ 32,498.00	$ 48,205.75	$ (13,787.23)
12/31/2016	965	63,863.00	594	$141.64	84,134.16	38,483.81	83,080.00	121,563.81	(37,429.65)
3/31/2017	1043	66,937.00	605	$141.64	85,692.20	38,780.38	91,883.00	130,663.38	(44,971.18)
6/30/2017	1037	65,876.00	619	$141.64	87,675.16	38,437.42	92,031.00	130,468.42	(42,793.26)
9/30/2017	909	56,193.00	613	$143.76	88,124.88	35,597.61	83,884.00	119,481.61	(31,356.73)
12/31/2017	840	56,343.00	717	$143.76	103,075.92	46,191.83	73,101.00	119,292.83	(16,216.91)
3/31/2018	970	61,377.00	781	$143.76	112,276.56	47,432.48	88,100.00	135,532.48	(23,255.92)
6/30/2018	1000	62,346.00	809	$143.76	116,301.84	48,231.98	91,754.00	139,985.98	(23,684.14)
9/30/2018	949	59,417.00	777	$145.92	113,379.84	48,765.36	88,871.00	137,636.36	(24,256.52)
12/31/2018	836	54,177.00	677	$145.92	98,787.84	43,791.33	76,454.00	120,245.33	(21,457.49)
3/31/2019	616	41,998.00	643	$145.92	93,826.56	41,151.07	54,257.00	95,408.07	(1,581.51)
6/30/2019	573	38,177.00	500	$145.92	72,960.00	33,591.94	51,358.00	84,949.94	(11,989.94)
	10,110	$ 650,851.00	7,578		$ 1,090,653.48	$ 476,162.96	$ 907,271.00	$ 1,383,433.96	$ (292,780.48)

Amount Due to TennCare: Overreported TennCare Visits	$ (361,939.92)
Amount Due to the RHC: Overreported Payments	174,688.04
Amount Due to TennCare: Rate Change	(105,528.60)
Total Amount Due to TennCare	$ (292,780.48)