Office of Inspector General

Texas Health and Human Services Commission

Stuart W. Bowen, Jr., Inspector General

Performance Audit Report
Memorial Medical Center - Lufkin
2010 Medicaid Outpatient Hospital Costs

October 27, 2015

IG Report No. 15-80-139172412-10-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 Memorial Medical Center - Lufkin (Provider), Texas Provider Identifier (TPI) 139172412, 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 identified expense findings that were noted in the audit and resulted in adjustments totaling $1,658,493.

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 139172412. 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. 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 – Unallowable Interest Swap Costs

The Provider included unallowable interest swap expense in the Cost Report. The Provider mistakenly labeled the interest swap payments for two separate series of bonds as interest expense and did not remove the payments from the Cost Report. As a result Cost Center 3.00 was overstated by $864,459.

According to Provider Reimbursement Manual, 15-1, Chapter 2, Section 202.2 (A), "Interest expense incurred under an interest rate swap agreement is not recognized for Medicare payment purposes because the interest expense incurred under such agreement does not result from a loan made to satisfy a financial need of the provider."

The following table illustrates the recommended adjustment:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
3.00	New Cap Rel Costs-Bldg & Fixt	$6,951,826	($864,459)	$6,087,367

Recommendation:

The Provider should ensure that reported interest expense costs comply with PRM instructions.

Management Response:

Provider agrees with the finding and the Inspector's report will be placed in the permanent file and all recommendations not related to simple clerical error will be made on future filings from date of the report (September 15, 2015)

Finding 2 – Overstatement of Pension Contribution

The Provider reported pension costs on an accrual, rather than cash, basis. Contributions were allocated based on the 2006 Eligible Salary table provided by the Provider. Lufkin's 75.15% share of the cash contributions amounts to $916,830. Expenses claimed for the pension were $1,527,147. The variance of $546,192 resulted in an overstatement of Cost Center 5.

According to 1 TAC, §355.105(b)(1)(A)(iii)(III)(b), "... Only the amount the contracted provider or employer contributed to the pension fund during the reporting period is allowable and should be reported as an employee benefit."

The following table illustrates the recommended adjustment:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
5.00	Employee Benefits	$9,972,815	($546,193)	$9,426,622

Recommendation:

The Provider should ensure reported pension costs comply with TAC.

Management Response:

Provider agrees with the finding and the Inspector's report will be placed in the permanent file and all recommendations not related to simple clerical error will be made on future filings from date of the report (September 15, 2015)

Finding 3 – Malpractice Self-Insurance Costs

The Provider included unallowable self-insurance costs in the Cost Report. The Provider was not aware that accrual basis self-insurance costs were not allowed for Medicaid cost reimbursement. As a result Cost Center 6.00 was overstated by $216,000.

According to 1 TAC, §355.103 (b)(10)(B)(i), "Costs related to self-insurance are allowable on a claims-paid basis. Contributions to the self-insurance fund or reserve which do not represent payments based on current liabilities are not considered actual incurred expenses and are not allowable costs. For cost-reporting purposes, self-insurance costs are reported on a cash basis."

The following table illustrates the recommended adjustment:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative & General	$13,754,396	($216,000)	$13,538,396

Recommendation:

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

Management Response:

Provider agrees with the finding and the Inspector's report will be placed in the permanent file and all recommendations not related to simple clerical error will be made on future filings from date of the report (September 15, 2015)

Finding 4 – Unallowable Self-Insurance Costs

The Provider included unallowable accrual costs for their self-insured employee worker's compensation plan on the Cost Report. The Provider does not always receive timely bills and so will accrue, and later reverse, worker's compensation expense. At the end of the 2010 fiscal year there was a balance of accruals that had not been reversed. As a result Cost Center 5.00 was overstated by $16,707.

According to 1 TAC, §355.103 (b)(10)(B)(i), "Costs related to self-insurance are allowable on a claims-paid basis. Contributions to the self-insurance fund or reserve which do not represent payments based on current liabilities are not considered actual incurred expenses and are not allowable costs."

The following table illustrates the recommended adjustment:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
5.00	Employee Benefits	$9,426,622	($16,707)	$9,409,915

Recommendation:

The Provider should ensure to only report self-insurance costs that represent current liabilities in compliance with TAC.

Management Response:

Provider agrees with the finding and the Inspector's report will be placed in the permanent file and all recommendations not related to simple clerical error will be made on future filings from date of the report (September 15, 2015)

Finding 5 – Unallowable Advertising Costs

The Provider has advertising and public relations expense accounts in different departments totaling $29,848 that had not been removed from the Cost Report. A detailed review of the expenses revealed that only $14,713 was allowable. As a result various cost centers were overstated by $15,134.

According to 1 TAC §355.103 (b)(13)(B), "Unallowable advertising and public relations include: (i) costs of advertising of a general nature designed to invite physicians to utilize a contracted provider's facilities in their capacity as independent practitioners; (ii) costs of advertising incurred in connection with the issuance of a contracted provider's own stock, or the sale of stock held by the contracted provider in another corporation considered as reductions in the proceeds from the sale; (iii) costs of advertising to the general public which seeks to increase client utilization of the contracted provider's facilities; (iv) public relations costs;"

The following table illustrates the recommended adjustments:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
14.00	Nursing Administration	$876,987	($8,585)	$868,402
39.00	Delivery Room & Labor Room	610,042	(3,738)	606,304
44.00	Laboratory	4,941,612	(192)	4,941,420
49.00	Respiratory Therapy	2,076,554	(2,427)	2,074,127
71.00	Home Health Agency	1,565,536	(192)	1,565,344
	Total		($15,134)	

Recommendation:

The Provider should ensure reported advertising costs comply with TAC.

Management Response:

This was a unique clerical error

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 outpatient 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. 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

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