Office of Inspector General

Texas Health and Human Services Commission

Stuart W. Bowen, Jr., Inspector General

Performance Audit Report

Methodist Hospital
2010 Medicaid Outpatient Hospital Costs

November 20, 2015

IG Report No. 13-80-094154402-10-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 Methodist Hospital (Provider), Texas Provider Identifier (TPI) 094154402, 2010 Medicare Cost Report (Cost Report) for the period July 1, 2009 through June 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 identifies expense findings that resulted in adjustments totaling $1,935,726.

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 094154402. 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 July 1, 2009 through June 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. See Appendix A for a detailed description of the audit scope and methodology.

DETAILED FINDINGS AND RECOMMENDATIONS

Finding 1 – Unallowable Consulting Costs

The Provider included consultant services to review the cost reports for years 2002, 2003, and 2004. Expenses related to prior years are not reasonable, necessary or significant to current period patient care and therefore do not qualify for reimbursement purposes. The Provider did not submit invoices to substantiate their claims for reimbursement of consulting costs. As a result, Cost Center 6.00 was overstated by $733,354.

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	$141,814,972	($733,354)	$141,081,618

Recommendation:

The Provider should ensure that reported costs are related to the current audit period and are in compliance with the TAC.

Management Response:

We disagree with the proposed adjustment as described in the body of the HHSC/OIG audit report. Of the $733,054 of cost in question, $319,486 is the difference between the prior period reversal and the current period accrual. The current period accrual was reversed out during the first month of the 6/30/2011 cost report. We are required to file the cost report on an accrual basis. If this difference is going to be removed in the current period then an adjustment will need to be made to add it to the 6/30/2011 cost report.

As indicated in the opening paragraph, we also disagree with the notion that a dollar in

overstated expense results in a dollar at risk to the Texas Medicaid Program as indicated in the HHSC/OIG letter sent to the Hospital CEO dated 09/15/2015. While we are not downplaying the significance of the gross adjustments, we wanted to note that the HHSC/OIG audit report does not take the Medicaid Program utilization in to account. Removing the $733,354 cost in question results in amount due to the Traditional Medicaid Program of $2,451 and an amount due to the Medicaid Primary Care Management (PCCM) program of $544 (See Exhibit 1&2). The HHSC audit staff has confirmed they have the software to calculate these impacts. Inferring the gross adjustment is at risk to program is very misleading to the individuals relying on this report.

Auditor's Comment:

The accruals mentioned by the Provider above reflected the cost of hiring consultants to review prior years' cost reports. This review benefited the Provider; it does not represent services for Medicaid clients. Therefore, the costs in question do not qualify under administrative support services for Medicaid clients. Although accruals and reversals are acceptable in accordance with Generally Accepted Accounting Principles, accruals and reversals for disallowed costs are also unallowable in accordance with TAC criteria. The finding remains unchanged.

Finding 2 – Upper Payment Limit Costs

The Provider included costs related to Upper Payment Limit in the cost report. The costs for services were reported in Administration/Purchase Services general ledger accounts. In accordance with TAC; funds received cannot be used to pay for legal or consulting expenses. The Provider was not aware that the costs were unallowable. As a result, Cost Center 6.00 was overstated by $368,380

According to 1 TAC, §355.8063(t)(4)(C)(ii), "No part of any supplement payment paid to the hospital under this paragraph will be used to pay a contingent fee, consulting fee, or legal fee associated with the hospital's receipt of the supplemental funds...."

The following table illustrates the recommended adjustment:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative & General	$141,081,618	($368,380)	$140,713,238

Recommendation:

The Provider should ensure that Upper Payment Limit funds are used in accordance with the TAC.

