Office of Inspector General

Texas Health and Human Services Commission

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Performance Audit Report

Park Plaza Hospital
2010 Medicaid Outpatient Hospital Costs

September 18, 2015

IG Report No. 14-80-121811703-10-MO-02

CONTENTS

EXECUTIVE SUMMARY 1
DETAILED FINDINGS AND RECOMMENDATIONS 2
Finding 1 – Unsubstantiated Advertising and Public Relations Costs 2
Finding 2 – Insurance-Professional Liability Costs 3
Finding 3 – Miscellaneous Costs 4
Finding 4 – Employee Relations Costs 5
Finding 5 – Governing Board of Directors Costs 6
APPENDICES 8
Appendix A - Objective, Scope, and Methodology 9
Appendix B - Report Distribution 11

EXECUTIVE SUMMARY

The Texas Health and Human Services Commission (HHSC), Inspector General (IG), Audit Section completed an audit of Park Plaza Hospital (Provider), Texas Provider Identifier (TPI) 121811703, 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 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 $1,602,057.

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 121811703. 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 – Unsubstantiated Advertising and Public Relations Costs

The Provider submitted time studies which allocated expenses across Advertising, Public Relations and Business Development Call Back centers. The Provider did not provide requested explanations and substantiating documentation for the auditor to review and determine if the costs were allowable. As a result, Cost Center 6.00 was overstated by $1,002,470.

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	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative & General	$18,730,092	($1,002,470)	$17,727,622

Recommendation:

The Provider should ensure that substantiating documentation is maintained and provided when requested.

Management Response:

The Provider reclassified a portion of advertising, public relations and business development call back costs from the Administrative and General cost center to a Public Relations nonreimbursable cost center in its Medicaid filed cost report. The reclass was based on time studies completed by the hospital during the year. The auditor maintains that the hospital did not provide requested explanations and substantiating documentation for the auditor to review to determine if the costs were allowable. As a result, the auditor maintains that costs in cost center 6.00 (Administrative & General) were overstated by $1,002,470. The adjustment basically removes all costs in Accounts 8630, 8111 and 8610.6710.

Rather than supplying the auditor with invoices to support every public relations, advertising and business development expense incurred during the year, the hospital employed the time study methodology contained in the Medicare Program instructions

to estimate non-allowable costs for reclass to a nonreimbursable cost center. Notwithstanding the Provider's position that the time studies provide a reasonable basis for estimating the non-allowable costs, the additional costs of providing the auditor with each and every invoice is not justified, given the insignificant reimbursement impact. Therefore, the Provider accepts the OIG's audit finding and 100% of the Provider's advertising and public relation's costs will be self-disallowed on its future Medicaid cost report filings without prejudice.

Finding 2 – 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 the course of the audit, 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 $458,548.

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 & General	$17,727,622	($458,548)	$17,269,074

Recommendation:

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

Management Response:

According to the OIG auditor, the Provider's self-insurance program does not comply with TAC. To be allowable, OIG maintains that the provider's self-insurance program requires a written agreement with an unrelated party. During the course of the audit, the hospital explained that the self-insurance fund is administered by the home office entity (Tenet Healthcare) and that there is no separate self-insurance fund maintained for each of Tenet's hospitals. The auditor states that the hospital was unaware of the TAC rule for qualification of its self-insurance program. As a result, costs in the Administrative & General cost center were overstated by $458,548.

Contrary to the auditor's comments above, the hospital is aware of the TAC rules governing self-insurance programs; however, Park Plaza hospital is owned by the parent corporation, Tenet Healthcare Corporation and both the hospital and the parent entity are subject to the related party instructions contained in the Medicare Provider Reimbursement Manual. Tenet provides for the first $5 million of malpractice coverage for each of its hospitals through a self- insurance fund because it is more cost effective to self-insure the first $5 million of loss per occurrence for each hospital rather than purchasing such coverage on the market through an unrelated party. As stated in the Medicare Provider Reimbursement Manual, Part I, Section 2103- Prudent Buyer, it states.... "(A). General- The prudent and cost conscious buyer not only refuses to pay more than the going price for an item or service, he/she also seeks to economize by minimizing cost." The hospital takes exception to this OIG finding because Tenet's self- insurance program for the first $5 million of coverage is the most cost effective means of providing malpractice coverage for its hospitals.

