Office of Inspector General

Texas Health and Human Services Commission

Stuart W. Bowen, Jr., Inspector General

Performance Audit Report

Denton Regional Medical Center
2010 Medicaid Outpatient Hospital Costs

December 28, 2015

IG Report No. 14-80-111905902-10-MO-02

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EXECUTIVE SUMMARY

The Texas Health and Human Services Commission (HHSC), Inspector General (IG), Audit Section completed an audit of Denton Regional Medical Center (Provider), Texas Provider Identifier (TPI) 111905902, 2010 Medicare Cost Report (Cost Report) for the period January 1, 2010 through December 31, 2010.

Audit Results

The Cost Report submitted by the Provider did not comply with Texas Administrative Code (TAC) and Centers for Medicare & Medicaid Services (CMS) instructions. The Detailed Findings and Recommendations section of this audit report identifies expense findings that resulted in adjustments totaling $704,860.

Objective

The objective of the IG's audit was to determine whether the Medicaid outpatient hospital costs included in the 2010 Cost Report submitted by the Provider were in compliance with TAC and CMS instructions.

Background

The Provider agreed to abide by the policies, procedures, laws, and regulations of the Texas Medicaid program by signing a Texas Medicaid Provider Agreement and submitting Medicaid claims under TPI 111905902. Medicaid outpatient hospital costs are reimbursed in accordance with 1 TAC §355.8061. The reimbursement methodology is based on reasonable cost/interim rates and is similar to that used by Title XVIII (Medicare). The hospital must submit the Medicare Cost Report to CMS for reimbursement and reporting purposes. A copy of the cost report is submitted to Texas Medicaid & Healthcare Partnership for review and settlement of requested Texas Medicaid cost reimbursement.

Summary of Scope and Methodology

The audit of the Provider covered the cost report period beginning January 1, 2010 through December 31, 2010. The IG 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. See Appendix A for a detailed description of the audit scope and methodology.

DETAILED FINDINGS AND RECOMMENDATIONS

Finding 1 – Overstated Employee Relations Costs

The Provider included employee relations costs that exceeded the allowable limit of $50 per eligible employee. The Provider was unaware of the TAC limit for employee relations costs. As a result, various cost centers were overstated collectively by $273,477, which represents $312,282 total reported employee relations costs minus $38,805 (776.09 average full time equivalents (FTEs) as reported on the cost report times $50 per FTE).

According to 1 TAC, §355.103 (b)(17)(A), "Employee relations expenses...Employee relations costs are limited to a ceiling of $50 per employee eligible to participate per year."

The following table illustrates the recommended adjustments:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
5.00	Employee Benefits	$9,050,023	($44,828)	$9,005,195
6.00	Administrative & General	18,064,622	(78,904)	17,985,718
8.00	Operation of Plant	3,616,534	(924)	3,615,610
10.00	Housekeeping	1,144,581	(1,094)	1,143,487
11.00	Dietary	2,041,915	(9,867)	2,032,048
14.00	Nursing Administration	1,138,875	(6,862)	1,132,013
25.00	Adults & Pediatrics	16,619,880	(90,619)	16,529,261
26.00	Intensive Care Unit	6,571,070	(24,457)	6,546,613
31.00	Subprovider	1,212,950	(1,622)	1,211,328
37.00	Operating Room	6,503,654	(2,467)	6,501,187
37.01	Cardiac Rehab	305,827	(397)	305,430
37.02	Endovascular	375,698	(520)	375,178
37.03	Endoscopy	415,155	(383)	414,772
38.00	Recovery Room	2,180,319	(815)	2,179,504
39.00	Delivery Room & Labor Room	1,984,957	(624)	1,984,333
41.00	Radiology – Diagnostic	5,139,409	(1,179)	5,138,230
44.00	Laboratory	4,351,248	(481)	4,350,767
49.00	Respiratory Therapy	1,811,570	(186)	1,811,384
50.00	Physical Therapy	1,881,145	(427)	1,880,718
55.00	Medical Supplies Charged to Patients	4,117,709	(82)	4,117,627

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Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
56.00	Drugs Charged to Patients	10,505,882	(47)	10,505,835
59.00	Behavior Medicine	181,231	(881)	180,350
59.01	Cardiac Catherization Laboratory	1,622,105	(459)	1,621,646
61.00	Emergency	4,580,086	(3,667)	4,576,419
65.00	Ambulance	1,459,267	(1,685)	1,457,582
	Total		($273,477)	

Recommendation:

The Provider should ensure that reported employee relations costs comply with TAC limits.

