DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

FEB 19 2003

TO: Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

FROM: Janet Rehnquist
Inspector General

SUBJECT: Audit of Texas Medicaid Inpatient Disproportionate Share Hospital Program for Hospital Fiscal Years 1996 through 1998 (A-06-01-00041)

This memorandum is to alert you to the issuance of the subject audit report within 5 business days from the date of this memorandum. A copy of the report is attached. The review was conducted at the request of the Centers for Medicare and Medicaid Services (CMS) as part of a multi-state initiative focusing on Medicaid disproportionate share hospital (DSH) payments made under section 1923 of the Social Security Act (the Act), as amended. The objectives of our audit were to verify that DSH payments were calculated in accordance with the approved state plan and that the payments to individual hospitals did not exceed the limits imposed by the Omnibus Budget Reconciliation Act (OBRA) of 1993.

Our review showed that the state calculated the DSH payment limits in accordance with the approved state plan with the exception of handling the negative Medicaid shortfall. However, we believe the approved state plan does not comply with the apparent purpose of OBRA 1993. As a result, DSH payments totaling approximately $511.4 million ($319.2 million federal share) were paid to hospitals in excess of hospital specific limits for hospital fiscal years 1996 through 1998. This amount includes adjustments resulting from the negative Medicaid shortfalls not being properly accounted for and adjustments made during our hospital specific reviews at three selected hospitals to determine the accuracy of the calculations for uncompensated care costs.

These excess payments occurred for the following reasons:

- The state plan required that the Medicaid shortfall and uninsured patient cost be summed to calculate the hospital specific limit. However, the state limited negative Medicaid shortfalls, i.e. Medicaid payments exceeding Medicaid cost of services, to zero.

- The state made payments to hospitals on a prospective basis as required by the state plan, but did not have controls in place to assure that payments did not exceed the actual cost of providing services to patients that were eligible for medical assistance under the state plan or have no health insurance or other source of third-party coverage.

- The state did not verify the accuracy of the self-reported uninsured charges and payments submitted by the hospitals, which it used in the calculation of uninsured patient cost.

A proxy method, as provided in the state plan, was used by the state to calculate uninsured patient charges for hospitals that did not provide, or were unable to accurately determine, charge and payment data for such patients. We believe the proxy method was being used regularly by some hospitals instead of on an exception-only basis. By not reporting the uninsured charges and payments, a hospital was relieved of its responsibility to maintain accurate records. Also, by using the proxy method, a hospital could increase its hospital specific limit over what it would be if it had reported charges and payments. In addition, there was no independent review or approval of the state's proxy calculations.

The state used incorrect cost report information to calculate uninsured patient cost of all state mental hospitals. We used the correct report information to recalculate uninsured patient cost at the state mental hospital we selected for review. However, we did not review cost report information for the other state mental hospitals. Therefore, we did not determine the effect of using incorrect cost report information for the other hospitals.

The state calculated each hospital's ratio of cost-to-charges according to the state plan, which specified the ratio to be total cost divided by total charges per each hospital's cost report. However, for two of the hospitals we selected for review, the ratio included cost centers for separately licensed or certified entities that provided non-hospital services. We removed these cost centers and recalculated the ratio in our calculation of the hospital specific limit for those two hospitals.

We recommended that the state*:*

- Work with CMS to address and resolve the $511.4 million ($319.2 million federal share) of DSH payments in excess of hospital specific limits. Although the state plan was silent on the use of, or reconciliation to, incurred costs and payments, we believe that the apparent purpose of section 1923 of the Act was to limit the state's reimbursement to hospitals to the cost of providing hospital services for each year.

- Issue guidance requiring that a negative Medicaid shortfall be used in determining the hospital specific limit.

- Establish procedures to assure that the uninsured data submitted by hospitals is accurate and supported.

- Review the calculations of uninsured patient cost for all other state mental hospitals to determine if similar incorrect information was used, and if so, make appropriate adjustments and refunds.

- Establish procedures to limit the use of the proxy method for calculating uninsured patient charges. Also, establish internal controls to have the proxy calculations independently approved and reviewed.

- Provide guidance for calculating the cost-to-charge ratio. Non-allowable cost centers of separately licensed or certified entities should not be included.

The state disagreed with the finding that excess DSH payments of approximately $511.4 million ($319.2 million federal share) were made to the hospitals for hospital fiscal years 1996 through 1998. While the state plan did not address a specific action to limit the payments to the costs of services, we continue to believe that the apparent congressional purpose of section 1923(g) of the Act was to limit the state's reimbursement to hospitals to the cost of providing hospital services for each year. The state also disagreed with the finding regarding the handling of a negative Medicaid shortfall when calculating hospital specific limits but agreed to address this issue with CMS for DSH calculations in future years.

The state agreed with the findings regarding the accuracy of self-reported information submitted by the hospitals and stated that it would discuss with CMS methods to verify the accuracy of the data. Further, the state agreed with our concerns over the utilization of the proxy method and will explore with CMS ways to review and regulate its use. Finally, the state indicated a willingness to work with CMS to develop additional guidance for calculating the cost-to-charge ratio and would include more specific information on non-allowable cost centers.