Auditor's Response:

While we encourage Park Plaza Hospital to observe the Prudent Buyer Section 2103 of the PRM, the TAC clearly states that the Provider must enter into an agreement with an unrelated third party to administer and liquidate their liabilities. Therefore, the finding remains unchanged.

Finding 3 – Miscellaneous Costs

The provider included unallowable expenses in the cost report for art work, subscriptions, trial exhibits, contributions, and physician income guarantees. The Provider considered these costs to be allowable and reported them in the cost report. As a result, Cost Center 6.00 was overstated by $59,341.

According to the Provider Reimbursement Manual, Chapter 21, 2102.3, "Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity."

The following table illustrates the recommended adjustment:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.00	Administrative & General	$17,269,074	($59,341)	$17,209,733

Recommendation:

The Provider should ensure that costs reported in the cost report comply with TAC.

Management Response:

The Provider accepts this finding and will ensure that subsequent year Medicaid cost report filings do not include these types of expenses.

Finding 4 – 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 $44,024, which represents $71,074 total costs minus $27,050 (541 average full time equivalents (FTEs) as reported in the cost report times $50 per FTE).

According to 1 TAC, §355.103(b)(20)(A), "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....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	$4,616,679	($31,108)	$4,585,571
6.00	Administrative & General	$17,209,733	(12,916)	$17,196,817
	Total		($44,024)	

Recommendation:

The Provider should ensure that reported Employee Relations costs comply with TAC limit of $50 per employee per year.

Management Response:

The Provider takes exception to the audit finding for two reasons. First, the Provider is aware of the TAC provision related to employee relation costs. Second, in the Medicaid filed cost report, the Provider self-disallowed $47,940 of employee relation costs due to the TAC limit (Worksheet A-8, line 39) and this adjustment was not taken into account

by the auditor when posting the Finding 4 adjustment. This TAC adjustment was not posted in the hospital's Medicare filed cost report, only in its Medicaid filed cost report, because the Medicare Program instructions don't impose a $50 cap per employee. The Provider is unsure why the OIG is auditing the Medicaid cost report but not taking into account adjustments posted by the hospital in its Medicaid filed cost report.

Auditor's Response:

The auditor requested and received a copy of the Provider's submitted adjusted Cost Report, Worksheet A-8, from Texas Medicaid & Healthcare Partnership; in reviewing Worksheet A-8, line 39, the auditor found no evidence of the self-disallowed adjustment mentioned in the Provider's management response. Finding 4 remains unchanged.

Finding 5 – Governing Board of Directors Costs

The Provider paid compensation in the form of fees and expenses to the Board of Directors which is not allowed according to the TAC. The Provider was unaware that these types of costs are limited to travel, lodging, and insurance expense. As a result, Cost Center 6.00 was overstated by $37,674.

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 & General	$17,196,817	($37,674)	$17,159,143

Recommendation:

The Provider should ensure reported board of directors costs comply with TAC.

Management Response:

The Provider takes exception to the audit finding for two reasons. First, the Provider is aware of the TAC provision relating to Board of Director allowable costs. Second, in the Medicaid filed cost report, the Provider self-disallowed $46,690 of Board of Director costs per TAC (Worksheet A-8, line 40). This adjustment was not taken into account by

the auditor when the Finding 5 adjustment was posted. Again, the Provider is unsure why the OIG is auditing the Medicaid cost report but not taking into account adjustments posted by the Provider in its filed Medicaid cost report

Auditor's Response.

The auditor requested and received a copy of the Provider's submitted adjusted Cost Report, Worksheet A-8, from Texas Medicaid & Healthcare Partnership; in reviewing Worksheet A-8, line 40, the auditor found no evidence of the self-disallowed adjustment mentioned in the Provider's management response. Finding 5 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 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. 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 March 24, 2014 through March 28, 2014.

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