
# Inspector General

## Texas Health and Human Services Commission

**Stuart W. Bowen, Jr., Inspector General**

# Performance Audit Report

## Lake Granbury Medical Center
## 2010 Medicaid Outpatient Hospital Costs

**August 31, 2015**

IG Report No. 14-80-094178302-10-MO-24

# CONTENTS

# EXECUTIVE SUMMARY

The Texas Health and Human Services Commission (HHSC), Inspector General (IG), Audit Section completed an audit of Lake Granbury Medical Center (Provider), Texas Provider Identifier (TPI) 094178302, 2010 Medicare Cost Report (Cost Report) for the period December 1, 2009 through November 30, 2010.

## 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 $208,212 of adjustments.

## 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 094178302. 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 December 1, 2009 through November 30, 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. The IG believes that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

# DETAILED FINDINGS AND RECOMMENDATIONS

## Finding 1 – Ambulance Costs

The Provider improperly reclassified ambulance service expenses from Cost Center 65.00 to Cost Centers 4.00 and 61.00. The Provider did not realize that all ambulance costs must be reported in Cost Center 65.00 of the cost report. As a result, Cost Centers 4.00, Other Leases/Rentals, and 61.00, Other Purchase Service, were collectively overstated by $153,314; and Cost Center 65.00 was understated by $153,314.

According to the Provider Reimbursement Manual, 15-2, Chapter 36, Section 3610, Worksheet A: Reclassification and adjustment of Trial Balance of Expenses: Line 65, "Report all ambulance costs on this line for both owned and operated services and services under arrangement. No subscripting is allowed for this line (9/96)."

The following table illustrates the recommended adjustments:

| Cost Center | Cost Center Description | Reported Amount | Adjustment Amount | Adjusted Amount |
|---|---|---|---|---|
| 4.00 | Leases/Rentals | $3,783,328 | ($6,152) | $3,777,176 |
| 61.00 | Other Purchase Service | 1,867,531 | (147,162) | 1,720,369 |
| 65.00 | Ambulance | 0 | 153,314 | 153,314 |
| | Total | | $0 | |

**Recommendation:**

The Provider should ensure reported ambulance costs comply with CMS instructions.

**Management Response:**

*Administration agrees with the findings. The Provider will ensure future ambulance costs are reported to CMS under the correct classification.*

## Finding 2 – Unsubstantiated Costs

The Provider reported unsubstantiated meal & entertainment, travel, education, and other operating costs in the cost report. The Provider did not submit requested substantiating documentation to determine if these costs were allowable. As a result, Cost Center 6.00 was overstated by $25,495.

According to HHSC Medicaid Provider Agreement, Paragraph 1.2.3., "This Agreement is subject to all state and federal laws and regulations relating to fraud, abuse and waste in health care and the Medicaid program. As required by 42 CFR § 431.107, Provider agrees to create and maintain all records necessary to fully disclose the extent and medical necessity of services provided by the Provider to individuals in the Medicaid program and

any information relating to payments claimed by the Provider for furnishing Medicaid services. On request, Provider also agrees to provide these records immediately and unconditionally to HHSC, HHSC's agent, the Texas Attorney General's Medicaid Fraud Control Unit, DARS, DADS, DFPS, DSHS and the United States Department of Health and Human Services. The records must be retained in the form in which they are regularly kept by the Provider for a minimum of five years from the date of service (six years for freestanding rural health clinics and ten years for hospital based rural health clinics); or, until all audit or audit exceptions are resolved; whichever period is longest."

The following table illustrates the recommended adjustment:

| Cost Center | Cost Center Description | Reported Amount | Adjustment Amount | Adjusted Amount |
|---|---|---|---|---|
| 6.00 | Administrative & General | $4,902,935 | ($25,495) | $4,877,440 |

**Recommendation:**

The Provider should ensure requested documents to substantiate the cost reported are provided upon request in compliance with the HHSC Medicaid Provider Agreement.

**Management Response:**

*Administration agrees with the findings. The requested documentation could not be provided. The Provider will ensure the costs reported have proper documentation going forward.*

**Finding 3 – Employee Relations Costs**

The Provider included employee relations costs in the cost report 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, Cost Center 6.00 was overstated by $14,784, which represents $27,534 total costs minus $12,750 (255 average full time equivalents (FTEs) reported in the cost report, times $50 per FTE).

According to 1 TAC §355.103 (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 adjustment:

| Cost Center | Cost Center Description | Reported Amount | Adjustment Amount | Adjusted Amount |
|---|---|---|---|---|
| 6.00 | Administrative & General | $4,877,440 | (14,784) | $4,862,656 |

**Recommendation:**

The Provider should ensure that employee relations costs are reported in compliance with TAC limits.

**Management Response:**

*Administration agrees with the findings. The Provider will ensure any employee related costs comply with the TAC limits.*

## Finding 4 – Board of Directors Costs

The Auditor questioned and requested documentation of board of directors costs in the cost report. The Provider did not submit appropriate documentation. The board of directors costs are disallowed due to lack of supporting documentation. As a result, Cost Center 6.00 was overstated by $14,619.

According to HHSC Medicaid Provider Agreement, Paragraph 1.2.3, "This Agreement is subject to all state and federal laws and regulations relating to fraud, abuse and waste in health care and the Medicaid program. As required by 42 CFR § 431.107, Provider agrees to create and maintain all records necessary to fully disclose the extent and medical necessity of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. On request, Provider also agrees to provide these records immediately and unconditionally to HHSC, HHSC's agent, the Texas Attorney General's Medicaid Fraud Control Unit, DARS, DADS, DFPS, DSHS and the United States Department of Health and Human Services. The records must be retained in the form in which they are regularly kept by the Provider for a minimum of five years from the date of service (six years for freestanding rural health clinics and ten years for hospital based rural health clinics); or, until all audit or audit exceptions are resolved; whichever period is longest."

The following table illustrates the recommended adjustment:

| Cost Center | Cost Center Description | Reported Amount | Adjustment Amount | Adjusted Amount |
|---|---|---|---|---|
| 6.00 | Administrative & General | $4,862,656 | ($14,619) | $4,848,037 |

**Recommendation:**

The Provider should ensure requested documents to substantiate the costs reported are provided upon request in compliance with the HHSC Medicaid Provider Agreement and ensure reported board of directors costs comply with TAC.

**Management Response:**

*Administration agrees with the findings. The requested documentation could not be provided. The Provider will ensure the costs reported have proper documentation going forward.*

# APPENDICES

## Appendix A - Objective, Scope, and Methodology

### Objective

The objective of the IG 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.

### Scope

The audit scope was limited to outpatient hospital costs reported by the Provider, for the period December 1, 2009 through November 30, 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. 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
- 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
- Testing depreciation expense schedules

### 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

**Team Members**

Kacy J. VerColen, CPA, Director of Audit
Jose Oliva, CFE, Manager
Albert Alberto, CIGA, Team Lead
Lorraine Wayland, CFE, Project Lead

## Appendix B - Report Distribution

### Health and Human Services Commission

Nicole Guerrero, MBA, 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
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

Derrick Cuenca
Chief Executive Officer
Lake Granbury Medical Center
1310 Paluxy Road
Granbury, TX 76048