The state did not respond to the recommendation pertaining to reviewing the calculations of the uninsured patient cost for all the other state mental hospitals and make appropriate adjustment and refunds. We continue to believe that the state should address this recommendation.

We summarized the state's comments and included the Office of Inspector General's response to those comments in a separate section of the report. We also appended the state's comments, in their entirety, to the report.

If you have any questions or comments about this report, please do not hesitate to call me or George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits, at (410) 786-7104 or Gordon Sato, Regional Inspector General for Audit Services, Region VI, at (214) 767-8414.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 6B6
Dallas, TX 75242

Report Number: A-06-01-00041

FEB 24 2003

Mr. Don Gilbert, Commissioner
Texas Health and Human Services Commission
P. O. Box 13247
Austin, Texas 78711-3247

Dear Mr. Gilbert:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) final report entitled, "Audit of Texas Medicaid Inpatient Disproportionate Share Hospital Program for Hospital Fiscal Years 1996 through 1998." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (see 45 CFR part 5). As such, within 10 business days after the final report is issued, it will be posted to the Internet at http://oig.hhs.gov.

To facilitate identification, please refer to report number A-06-01-00041 in all correspondence relating to this report.

Sincerely,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

Dr. James R. Farris, M.D.
Regional Administrator
Centers for Medicare and Medicaid Services
1301 Young Street, Suite 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

AUDIT OF TEXAS MEDICAID INPATIENT DISPROPORTIONATE SHARE HOSPITAL PROGRAM FOR HOSPITAL FISCAL YEARS 1996 THROUGH 1998

JANET REHNQUIST
Inspector General

FEBRUARY 2003
A-06-01-00041

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

In 1965, Medicaid was established as a jointly funded federal and state program providing medical assistance to qualified low-income people. At the federal level, the program is administered by the Centers for Medicare and Medicaid Services (CMS), an agency within the Department of Health and Human Services. Within a broad legal framework, each state designs and administers its own Medicaid program. Each state prepares a state plan that defines how a state will operate its Medicaid program and is required to submit the plan for CMS approval.

The disproportionate share hospital (DSH) program originated with the Omnibus Budget Reconciliation Act (OBRA) of 1981, which required state Medicaid agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs. States had considerable flexibility to define DSH under sections 1923(a) and (b) of the Social Security Act (the Act).

Section 13261 of OBRA 1993 amended section 1923 of the Act to limit DSH payments to the amount of a hospital's incurred uncompensated care costs (UCC). The UCC was limited to the costs of medical services provided to Medicaid and uninsured patients less payments received for those patients excluding Medicaid DSH payments.

The OBRA 1993 provided for a transition period during which public hospitals deemed high DSH[1] could receive payments up to 200 percent of uncompensated cost but limited payments to all hospitals to 100 percent of UCC for state fiscal years (SFY) beginning on or after January 1, 1995.

OBJECTIVES

The objectives of the audit were to (1) review the Texas DSH program and determine that DSH payment limits were calculated in accordance with the approved state plan and (2) verify that payments to individual hospitals did not exceed the hospital specific limits imposed by OBRA 1993.

SUMMARY OF FINDINGS

Our review showed that the state calculated the DSH payment limits in accordance with the approved state plan with the exception of handling the negative Medicaid shortfall. However, we believe the approved state plan does not comply with the apparent purpose of OBRA 1993. As a result, DSH payments totaling approximately $511.4 million ($319.2 million federal share)

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[1] *High DSH public hospitals must have either (1) a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state or (2) the greatest number of Medicaid inpatient days of any hospital in the state in the previous fiscal year.*

were paid to hospitals in excess of hospital specific limits for hospital fiscal years (HFY) 1996 through 1998. This amount included adjustments resulting from the negative Medicaid shortfalls not being properly accounted for and adjustments made during our hospital specific reviews at three selected hospitals to determine the accuracy of the calculations for UCC.

These excess payments occurred for the following reasons:

- The state plan required that the Medicaid shortfall and uninsured patient cost be summed to calculate the hospital specific limit. However, the state limited negative Medicaid shortfalls, i.e. Medicaid payments exceeding Medicaid cost of services, to zero.

- The state made payments to hospitals on a prospective basis as required by the state plan, but did not have controls in place to assure that payments did not exceed the actual cost of providing services to patients that were eligible for medical assistance under the state plan or have no health insurance or other source of third-party coverage.

- The state did not verify the accuracy of the self-reported uninsured charges and payments submitted by the hospitals, which it used in the calculation of uninsured patient cost.

A proxy method, as provided in the state plan, was used by the state to calculate uninsured patient charges for hospitals that did not provide, or were unable to accurately determine, charge and payment data for such patients. We believe the proxy method was being used regularly by some hospitals instead of on an exception-only basis. By not reporting the uninsured charges and payments, a hospital was relieved of its responsibility to maintain accurate records. Also, by using the proxy method a hospital could increase its hospital specific limit over what it would be if it had reported charges and payments. In addition, there was no independent review or approval of the state's proxy calculations.