Management Response:

Finding 1 – Overstated Employee Relations Costs.

The primary item in this adjustment is food distributed to departments for meetings. This is provided when necessary meetings can only be coordinated during times when the employees would normally be leaving for lunch. We feel this does not qualify as employee relations and the interpretation is incorrect. The total adjustment was of $<237,477>. However, it should be noted that the calculated impact to the Medicaid outpatient settlement is $<868>.

Auditor Comments:

The finding included monthly recurring transactions from internal and external sources for catered food to the various departments. The Auditor reviewed all transactions and based on the TAC, which states a limit of $50 per employee per year for employee relations. The Provider had exceeded the TAC limit for this type of costs. Transactions related to meetings were mainly for the convenience of the Provider which is not an allowable cost. The finding will remain $273,477.

Finding 2 – Unsubstantiated and Undocumented Costs

The Provider included unsubstantiated and undocumented costs in the cost report. The Auditor selected 401 expense transactions to be tested. The Provider supplied adequate supporting documentation to clear 290 transactions. The remaining 111 transactions could not be substantiated and were deemed unallowable due to insufficient or lack of support documentation. The Provider was unaware of these undocumented costs and processed as

allowable and included them in the hospital cost report. As a result, various cost centers were overstated by $235,724.

According to 1 TAC, §355.103(b)(2)(B)(xix), "Adequate documentation. To be allowable, the relationship between reported costs and contracted services must be clearly and adequately documented. Adequate documentation consists of all materials necessary to demonstrate the relationship of personnel, supplies, and services to the provision of contracted client care or the relationship of the central office to the individual service delivery entity level. These materials may include, but are not limited to, accounting records, invoices, organizational charts, functional job descriptions, other written statements, and direct interviews with staff, as deemed necessary by HHSC auditors to perform required tests of reasonableness, necessity, and allowability.... Any expense that cannot be adequately documented or substantiated is disallowed. HHSC is not responsible for the contracted provider's failure to adequately document and substantiate reported costs..."

The following table illustrates the recommended adjustments:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
14.00	Nursing Administration	$1,132,013	($74,457)	$1,057,556
41.00	Radiology – Diagnostic	5,138,230	(44,421)	5,093,809
57.00	Renal Dialysis	629,430	(57,827)	571,603
61.00	Emergency	4,576,419	(30,926)	4,545,493
62.01	Observation Beds	1,168,130	(28,093)	1,140,037
	Total		($235,724)	

Recommendation:

The Provider should ensure that all reported costs are accurate and sufficiently documented in accordance with the TAC.

Management Response:

Finding 2 – Unsubstantiated and Undocumented Costs.

We maintain the auditor was provided with adequate support for all expense items noted. Unfortunately, the auditor had difficulty following the support in some cases – including a payroll accrual for one part-time employee. We believe the adjustment is incorrect. The total adjustment was for $<235,724>. However, it should be noted that the calculated impact to the Medicaid outpatient settlement is $<4,377>.

Auditor Comments:

The Auditor requested additional support documentation with detailed explanations as to what was needed to clear the transactions. The Auditor reviewed all of the Provider's submitted support documentation and cleared 290 of 401 transactions with adequate documentation (all payroll transactions had been cleared with additional support received). The Auditor still needed clarification or additional support documentation for the remaining 111 transactions. An email was sent to Provider 10/28/2015 with detailed explanations of which transactions had been disallowed and the Provider was given the opportunity to submit any additional support documentation to clear the transactions before the draft report was completed. The finding will remain unchanged.

Finding 3 – Legal Costs

The Provider included legal costs associated with litigation in the cost report. These legal costs were associated with the Kyphoplasty class action lawsuit and not associated with Medicaid contracted services. As a result, Cost Center 6.00 was overstated by $53,244.

According to 1 TAC, §355.103(b)(17)(I), "Litigation expenses and awards. Unless explicitly allowed elsewhere in this chapter, no court-ordered award of damages or settlements made in lieu thereof or legal fees associated with litigation which resulted in any court-ordered award of damages or settlements made in lieu thereof, or a criminal conviction, are allowable."