Management Response:

We disagree with the proposed adjustment as described in the body of the HHSC/OIG audit report. The HHSC/OIG audit staff cited Texas Administrative Code (TAC), 1 TAC, 355.8063(t)(4)(C)(ii) to support their claim that the $368,380 of expenses in question was unallowable. While the TAC did appear to address UPL fund proceeds, it was repealed on 09/01/2010. In the last published TAC prior to the repealed date the correct reference was 355.8063(t)(2)(C)(ii). During audit engagements of other HCA facilities the HHSC/OIG Audit Team has also cited 1 TAC 355.8201(C)(1)(B)(i)(III) as support for their exclusion of the cost in dispute. This TAC address "Waiver Payments to Hospital for Uncompensated Care." It does not address Upper Payment Limit (UPL) funds. Based on this we do not feel that either regulation identified above is applicable to the expenses in questions. We also believe that the HHSc/OIG audit staff has misinterpreted the purpose, as well as the intent, of the written code they are applying to the expenses in question. The verbiage in both (TAC's) cited by HHSC/OIG audit staff are very similar to one another. The TAC originally sighted in this OIG draft report states the following:

> t*) Non-State Owned Hospital Supplemental Inpatient Payments. Except as otherwise provided in this chapter, supplemental payments will be made each state fiscal year in accordance with this subsection to eligible hospitals that serve high volumes of Medicaid and uninsured patients.*
>
> > *(1) Effective September 1, 2009, supplemental payments to certain eligible publicly-owned or -affiliated urban hospitals are determined and paid in accordance with §355.8068 of this title (relating to Supplemental Payments to Certain Urban Hospitals).*
> >
> > *(2) Notwithstanding the provisions of paragraph (1) of this subsection, a privately-operated hospital that executes an indigent care affiliation agreement (as defined in this subsection) with a hospital district or state or local governmental entity is eligible to receive supplemental payments under this paragraph. The purpose of the affiliation is to pay for unreimbursed care to the Medicaid population to ensure the continued viability of the communities Medicaid providers.*
> >
> > > *(A) Supplemental payments will be made for inpatient services on or after June 11, 2005, for eligible hospitals in Hidalgo, Maverick, Montgomery, Travis, Bexar, and Webb counties, Supplemental payments will be made for inpatient services on or after November 12, 2005, for eligible hospitals in all other counties in the State of Texas.*
> > >
> > > *(B) A hospital that is eligible to receive supplemental payments under this paragraph must provide a copy of the fully executed indigent care affiliation agreement to HHSC prior to payment of any supplemental funds under this paragraph.*
> > >
> > > *(C) An eligible hospital must certify, on a form prescribed by HHSC and prior to payment of any supplemental funds under this paragraph, the following:*

(i) No part of any supplemental payment paid to the hospital under this paragraph will be returned or reimbursed to the hospital district or state or local governmental entity;
(ii) ***No part of any supplemental payment paid to the hospital under this paragraph will be used to pay a contingent fee, consulting fee, or legal fee associated with the hospitals receipt of the supplemental funds; and.***

In order to be eligible for these UPL funds, the hospital certifies upfront, prior to the UPL funds being distributed, that it will meet these requirements. The TAC identified above does not restrict funds received from normal operations. It simply states that no payment under this section will be utilized to pay for contingent fees, consulting fees, or legal fees associated with the hospitals receipt of the supplemental funds. By deeming the UPL Legal cost above as unallowable the HHSC/OIG audit staff has alleged that Methodist Hospital has utilized the UPL proceeds to pay for the expenses in dispute. The HHSC/OIG audit team has no substantive support for this allegation.

Due to the Federal and State scrutiny over the receipt and usage these funds, it is imperative that we obtain legal counsel to ensure that we are following the applicable Federal and State Regulations governing this issue. Ensuring we follow the applicable regulations helps ensure access to these funds and helps us provide access to quality care for the uninsured and underserved patient populations of our community.

We feel that this adjustment is arbitrary, capricious and is without merit. As such we are requesting it to be removed prior to any final audit report being issued.

Removing the $368,380 of cost in question results in an amount due to the Traditional Medicaid Program of $1,236 and an amount due to the Medicaid Primary Care Case Management (PCCM) program of $275 (See Exhibit 1&2).

Auditor's Comment:

The 1 TAC, §355.8063(t)(4)(C)(ii) was repealed on 09/01/2010 which was three months after the close of this audit period ending 06/30/2010. Therefore, the TAC was still in effect and was valid for the period being audited.

