Office of Inspector General

Texas Health and Human Services Commission

Stuart W. Bowen, Jr., Inspector General

Performance Audit Report

Houston Northwest Medical Center
2009 Medicaid Outpatient Hospital Costs

September 30, 2015

IG Report No. 13-80-193867201-09-MO-24

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EXECUTIVE SUMMARY

The Texas Health and Human Services Commission (HHSC), Inspector General (IG), Audit Section completed an audit of Houston Northwest Medical Center's (Provider), Texas Provider Identifier (TPI) 193867201, 2009 Medicare Cost Report (Cost Report) for the period June 1, 2008 through May 31, 2009.

Audit Results

The Cost Report submitted by the Provider did not comply with Texas Administrative Code (TAC) and Centers for Medicare and Medicaid Services (CMS) instructions. The Detailed Findings and Recommendations section of this audit report identified expense findings that were noted in the audit and resulted in adjustments totaling $3,561,214.

Objective

The objective of the IG's audit was to determine whether the Medicaid outpatient hospital costs included in the 2009 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 193867201. 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 June 1, 2008 through May 31, 2009. 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. The IG believes that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. See Appendix A for a more detailed description of the audit scope and methodology.

DETAILED FINDINGS AND RECOMMENDATIONS

Finding 1 – Insurance – Professional Liability Costs

The Provider's self-insurance program did not comply with TAC. To be allowable, a provider's self-insurance program requires a written agreement with an unrelated party. During an audit of the Provider's 2010 Medicare Cost Report for the period June 1, 2009 through May 31, 2010, the Provider explained that the self-insurance fund is administered by the home office, and there is no separate self-insurance fund for each hospital. The Provider was unaware of the TAC rule for qualification of a self-insurance program. As a result, Cost Center 6.00 was overstated by $3,286,201.

According to 1 TAC, §355.103(b)(10)(B), "Self-insurance. Self-insurance is a means whereby a contracted provider undertakes the risk to protect itself against anticipated liabilities by providing funds in an amount equivalent to liquidate those liabilities. Self-insurance can also be described as being uninsured. To qualify as an allowable self-insurance plan, a contracted provider must enter into an agreement with an unrelated party that does not provide for the shifting of risk to the unrelated party designed to provide only administrative services to liquidate those liabilities and manage risks..."

The following table illustrates the recommended adjustment:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative and General	$41,078,264	($3,286,201)	$37,792,063

Recommendation:

The Provider should ensure its self-insurance program complies with the TAC for self-insurance costs reported in the cost report.

Management Response:

Finding 1 - Insurance-Professional Liability Costs - the adjustment removes $3,286,201 of malpractice costs from the Administrative and General cost center. The Provider is aware of the TAC rules governing self-insurance of Tenet Healthcare Corporation (Tenet), and is subject to rules governing related-party *transactions. Tenet secures malpractice coverage on behalf of all of its subsidiaries, and has determined that it is more cost effective to self-insure the first $5 million of losses per occurrence. Claims expenses for losses below the $5 million threshold are paid by Tenet on behalf of the subsidiary provider. Because the Provider's coverage for the self-insurance portion of losses is paid by a* related *party, the provisions in the TAC regarding unrelated parties cited by the auditor do not apply. We believe the facts support the allowability of the claims expense paid by a related party, thus we do not believe the application of the TAC rule cited by the auditor is correct.*

Auditor's Comment:

The Provider explained that the claims expenses for losses below $5 million are paid by the home office and above $5 million are paid by insurance; the Provider stated that this process is cost effective. While we applaud the Provider for utilizing cost effective practices, the TAC explicitly states that for a self-insurance plan to be allowable, the Provider must enter into an agreement with an unrelated party to administer their liabilities. This requirement was not met by the Provider; therefore, the finding remains unchanged.

Finding 2 – Employee Relations Costs

The Provider included employee relations costs that exceeded the allowable limit of $50 per eligible employee. The Provider stated they had submitted an adjusted Cost Report to TMHP; however, the cost report the IG obtained from TMHP did not substantiate the costs in question. As a result, various cost centers were overstated collectively by $182,561, which represents $246,621 total costs minus $64,060 (1,281.20 average full time equivalents (FTE) as reported in the cost report times $50 per FTE).

According to 1 TAC, §355.103(b)(17)(A), "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	$592,502	($12,295)	$580,207
6.00	Administrative and General	37,792,063	(118,810)	37,673,253
8.00	Operation of Plant	7,827,885	(845)	7,827,040
11.00	Dietary	602,376	(2,574)	599,802
14.00	Nursing Administration	3,758,475	(3,019)	3,755,456
15.00	Central Services and Supply	1,764,195	(630)	1,763,565
16.00	Pharmacy	4,781,771	(304)	4,781,467
17.00	Medical Records and Library	3,131,814	(1,142)	3,130,672
25.00	Adults & Pediatrics	28,156,268	(3,368)	28,152,900
26.00	Intensive Care Unit	10,188,060	(692)	10,187,368
33.00	Nursery	2,111,026	(117)	2,110,909
37.00	Operating Room	11,844,818	(3,204)	11,841,614
39.00	Delivery Room and Labor Room	3,176,181	(408)	3,175,773

Continued from last page:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
40.00	Anesthesiology	1,522,269	(222)	1,522,047
41.00	Radiology - Diagnostic	9,565,536	(32,350)	9,533,186
44.00	Laboratory	7,354,542	(567)	7,353,975
49.00	Respiratory Therapy	3,352,808	(663)	3,352,145
50.00	Physical Therapy	1,502,497	(279)	1,502,218
53.00	Electrocardiology	735,392	(156)	735,236
53.03	Cardiac Rehab	269,825	(130)	269,695
61.00	Emergency	6,941,917	(786)	6,941,131
	Total		($182,561)	

Recommendation:

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

Management Response:

Finding 2 - Employee Relations Costs - the adjustment removes $182,561 of unallowable employee relations costs that exceeded the $50 per employee allowance. While we agree with the adjustment in principle we do not believe the OIG complied with the regulatory language when calculating this adjustment. Additionally, we do not believe a corrective action plan is warranted as HNMC routinely disallows this item (see notes under Finding 3 below). However, we will employ a methodology similar to the OIG's for determining allowable employee relation costs in future Medicaid Cost Report filings.