The following table illustrates the recommended adjustment:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative & General	$17,985,718	($53,244)	$17,932,474

Recommendation:

The Provider should ensure that all reported legal costs are allowable in accordance with the TAC.

Management Response:

Finding 3 – Legal Costs

We disclosed that new information had come to our attention subsequent to filing the cost report which made a portion of our legal expenses non-allowable. We concur with this adjustment. The total adjustment was for $<53,244>. However, it should be noted that the calculated impact to the Medicaid outpatient settlement is $<224>.

Finding 4 – Unallowable Dues Costs

The Provider included unallowable rotary club, chamber of commerce and community non-professional organizations dues in the cost report. The Provider considered these costs allowable and reported them in the hospital cost report. As a result, Cost Center 6.00 and Cost Center 8.00 were overstated by $48,903.

According to 1 TAC, §355.103(b)(11)(B), "Unallowable dues and contributions to organizations. Dues to nonprofessional organizations are unallowable...Costs of membership in civic organizations whose primary purpose is the promotion and implementation of civic objectives are unallowable. Dues or contributions made to any type of political, social, fraternal, or charitable organization are unallowable. Chamber of Commerce dues are unallowable. Franchise fees are not considered dues or contributions to organizations. Contributions are unallowable costs."

The following table illustrates the recommended adjustments:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative & General	$17,932,474	($48,578)	$17,883,896
8.00	Operation of Plant	3,615,610	(325)	3,615,285
	Total		($48,903)	

Recommendation:

The Provider should ensure that reported dues comply with the TAC.

Management Response:

Finding 4 – Unallowable Dues Costs

The majority of this adjustment relates to the DFW Hospital Council which is a professional organization. The TAC cited references nonprofessional and civic organizations, and therefore not applicable. We feel the interpretation is incorrect. The total adjustment was for $<48,903>. However, it should be noted that the calculated impact to the Medicaid outpatient settlement is $<212>.

Auditor Comments:

The Auditor requested an explanation for the nature of the costs regarding DFW Hospital Council (Council) from the Provider. The Auditor's research of the organization identified that the Council is a 501(c)(6) not-for-profit trade organization. Research revealed that trade organizations are founded by businesses that operate in a specific industry and participate in public relations activities such as advertising, education, political donations, lobbying and publishing. Other activities may include conferences, networking and charitable events. Research with the Internal Revenue Service identifies 501(c)(6)

organizations as chambers of commerce, business leagues, and boards of trade as similar organizations to the Council. As the Provider did not submit explanation to clarify the costs, the Auditor disallowed the costs. The finding will remain $48,903.

Finding 5 – Unallowable Audit Costs

The Provider included costs for non-financial audits in the cost report. The audits included audits for sales tax and patient charts. The Provider was unaware that these costs were unallowable. As a result, Cost Center 6.00 was overstated by $29,788.

According to 1 TAC, §355.102(f)(2)(C)(D)(E), ""Necessary" refers to the relationship of the cost, direct or indirect, incurred by a provider to the provision of contracted client care. Necessary costs are direct and indirect costs that are appropriate in developing and maintaining the required standard of operation for providing client care in accordance with the contract and state and federal regulations. In addition, to qualify as a necessary expense, a direct or indirect cost must meet all of the following requirements:... (C) if a direct cost, it bears a significant relationship to contracted client care. To qualify as significant, the elimination of the expenditure would have an adverse impact on client health, safety, or general well-being; (D) the direct or indirect expense was incurred in the purchase of materials, supplies, or services provided to clients or staff in the normal conduct of operations to provide contracted client care; (E) the direct or indirect costs are not allocable to or included as a cost of any other program in either the current, a prior, or a future cost-reporting period;..."

The following table illustrates the recommended adjustment:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative & General	$17,883,896	($29,788)	$17,854,108

Recommendation:

The Provider should ensure that reported non-financial audit costs are removed from the cost report in accordance with the TAC.

Management Response:

Finding 5 – Unallowable Audit Costs.

A portion of this adjustment (5,900) relates to chart reviews to ensure we are in compliance with the changing regulations. However, the term audit was used instead of the word review on the invoice. We believe that occasional reviews to ensure compliance are valid expenses and should not be disallowed. The total adjustment was for $<29,788>. The estimated impact to the Medicaid outpatient settlement is $<124>.