According to the Provider, they do not segregate supplemental funds received from the State within their general operating fund. Further, the Provider stated that they paid their legal costs from their (non-segregated) operating funds. The facts are: the Provider received Supplemental funds and included the legal costs related to Upper Payment Limit in the reimbursable data base for cost reporting purposes. The finding remains unchanged.

Finding 3 – Miscellaneous Costs

The Provider included unallowable miscellaneous costs in the cost report. In accordance with the TAC, costs related to issues such as survey of Medical Office Building tenants,

medical staff holiday party, out of state research costs, valet services, lost patient items and other miscellaneous non-patient care related 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 $218,048

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	$140,713,238	($211,603)	$140,501,635
61.00	Emergency	24,586,816	(6,445)	24,580,371
	Total		($218,048)	

Recommendation:

The Provider should ensure that reported costs comply with TAC.

Management Response:

We agree with the proposed adjustment as described in the body of the HHSC/OIG audit report.

Removing the $218,048 of cost in question results in an amount due to the Traditional Medicaid Program of $936 and an amount due to the Medicaid Primary Care Case Management (PCCM) program of $195 (See Exhibit 1&2).

Finding 4 – Unallowable Audit Costs

The Provider included unallowable sales tax audit costs in the cost report. The Provider was unaware that these costs were unallowable. As a result, Cost Center 6.00 was overstated by $163,340.

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	$140,501,635	($163,340)	$140,338,295

Recommendation:

The Provider should ensure that unallowable audit costs are removed from the cost report in accordance with the TAC.

Management Response:

We agree with the proposed adjustment as described in the body of the HHSC/OIG audit report.

Removing the $163,340 of cost in question results in an amount due to the Traditional Medicaid Program of $548 and an amount due to the Medicaid Primary Care Case Management (PCCM) program of $121 (See Exhibit 1&2).

Finding 5 – Consulting Costs

The Provider included costs for consulting in the cost report. These costs included services for real estate and property tax issues, lien searches and various non-contract client care related types of appraisals and valuations. The Provider considered these as normal operating costs and included the costs in the cost report. The auditor determined that the explanation provided did not sufficiently substantiate these costs and therefore disallowed the costs. As a result, Cost Center 6.00 was overstated by $153,854.

According to 1 TAC, §355.105(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 adjustment:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative & General	$140,338,295	($153,854)	$140,184,441

Recommendation:

The Provider should ensure that all services reported to the cost report are adequately documented in accordance with the TAC.

Management Response:

We disagree with the proposed adjustment as described in the body of the HHSC/OIG audit report. Of the $153,854 of cost in question, $88,400 is related to the June 2010 accrual. The current period accrual was reversed out during the first month of the 6/30/2011 cost report. The HHSC/OIG audit staff did not remove any of the prior period (July 2009) reversals for the same consulting cost. If these expenses are removed on the 6/30/2010 cost report then an adjustment will need to be made to add them to the 6/30/2011 report. In addition to the TAC referenced in the Draft Report the HHSC/OIG audit staff has also referenced 1 TAC 355.105(b)(1) to support some of their audit findings for the cost identified above. This TAC states the following:

> *"(1) Accounting methods. All financial and statistical information submitted on cost reports must be based upon the accrual method of accounting, except where otherwise specified in §355.102 and §355.103 of this title (relating to General Principles of Allowable and Unallowable Costs, and Specifications for Allowable and Unallowable Costs) and in the case of governmental entities operating on a cash or modified accrual basis. For cost-reporting purposes, accrued expenses must be incurred during the cost reporting period and* ***must be paid within 180 days after the end of that cost reporting period."***

The HHSC/OIG audit staff has applied the 180 days from the date incurred (vs.) the end of the cost reporting period. We are unaware of any testing they performed to determine if the expenses in questions were paid 180 days after the cost reporting period.

Removing the $153,854 of cost in question results in an amount due to the Traditional Medicaid Program of $506 and an amount due to the Medicaid Primary Care Case Management (PCCM) program of $113 (See Exhibit 1&2).