TAC 355.103(b)(20)(A) states "[e]mployee relations costs are limited to a ceiling of $50 per employee eligible to participate per year." [emphasis added] We don't believe the OIG's substitution of FTE count for employee count complies with this regulation. We can find no reference to FTE counts as a proxy for employees in the regulations. The OIG's approach using FTE's overstates the adjustment, i.e., understates the allowable total, for all employees in a given year due to staff turnover. However, we will not request a change to the adjustment at this time as the savings to Tenet are immaterial and do not justify the time we would need to invest.

Auditor's Comment:

During the audit of the Provider's 2010 Medicare Cost Report, it was determined that the Provider has no policy or reliable procedure in place to determine how to calculate employee relations expense for a cost reporting period. Therefore, the auditor used the most reasonable basis of calculating the employees eligible to participate for the purpose of

employee relations expense, which is the average FTEs in the Cost Report as identified on Schedule S-3 of the Cost Report.

Finding 3 – Board of Directors Costs

The Provider included unallowable board of directors costs in the Cost Report. The Provider stated they had submitted an adjusted Cost Report to TMHP; however, the cost report the IG obtained from TMHP did not substantiate the costs in question. As a result, Cost Center 6.00 was overstated by $9,900.

According to 1 TAC, §355.103(b)(2)(E), "Board of Directors and Trustees. Fees and expenses related to boards of directors and trustees are unallowable costs except for: (i) Travel costs incurred by the contracted provider's board members or trustees to attend meetings of the contracted provider's board of directors or trustees are allowable costs in accordance with the travel guidelines as stated in paragraph (12)(B) of this subsection; and (ii) Errors and omissions (liability) insurance for boards of directors or trustees are allowable costs."

The following table illustrates the recommended adjustment:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative and General	$37,673,253	($9,900)	$37,663,353

Recommendation:

The Provider should ensure board of directors costs are reported in compliance with TAC.

Management Response:

Finding 3 - Board of Directors Costs - the adjustment removes $9,900 of unallowable governing board related expenses. While we agree with this adjustment, we do not believe a corrective action plan is warranted as HNMC routinely disallows this item. (See attachment 2)

HNMC properly filed a Medicaid cost report with TMHP, excluding both board of directors' costs and employee relations costs. Due to a procedural oddity the OIG audits the as-filed, or as-settled, Medicare cost report, received from our Medicare Audit Contractor, Novitas. That cost report does not reflect the Medicaid related adjustments to charges and expenses included in our TMHP-filed cost report. Since we are properly filing our Medicaid cost report already we do not believe a CAP is necessary. Further, we believe the OIG should base their audit on the Medicaid cost report, not the Medicare cost report, to avoid findings such as these.

We note that in your 'Auditor's Follow-up Comment' to this issue for the 2010 audit you state that our adjustments for board of directors and employee relations costs 'were not in

the TMHP-filed cost report.' That statement is patently false. We can document that our Medicaid cost report did indeed include those adjustments. We note that you choose to audit the Medicare cost report, not the TMHP-filed Medicaid cost report.

Auditor's Follow-up Comment:
The IG received confirmation from TMHP that the adjustments for board of directors and employee relations costs were not in the TMHP-filed cost report. Therefore, our finding remains unchanged.

Finding 4 – Legal Fees Associated with Malpractice Insurance Costs

The Provider included unallowable legal litigation expenses associated with malpractice insurance. Since the malpractice insurance cost was disallowed due to non-compliance with the TAC rules, the associated legal litigation expenses are disallowed also. These costs were included because the Provider considered these legal fees allowable. As a result, Cost Center 6.00 was overstated by $82,552.

According to 1 TAC §355.103(b)(2)(C)(ii), "...Legal costs associated with any other unallowable costs are also unallowable."

The following table illustrates the recommended adjustment:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative and General	$37,663,353	($82,552)	$37,580,801

Recommendation:

The Provider should implement a procedure to ensure reported legal fees comply with TAC.

Management Response:

Finding 4 - Legal Fees - the adjustment removes $82,552 of unallowable litigation costs related to malpractice. We disagree with this adjustment, in part, due to the relation to malpractice insurance per the above notes in Finding 1. However, for future Medicaid Cost Report filings we will ensure that we remove any non-allowable litigation costs related to claims under $5 million.

Auditor's Follow-up Comment:

Since the insurance-professional liability costs are unallowable as cited in Finding 1, the associated legal litigation expenses are also unallowable. 1 TAC, 355.103(b)(2)(C)(ii), "Legal costs associated with any other unallowable costs are also unallowable." The finding remains unchanged.

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 2009 Cost Report submitted by the Provider were in compliance with TAC and CMS instructions.

Scope

The audit scope was limited to outpatient hospital costs reported by the Provider for the period June 1, 2008 through May 31, 2009.

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. The IG believes 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 (entrance and exit conferences are not performed on desk audits)
- 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

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
- Provider policies and procedures

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