Office of Inspector General

Texas Health and Human Services Commission

Stuart W. Bowen, Jr., Inspector General

Performance Audit Report

St. David's Medical Center
2010 Medicaid Outpatient Hospital Costs

September 15, 2015

IG Report No. 14-80-94160102-10-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 St. David's Medical Center (Provider), Texas Provider Identifier (TPI) 94160102, 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 $483,070.

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.

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 94160102. 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 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. 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 – Unallowable Malpractice Paid Claims

The Provider's self-insurance program did not comply with TAC. The Provider included Malpractice Paid Claims in the Cost Report. For these claims to be allowable, a Provider's self-insurance program requires a written agreement with an unrelated party. 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 not aware that the TAC requires the Provider "must" enter into an agreement with an unrelated party for the self-insurance plan to be allowable. The Provider did not submit documentation to substantiate compliance with TAC. As a result, Cost Center 6.02 is overstated by $455,990.

According to 1 TAC, §355.103(b)(10)(B), "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
6.02	Acute Care Specific Administrative and General	$28,017,621	($455,990)	$27,561,631

Recommendation:

The Provider should ensure that the self-insurance plan complies with TAC before Malpractice Paid Claims costs are reported in the Cost Report.

Management Response:

We agree with HHSC/OIG's finding on removing the Malpractice paid claims amount based provision set out in 1 TAC, 355.103(b)(10)(B), which states "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 those risk".

Although we agree to the finding above, we 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 plain language text of the HHSC/OIG letter sent to the Hospital CEO dated 8/3/2015. While we are not downplaying the significance of the gross adjustment, we wanted to note that the HHSC/OIG audit report does not take the Medicaid Program

utilization into account. Removing the $455,990 of cost in question results in amount due to the Traditional Medicaid Program of $1,246 and an amount due to the Medicaid Primary Care Case Management (PCCM) program of $171(See Exhibit 1). 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.

Our cost report process is designed to ensure that prior period adjustment such as the one addressed above are carried forward to future periods. That being said, this is a report on the 2010 cost report and the cost reporting periods 2011-2014 have already been filed.

Auditor's Comment:

We believe that reporting the gross adjustment is consistent with the IG's audit objective as defined in our audit report: to determine if costs reported are in compliance with TAC and CMS instructions.

Finding 2 – Incorrect Reporting of Ambulance Costs

The Provider incorrectly reported Ambulance cost in Cost Center 61.00 instead of Cost Center 65.00. The Provider was unaware that ambulance related costs should be reported in Cost Center 65.00. As a result, Cost Center 61.00 was overstated by $26,452.

According to PRM 15, Part II, Chapter 3610, Section 2104.1, 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
61.00	Emergency	$8,282,548	($26,452)	$8,256,096
65.00	Ambulance	$0.00	$26,452	$26,452
	Total		$0.00	

Recommendation:

The Provider should ensure that ambulance related expenses are reported in the appropriate cost centers.

Management Response:

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

However, as indicated in finding 1 above we 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 plain language text of the HHSC/OIG letter sent to the Hospital CEO dated 8/3/2015. While we are not downplaying the significance of the gross adjustment, we wanted to note that the HHSC/OIG audit report does not take the Medicaid Program utilization into account. Reclassing the $26,452 of cost in question from CMS CC 61, Emergency, to CMS CC 65, Ambulance, results in amount due to the Traditional Medicaid Program of $734 and an amount due to the Medicaid Primary Care Case Management (PCCM) program of $52 (See Exhibit 1). 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.

Our cost report process is designed to ensure that prior period adjustment such as the one addressed above are carried forward to future periods. That being said, this is a report on the 2010 cost report and the cost reporting periods 2011-2014 have already been filed.

Finding 3 – Unallowable Penalty Costs

The Provider included unallowable penalty cost in the Cost Report. The Provider was unaware that these fines and penalty costs are violations of regulations, and therefore, unallowable. As a result, Cost Center 6.02 was overstated by $628.

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 adjustment:

Cost Center	Cost Center Description	Reported Amount	Adjustment Amount	Adjusted Amount
6.02	Acute Care Specific Administrative and General	$27,561,631	($628)	$27,561,003

Recommendation:

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

Management Response:

We agree with the proposed adjustment as described in the body of the HHSC/IG audit report. The inclusion of the $628 cost related to fines and penalties was a simple oversight on our part.

As indicated above, we 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 plain language text of the HHSC/OIG letter sent to the Hospital CEO dated 8/3/2015. While we are not downplaying the significance of the gross adjustment, we wanted to note that the HHSC/OIG audit report does not take the Medicaid Program utilization into account. Removing the $628 of cost in question results in amount due to the Traditional Medicaid Program of $1 and an amount due to the Medicaid Primary Care Case Management (PCCM) program of $1 (See Exhibit 1). 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.

Our cost report process is designed to ensure that prior period adjustment such as the one addressed above are carried forward to future periods. That being said, this is a report on the 2010 cost report and the cost reporting 2011-2014 have already been filed.

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 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 July 28, 2014 through August 1, 2014.

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