Auditor's Comment:

The original amount for the Finding was $198,041; the Provider submitted supporting explanation on some of the transactions on 7/1/2015, which reduce the amount to $153,854. The Auditor had no choice but to disallow the remaining unsupported or unsubstantiated transactions. Although accruals and reversals are acceptable in accordance with Generally Accepted Accounting Principles, these accruals and reversals would have been disallowed based on the TAC criteria due to inadequate support documentation. The finding remains $153,854.

Finding 6 – 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 $126,516, which represents $658,534 total employee relations costs minus $288,250 (5,765 average full time equivalents (FTEs) as reported in the cost report times $50 per FTE) minus $243,768 removed via a Provider adjustment for employee relations.

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
6.00	Administrative & General	$140,184,441	($74,890)	$140,109,551
8.00	Operation of Plant	30,559,012	(821)	30,558,191
10.00	Housekeeping	8,880,159	(166)	8,879,993
11.00	Dietary	9,184,248	(19,966)	9,164,282
14.00	Nursing Administration	10,383,914	(19,421)	10,364,493
18.00	Social Services	909,269	(263)	909,006
25.00	Adults and Pediatrics	105,947,409	(151)	105,947,258
26.00	Intensive Care Unit	32,330,668	(180)	32,330,488
31.01	Sub Provider II	2,676,509	(266)	2,676,243

Table continued from last page:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
37.00	Operating Room	39,750,201	(155)	39,750,046
44.00	Laboratory	32,666,389	(431)	32,665,958
49.00	Respiratory Therapy	13,433,602	(130)	13,433,472
50.00	Physical Therapy	5,250,907	(303)	5,250,604
53.00	Electrocardiology	2,908,506	(48)	2,908,458
56.00	Drugs Charged to Patients	65,264,598	(1,195)	65,263,403
59.01	Cardiac Rehab	889,268	(150)	889,118
59.04	Cardiac Catherization Laboratory	9,891,803	(1,450)	9,890,353
59.05	Diabetes Education	348,745	(17)	348,728
60.01	Heart Post Transplant Clinic	460,686	(282)	460,404
60.02	Pedi Clinic	869,139	(655)	868,484
60.03	Renal Post Transplant Clinic	734,846	(255)	734,591
60.04	CITC	646,020	(8)	646,012
60.06	Liver Post Transplant Clinic	414,339	(273)	414,066
61.00	Emergency	24,580,371	(2,557)	24,577,814
83.00	Kidney Acquisition	7,081,637	(1,362)	7,080,275
84.00	Liver Acquisition	1,969,953	(608)	1,969,345
85.00	Heart Acquisition	1,128,869	(513)	1,128,356
	Total		($126,516)	

Recommendation:

The Provider should ensure that reported employee relations costs are reported in accordance with the TAC limits and are adjusted from all general ledger accounts.

Management Response:

We disagree with HHSC assessment of unallowable employee relations cost. We feel that HHSC audit staff has misinterpreted the TAC being applied to the cost in question. The TAC being applied is 1 TAC 355.103 (b)(17)(A) which states the follwing:

"(17) Miscellaneous costs.

(A) Employee relations expenses. Costs relating to employee relations are different from fringe benefits, as specified in paragraph (1)(A)(iii) of this subsection, in that employee relations expenses incurred are for employees as a group rather than as a fringe benefit for an individual employee. Examples of allowable employee relations costs, which are reported as administrative costs for cost-reporting purposes, include a staff party, an employee outing, or other such staff expenses intended to boost employee morale and in turn increase the efficiency and quality of care provided. Other examples of allowable employee relations expenses are plaques or awards presented to employees for certain achievements or honors. Employee relations cost which discriminates in favor of certain employees, such as employees who are officers, stockholders, related parties, or the highest paid individual(s) in the organization are unallowable. ***Employee relations costs are limited to a ceiling of $50 per employee eligible to participate per year. ...***"