Auditor Comments:

The Auditor understands the need for periodic validation of compliance with regulations. An audit or review for compliance does not have any significant relationship to the contracted care provided. The finding will remain $29,788.

Finding 6 – Unallowable Advertising and Promotional Costs

The Provider included advertising and promotional costs, which are considered unallowable. Costs included motion picture license, digital/photo licensure and other promotional costs. The Provider assumed these were allowable expenses. As a result, various cost centers were overstated by $15,008.

According to 1 TAC, §355.103(b)(14), "Promotional and fundraising activities. Promotional refers to any activity whose intent is to advertise or aid in the development of the business. Expenses relating to fundraising and promotional activities are unallowable,... Other expenses associated with these activities are also unallowable, including advertising, publicity, travel, and meals."

The following table illustrates the recommended adjustments:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative & General	$17,854,108	($14,557)	$17,839,551
41.00	Radiology – Diagnostic	5,093,809	(451)	5,093,358
	Total		($15,008)	

Recommendation:

The Provider should ensure that all advertising and promotional costs are removed from the cost report in accordance with the TAC.

Management Response:

Finding 6 – Unallowable Advertising and Promotional Costs.

The majority of this adjustment relates to the digital and photo licenses related to departments within the facility not related to marketing or advertising. We feel the adjustment is incorrect. The total adjustment was for $<15,008>. However, it should be noted that the calculated impact to the Medicaid outpatient settlement is $<73>.

Auditor Comments:

The Auditor requested clarification of the costs (which at the time of the final report had not been provided) of licenses from the Provider. The general ledger descriptions of the questionable costs are generally associated with advertising and marketing; and are the reason for the Auditor disallowing the costs. The finding will remain $15,008.

Finding 7 – Unallowable Miscellaneous Costs

The Provider included unallowable miscellaneous costs in the cost report. In accordance with the TAC, costs not considered reasonable and necessary to provide contracted client care are unallowable, such as expenses for survey of Medical Office Building tenants, indoor plant maintenance, and freight charges associated with non-allowable costs are unallowable. The Provider believed the costs were allowable and included them in the cost report. As a result, various cost centers were overstated by $9,849.

According to 1 TAC, §355.102(a), "Allowable and unallowable costs. Allowable and unallowable costs, both direct and indirect, are defined to identify expenses that are reasonable and necessary to provide contracted client care and are consistent with federal and state laws and regulations. When a particular type of expense is classified as unallowable, the classification means only that the expense will not be included in the database for reimbursement determination purposes because the expense is not considered reasonable and/or necessary. The classification does not mean that individual contracted providers may not make the expenditure. The description of allowable and unallowable costs is designed to be a general guide and to clarify certain key expense areas. This description is not comprehensive, and the failure to identify a particular cost does not necessarily mean that the cost is an allowable or unallowable cost."

The following table illustrates the recommended adjustments:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative & General	$17,839,551	($9,342)	$17,830,209
41.00	Radiology – Diagnostic	5,093,358	(507)	5,092,851
	Total		($9,849)	

Recommendation:

The Provider should ensure that reported costs comply with TAC.

Management Response:

Finding 7 – Unallowable Miscellaneous Costs.

The majority of the adjustment related to the indoor plant maintenance. The emotional state of patients is improved with the addition of indoor plants. In turn, that emotional improvement aids in the physical recovery of those patients. The maintenance on these plants of $8,400 for the year is reasonable, not excessive, and we feel subjective opinion is incorrect. The total adjustment was for $<9,849>. However, it should be noted that the calculated impact to the Medicaid outpatient settlement is $<47>.

Auditor Comments:

While the Auditor understands the Provider's position that plants may have a positive impact on the patients' emotional well-being; these costs are not necessary to provide contracted client care. The finding will remain $9,849.

Finding 8 – Misclassified Interest Expense

The Provider misclassified interest expense on equipment. The interest expense for equipment was reported in Cost Center 6.00 should have been reclassified to Cost Center 4.00 as per cost report instructions. The Provider was unaware of the expenses and allowed the expense in cost report. As a result, Cost Center 6.00 was overstated and Cost Center 4.00 was understated by the amount of $38,867 respectively.

