Inspector General

Texas Health and Human Services Commission

Stuart W. Bowen, Jr., Inspector General

Performance Audit Report

Medical Center of Plano
2010 Medicaid Outpatient Hospital Costs

August 31, 2015

IG Report No. 14-80-127311205-10-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 Medical Center of Plano (Provider), Texas Provider Identifier (TPI) number 127311205, 2010 Medicare Cost Report (Cost Report) for the period April 1, 2009 through March 31, 2010.

Audit Results

The Cost Report submitted by Medical Center of Plano 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 $477,079.

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 number 127311205. 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 April 1, 2009 through March 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 more detailed description of the audit scope and methodology.

DETAILED FINDINGS AND RECOMMENDATIONS

Finding 1 – Ambulance Costs Classified Incorrectly

The Provider classified ambulance costs in Cost Center 25 instead of Cost Center 65 in the cost report. According to PRM criteria, all ambulance costs should be reported in Cost Center 65, whether owned or operated under arrangement. The Provider stated their cost allocation method is correct, because they believe their ambulance department does not meet the definition for an ambulance cost center. As a result, Cost Center 25 is overstated by $35,735.

According to PRM 15-2 Chapter 36, Sec. 3610, page 36-53, Rev. 20, "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
25.00	Adults & Pediatrics	$20,871,349	($35,735)	$20,835,614
65.00	Ambulance Services	0	35,735	35,735
	Total		$0	

Recommendation:

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

Management Response:
This adjustment is related to ambulance costs that we left in two cost centers. Although we disagree with your interpretation the effect is minor. The reclassification of $35,735 of costs to an ambulance cost center has a reimbursement impact to Medicaid outpatient settlement of $(18).

Auditor Follow-Up Comment:
Per PRM 15-2 Chapter 36, Sec. 3610 cost report instructions above, all ambulance costs must be reported on Cost Center 65; the finding remains unchanged.

Finding 2 – Unallowable Pharmacy Legal Settlements

The Provider overstated pharmacy legal settlements in the cost report by classifying drug restocking fees, for drugs provided to indigent patients, as pharmacy legal settlements. The Provider explained that the restocking fees were included in the cost report erroneously because they had not been offset. As a result, Cost Center 56.00 is overstated by $4,083.

According to 1 TAC, §355.102(c), "Accurate cost reporting is the responsibility of the contracted provider…"

The following table illustrates the recommended adjustment:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
56.00	Drugs Charged to Patients	$12,704,500	($4,083)	$12,700,417

Recommendation:

The Provider should ensure accurate cost reporting for all expenses included in the cost report.

Management Response:
The finding stated that this is a legal settlement cost. In fact, it is a restocking fee for drugs used for indigent patients. We agree that it needs to be offset and will put in steps to offset it in the future. The disallowance of $4,083 had a reimbursement impact to Medicaid outpatient settlement of $(6).

Finding 3 –Unallowable Employee Relations Costs

The Provider included employee relations costs that exceeded the allowable limit of $50 per eligible employee. The Provider made some mathematical errors in their calculations. As a result, various cost centers were overstated collectively by $435,738; which represents $897,777 total costs minus $58,854 (1,177.09 average full time equivalents (FTE) as reported in the cost report times $50 per FTE) and additional employee relations related adjustments of $403,185.

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	$15,271,836	($10,406)	$15,261,430
6.00	Administrative & General	25,900,614	(372,841)	25,527,773
11.00	Dietary	3,217,041	(8,106)	3,208,935
14.00	Nursing Administration	2,901,400	(1,404)	2,899,996
19.00	In-service Education	929,957	(1,852)	928,105
25.00	Adults & Pediatrics	20,835,614	(6,440)	20,829,174
30.00	NICU	5,085,296	(1,855)	5,083,441

Table continued from last page:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
37.00	Operating Room	10,330,967	(1,579)	10,329,388
37.01	Day Surgery	1,007,737	(323)	1,007,414
38.00	Recovery Room	886,531	(364)	886,167
39.00	Delivery Room and Labor Room	2,893,897	(2,088)	2,891,809
41.00	Radiology - Diagnostic	8,132,315	(1,995)	8,130,320
44.00	Laboratory	4,278,062	(2,418)	4,275,644
44.01	Histology	1,232,022	(319)	1,231,703
53.00	Electrocardiology	1,923,432	(671)	1,922,761
59.02	Cardiac Rehab Unit	448,243	(299)	447,944
60.00	Clinic	82,378	(1,251)	81,127
61.00	Emergency	5,553,291	(21,527)	5,531,764
	Total		($435,738)	

Recommendation:

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

Management Response:
The finding stated that we included $435,738 of unallowable entertainment and employee relations expense on the cost report. We made an attempt to offset all types of unallowable costs when we filed the report. We will do a better job following our processes as we go forward on unfiled reports. The reimbursement impact to Medicaid outpatient settlement is $(954).

Finding 4– Unallowable Depreciation Costs

During the physical verification of assets, one item could not be located. The Provider stated that the asset could not be found and that there was no documentation to substantiate its disposal or existence. As a result, the depreciation expense for Cost Center 4.00 was overstated by $1,523.

According to 1 TAC, §355.105(b)(2)(B), "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."

The following table illustrates the recommended adjustment:

Cost Center	Center Description Reported	Reported Amount	Adjustment	Adjusted Amount
4.00	New Cap Rel Costs – Moveable Equipment	$14,197,888	($1,523)	$14,196,365

Recommendation:

The Provider should ensure reported depreciation costs comply with TAC.

Management Response:
The finding was that we included $1,523 of depreciation expense for an asset that could not be located during the review of assets. We agree with this adjustment and have taken the asset off the depreciation listing after this was discovered. There is no reimbursement claimed on this asset for FYE 03/31/15 forward. The reimbursement effect for this adjustment was ($5).

The report references the total adjustments of $477,079 are considered at risk for Medicaid outpatient recovery or reimbursement, but does not reference that the actual impact of these items if $<983>. While we recognize the significance of the gross adjustment amount, we feel the difference between the two amounts is also significant.

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 TAC and CMS instructions.

Scope

The audit scope was limited to hospital costs reported by the Provider, for the period April 1, 2009 through March 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 on June 16, 2014 through June 20, 2014.

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