The HHSC/OIG audit staff has applied this $50 ceiling to expenses that we do not feel should be considered employee relations expense. The HHSC/OIG is subjecting expenses related to employee meals to the $50 ceiling. Employee meals are specifically addressed elsewhere in the Texas Administrative Code. Per 1 TAC 355.103 (b)(1)(A)(iii)(lll)(e) "Contracted provider's unrecovered cost of meals and room and board furnished on-site to direct care employees are not to be reported as employee benefits, but are to be reported as cost related to specific cost report line items. Any reasonable unrecovered cost of meals and/or room and board furnished on-site by a contracted provider to its direct care employees, which are equivalent to the meals and/or room and board provided to clients, are allowable costs since they are related to client care in that such reasonable cost are appropriate and helpful in developing and maintain the contacted provider's operations to deliver contacted services." During our discussion with the OIG/Audit Staff on 8/6/2015 they agreed to review the expense in nursing care areas; however the adjustments still remain in the draft report.

Subjecting the expenses in question to a $50 ceiling per employee, when the expense is specifically addressed in a separate TAC as an allowable expense is unreasonable. We feel that this adjustment is arbitrary, capricious and is without merit. As such we are requesting it to be removed prior to any final audit report being issued.

In addition to the comments above, $9,504 of the cost in question is the difference between the prior period reversal and the current period accrual. The current period accrual was reversed out on during the first month of the 6/30/2011 cost report. If this difference is going to be removed in the current period then an adjustment will need to be made to add it to the 6/30/2011 cost report.

Removing the $148,892 of cost in question results in an amount due to the Traditional Medicaid Program of $710 and an amount due to the Medicaid Primary Care Case Management (PCCM) program of $114 (See Exhibit 1&2).

Auditor's Comment:

The original finding was for the amount of $148,892. OIG revisited the captured cost of meal transactions as discussed with the Provider and has reconsidered our original position. An adjustment has been made in the amount of $22,376 for expenses related to continuity of direct patient care; the revised finding amount is $126,516. Although accruals and reversals are acceptable in accordance with Generally Accepted Accounting Principles, these accruals and reversals would have been disallowed based on the TAC criteria.

Finding 7 – Legal Costs Associated with Litigation

The Provider included legal costs associated with litigation in the cost report. These legal costs included services rendered for mediation, issues with medical staff, and lawsuits by employees. The costs identified during the audit totaled $159,238, of which $34,620 was allowable and $29,973 was adjusted out by the Provider from the cost report. The remaining costs were not removed as the Provider believed the costs were allowable. As a result, Cost Center 5.00 and Cost Center 6.00 were overstated by $94,645.

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 adjustments:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
5.00	Employee Benefits	$50,355,330	($65,927)	$50,289,403
6.00	Administrative & General	140,109,551	(28,718)	140,080,833
	Total		($94,645)	

Recommendation:

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

Management Response:

We disagree with the proposed adjustment as described in the body of the HHSC/OIG audit report. Of the $28,718 of Administrative and General cost in question, $1,050 is related to the June 2010 accrual. This accrual was reversed out during the first month of

the 6/30/2011 cost report. If this expense is going to be removed in the current period then an adjustment will need to be made to add it to the 6/30/2011 cost report.

Removing the $94,645 of cost in question results in an amount due to the Traditional Medicaid Program of $353 and an amount due to the Medicaid Primary Care Case Management (PCCM) program of $69 (See Exhibit 1&2).

Auditor's Comment:

During the audit, it was revealed that $94,645 were costs for arbitration or cost associated with litigation of lawsuits and settlements. In addition, the amounts in questioned were disallowed based on 1 TAC, 355.103(b)(17)(I) not due to accounting principles. Although accruals and reversals are acceptable in accordance with Generally Accepted Accounting Principles, these accruals and reversals would have been disallowed based on the TAC criteria. The finding remains unchanged.

Finding 8 – Unsubstantiated Costs

The Provider included unsubstantiated costs in the cost report. The Provider was unable to provide support documentation to substantiate 40 tested transactions. The Provider was unaware of these discrepancies and processed these costs as allowable and therefore included them in the cost report. As a result various, cost centers were overstated by $31,787.