According to 1 TAC, §355.102(c), "c) Accurate cost reporting. Accurate cost reporting is the responsibility of the contracted provider. The contracted provider is responsible for including in the cost report all costs incurred, based on an accrual method of accounting, which are reasonable and necessary, in accordance with allowable and unallowable cost guidelines in this section and in §355.103 of this title, revenue reporting guidelines in §355.104 of this title (relating to Revenues), cost report instructions, and applicable program rules. Reporting all allowable costs on the cost report is the responsibility of the contracted provider. The Texas Health and Human Services Commission (HHSC) is not responsible for the contracted provider's failure to report allowable costs; however, in an effort to collect reliable, accurate, and verifiable financial and statistical data, HHSC is responsible for providing cost report training, general and/or specific cost report instructions, and technical assistance to providers. Furthermore, if unreported and/or understated allowable costs are discovered during the course of an audit desk review or field audit, those allowable costs will be included on the cost report or brought to the attention of the provider to correct by submitting an amended cost report."

The following table illustrates the recommended adjustments:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative & General	$17,830,209	($38,867)	$17,791,342
4.00	Capital Related Costs – Movable Equipment	5,121,247	38,867	5,160,114
	Total		($0)	

Recommendation:

The Provider should ensure that reported costs comply with the TAC.

Management Response:

Finding 8 – Misclassified Interest Expense.

The total adjustment nets to $0.00, reclassifying interest from line 6.00 to line 4.00 and the calculated impact to the Medicaid outpatient settlement is $21.

APPENDICES

Appendix A - Objective, Scope, and Methodology

Objective

The objective of the IG's audit was to determine whether the Medicaid outpatient hospital costs included in the 2010 Cost Report submitted by the Provider were in compliance with the TAC rules and CMS instructions.

Scope

The audit scope was limited to hospital costs reported by the Provider, for the period January 1, 2010 through December 31, 2010.

Methodology

The IG 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. The audit included obtaining an understanding of compliance criteria, and the processes related to the preparation of the cost report. Accounting records, transactions, and supporting documentation were reviewed to determine that only reasonable, necessary, and allowable costs were submitted for reimbursement to the Texas Medicaid Program.

The audit methodology included:

- Discussions with Provider management and staff
- Obtaining an understanding of relevant controls, compliance criteria, and processes relating to the preparation of the cost report
- Reviewing applicable Medicaid laws and regulations
- Using the Medicare Cost Report to identify costs and charges
- Reviewing available accounting schedules, exhibits, and other supporting documentation to substantiate Medicaid costs and charges
- Testing costs to determine allowability
- Interviewing personnel and observing assets and expenditures
- Testing transactions in the general ledger
- Testing depreciation expense schedules
- Reviewing allocation methodology and results

Criteria Used

- 1 TAC, §§355.101 - 110
- Guidelines and policies to implement Medicare regulations set forth in CMS Publication 15-1, Provider Reimbursement Manual, Chapters 1 through 29

- Specific instructions for the completion of the hospital cost report, CMS Form 2552-96 as set forth in CMS Publication 15-2, Provider Reimbursement Manual, Chapter 36
- Generally Accepted Accounting Principles
- Provider policies and procedures

Other

Fieldwork was conducted July 28, 2014 through August 1, 2014.

Team Members

Kacy J. VerColen, CPA, Director of Audit
Jose Oliva, CFE, Manager
Albert Alberto, CIGA, Team Lead
Frederick Garcia, CIGA, Team Lead
Antoinette (Toni) Brewer, Project Lead
Grace Valentine, Auditor

Appendix B - Report Distribution

Health and Human Services Commission

Nicole Guerrero, CIA, CGAP
HHSC Director of Internal Audit
Mail Code BH-1600
4900 North Lamar Boulevard
Austin, TX 78751

John Spann
Director of Audit
Texas Medicaid & Healthcare Partnership
12365A Riata Trace Parkway, Building 9
Austin, TX 78758

Selvadas Govind
HHSC Director of Rate Analysis for Hospitals
Mail Code H-400
4900 North Lamar Boulevard
Austin, TX 78751

Cecile Young
HHSC Chief of Staff
Mail Code 1000
4900 North Lamar Boulevard
Austin, TX 78751

Provider

Mr. Caleb O'Rear,
Chief Executive Officer
Denton Regional Medical Center
3535 S I-35 East
Denton, TX 76210