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
37.00	Operating Room	$39,750,046	($12,628)	$39,737,418
44.00	Laboratory	32,665,958	(16,575)	32,649,383
49.00	Respiratory Therapy	13,433,472	(4)	13,433,468

Table continued from last page:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
61.00	Emergency	24,577,814	(2,580)	24,575,234
	Total		($31,787)	

Recommendation:

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

Management Response:

We agree with the proposed adjustment as described in the body of the HHSC/OIG audit report.
Removing the $31,787 of cost in question results in an amount due to the Traditional Medicaid Program of $101 and an amount due to the Medicaid Primary Care Case Management (PCCM) program of $14 (See Exhibit 1&2),

Finding 9 – Advertising and Promotional Costs

The Provider included unallowable advertising and promotional costs in the cost report. Costs included are for golf tournament, retreat video tapings, helicopter services promotion and miscellaneous promotional incentives. The Provider assumed these were allowable expenses. As a result various cost centers were overstated by $20,815.

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	$140,080,833	($5,487)	$140,075,346
10.00	Housekeeping	8,879,993	(1,233)	8,878,760
11.00	Dietary	9,164,282	(840)	9,163,442
14.00	Nursing Administration	10,364,493	(1,106)	10,363,387
25.00	Adults & Pediatrics	105,947,258	(1,783)	105,945,475

Table continued from last page:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
26.01	Neonatal Intensive Care Unit	14,306,243	(13)	14,306,230
39.00	Delivery Room & Labor Room	10,705,781	(13)	10,705,768
49.00	Respiratory Therapy	13,433,468	(1,302)	13,432,166
55.00	Medical Supplies Charged to Patients	47,341,355	(3,872)	47,337,483
59.01	Cardiac Rehab	889,118	(180)	888,938
60.02	Pedi Clinic	868,484	(501)	867,983
61.00	Emergency	24,575,234	(3,808)	24,571,426
85.00	Heart Acquisition	1,128,356	(677)	1,127,679
	Total		($20,815)	

Recommendation:

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

Management Response:

We disagree with the proposed adjustment as described in the body of the HHSC/OIG audit report. Of the $20,815 of cost in question, $3,678 is related to the June 2010 accrual. This accrual was reversed out during the first month of the 6/30/2011 cost report. If this expense is going to be removed in the current period then an adjustment will need to be made to add it to the 6/30/2011 cost report.

Removing the $20,815 of cost in question results in an amount due to the Traditional Medicaid Program of $216 and an amount due to the Medicaid Primary Care Case Management (PCCM) program of $27 (See Exhibit 1&2).

Auditor's Comment:

The reported advertising and promotional costs were disallowed based on 1 TAC, 355.103(b)(14) not due to accounting principles. These expenses were identified in other cost centers of the cost report. The Provider stated in a telephone conversation on 09/25/2015 that all advertising, promotional and marketing costs were to be recorded in designated non-reimbursable general ledger accounts and was unaware that costs were being recorded elsewhere. Although accruals and reversals are acceptable in accordance with Generally Accepted Accounting Principles, these accruals and reversals would have been disallowed based on the TAC criteria. The finding remains unchanged.

Finding 10 – Cable/TV Costs

The Provider included non-allowable television/cable costs in the cost report. After a review of general ledger transactions during the anomalies search, the Auditor identified additional television/cable costs that were overlooked. The Provider was unaware that these costs were not adjusted from the cost report. As a result, Cost Center 6.00 and Cost Center 61.00 were overstated by $5,103.

According to 1 TAC, §355.102(f)(1) & (2) states, "Allowable costs. Allowable costs are expenses, both direct and indirect, that are reasonable and necessary, as defined in paragraphs (1) and (2) of this subsection, and which meet the requirements as specified in subsections (i), (j), and (k) of this section, in the normal conduct of operations to provide contracted client services meeting all pertinent state and federal requirements. Only allowable costs are included in the reimbursement determination process. (1)"Reasonable" refers to the amount expended. The test of reasonableness includes the expectation that the provider seeks to minimize costs and that the amount expended does not exceed what a prudent and cost-conscious buyer pays for a given item or service... (2) "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..."

The following table illustrates the recommended adjustments:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative & General	$140,075,346	($4,595)	$140,070,751
61.00	Emergency	24,571,426	(508)	24,570,918
	Total		($5,103)	

Recommendation:

The Provider should ensure that all television/cable costs are removed from the cost report.

Management Response:

We agree with the proposed adjustment as described in the body of the HHSC/OIG audit report.

The Cable/TV cost for $5,103 should have been removed from the cost report.

Removing the $5,103 of cost in question results in an amount due to the Traditional Medicaid Program of $41 and an amount due to the Medicaid Primary Care Case Management (PCCM) program of $5 (See Exhibit 1&2).

Finding 11 – 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, various cost centers were overstated by $2,809.

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 adjustment:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative & General	$140,070,751	($2,809)	$140,067,942

Recommendation:

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

Management Response:

We agree with the proposed adjustment as described in the body of the HHSC/OIG audit report.

The Dues cost of $2,809 should have been removed from the cost report.

Removing the $2,809 of cost in question results in an amount due to the Traditional Medicaid Program of $8 and an amount due to the Medicaid Primary Care Case Management (PCCM) program of $2 (See Exhibit 1&2).

Finding 12 – Penalties Costs

The Provider included costs for penalties and fines in the cost report. Penalties and fines for violations of state and city regulations are unallowable per TAC. The Provider believed these costs were allowable and included them in the hospital cost report. As a result, various cost centers were overstated by $575.

According to 1 TAC, §355.103(b)(17)(G),"Fines and penalties for violations of regulations, statutes, and ordinances of all types are unallowable costs. Penalties or charges

for late payment of taxes, utilities, mortgages, loans or insufficient banking funds 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	$140,067,942	($500)	$140,067,442
8.00	Operation of Plant	30,558,191	(75)	30,558,116
	Total		($575)	

Recommendation:

The Provider should ensure that all reported costs in regards to penalties and fines are excluded in accordance with the TAC.

Management Response:

We agree with the proposed adjustment as described in the body of the HHSC/OIG audit report. The $575 of penalty cost should have been removed from the cost report.

Removing the $575 of cost in question results in no additional funds due to the Traditional Medicaid Program or Medicaid Primary Care Case Management (PCCM) program (see exhibit 1&2).

Finding 13 – Ambulance/Patient Transport Costs

The Provider included ambulance/patient transport costs in the cost report. Although the Provider Reimbursement Manual (PRM) states that all ambulance related costs need to be reclassified to Cost Center 65.00 on the Cost Report; the Provider elected to make an adjustment to remove $607,497 of ambulance/patient transport costs from the cost report. The Auditor identified additional ambulance/ patient transport related costs in other cost centers and deemed that these costs be reclassified to Cost Center 65.00 in accordance with PRM instructions. The Provider was unaware of these costs and agreed with the reclassification of the additional costs in accordance with the PRM. As a result, Cost Center 6.00 was overstated by $16,500 and Cost Center 65.00 was understated by $16,500.

According to PRM 15, Part II, Chapter 36, Section 3610, "...Line 65--Report all ambulance costs on this line for both owned and operated services and services under arrangement...."

The following table illustrates the recommended adjustments:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative & General	$140,067,442	($16,500)	$140,050,942
65.00	Ambulance Services	0.00	16,500	16,500
	Total		(0)	

Recommendation:

The Provider should ensure that costs related to ambulance/patient transport costs are reclassified in accordance with PRM.

Management Response:

We agree with the proposed adjustment as described in the body of the HHSC/OIG audit report.

Reclassing the $16,500 of cost in question from CMS CC 6, Administrative & General , to CMS CC 65, Ambulance, results in amount due to the Traditional Medicaid Program of $50 and an amount due to the Medicaid Primary Care Case Management (PCCM) program of $13 (See Exhibit 1 & 2).

APPENDICES

Appendix A - Objective, Scope, and Methodology

Objective

The objective of 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 July 1, 2009 through June 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
- 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

Other

Fieldwork was conducted May 16, 2014 through May 23, 2014.

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