The state used incorrect cost report information to calculate uninsured patient cost of all state mental hospitals. We used the correct report information to recalculate uninsured patient cost at the state mental hospital we selected for review. However, we did not review cost report information for the other state mental hospitals. Therefore, we did not determine the effect of using incorrect cost report information for the other hospitals.

The state calculated each hospital's ratio of cost-to-charges according to the state plan, which specified the ratio to be total cost divided by total charges per each hospital's cost report. However, for two of the hospitals we selected for review, the ratio included cost centers for separately licensed or certified entities that provided non-hospital services. We removed these cost centers and recalculated the ratio in our calculation of the hospital specific limit for those two hospitals.

RECOMMENDATIONS

We recommended that the state:

- Work with CMS to address and resolve the $511.4 million ($319.2 million federal share) of DSH payments in excess of hospital specific limits. Although the state plan was silent on the use of, or reconciliation to, incurred costs and payments, we believe that the apparent purpose of section 1923 of the Act was to limit the state's reimbursement to hospitals to the cost of providing hospital services for each year.

- Issue guidance requiring that a negative Medicaid shortfall be used in determining the hospital specific limit.

- Establish procedures to assure that the uninsured data submitted by hospitals is accurate and supported.

- Review the calculations of uninsured patient cost for all other state mental hospitals to determine if similar incorrect information was used, and if so, make appropriate adjustments and refunds.

- Establish procedures to limit the use of the proxy method for calculating uninsured patient charges. Also, establish internal controls to have the proxy calculations independently approved and reviewed.

- Provide guidance for calculating the cost-to-charge ratio. Non-allowable cost centers of separately licensed or certified entities should not be included.

The state disagreed with the finding that excess DSH payments of approximately $511.4 million ($319.2 million federal share) were made to the hospitals for HFY 1996 through 1998. While the state plan did not address a specific action to limit the payments to the costs of services, we continue to believe that the apparent congressional purpose of section 1923(g) of the Act was to limit the state's reimbursement to hospitals to the cost of providing hospital services for each year. The state also disagreed with the finding regarding the handling of a negative Medicaid shortfall when calculating hospital specific limits but agreed to address this issue with CMS for DSH calculations in future years.

The state agreed with the findings regarding the accuracy of self-reported information submitted by the hospitals and stated that it would discuss with CMS methods to verify the accuracy of the data. Further, the state agreed with our concerns over the utilization of the proxy method and will explore with CMS ways to review and regulate its use. Finally, the state indicated a willingness to work with CMS to develop additional guidance for calculating the cost-to-charge ratio and would include more specific information on non-allowable cost centers.

The state did not respond to the recommendation pertaining to reviewing the calculations of the uninsured patient cost for all the other state mental hospitals and make appropriate adjustment and refunds. We continue to believe that the state should address this recommendation.

We summarized the state's comments and included the Office of Inspector General's response to those comments in a separate section of the report. We also appended the state's comments, in their entirety, to the report.

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INTRODUCTION

BACKGROUND

In 1965, Medicaid was established as a jointly funded federal and state program providing medical assistance to qualified low-income people. At the federal level, the program is administered by the Centers for Medicare and Medicaid Services (CMS), an agency within the Department of Health and Human Services. Within a broad legal framework, each state designs and administers its own Medicaid program. Each state prepares a state plan that defines how a state will operate its Medicaid program and is required to submit the plan for CMS approval.

The Omnibus Budget Reconciliation Act (OBRA) 1981 established the disproportionate share hospital (DSH) program by adding section 1923 to Social Security Act (the Act). Section 1923 required state Medicaid agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs. States had considerable flexibility to define DSH under sections 1923(a) and (b) of the Act.

The OBRA 1993 established additional DSH parameters by amending section 1923 of the Act to limit DSH payments to a hospital's incurred uncompensated care costs (UCC). Under section 1923(g) of the Act, the UCC was limited to costs of medical services provided to Medicaid and uninsured patients less payments received for those patients excluding Medicaid DSH payments. The specific language contained in the Act, as amended, is as follows:

> "Section 1923…
> (g) Limit on Amount of Payment to Hospital.---
> (1) Amount of adjustment subject to uncompensated costs.---
> (A) IN GENERAL.---A payment adjustment during a fiscal year shall not be considered to be consistent with… respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year."

The OBRA 1993 provided for a transition period during which public hospitals deemed high DSH[1] could receive payments up to 200 percent of uncompensated cost but limited payments to all hospitals to 100 percent of uncompensated cost for state fiscal years (SFY) beginning on or after January 1, 1995.

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[1] *High DSH public hospitals must have either (1) a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state or (2) the greatest number of Medicaid inpatient days of any hospital in the state in the previous fiscal year.*

States receive allotments of DSH funds as set forth by federal statute. The Federal Government cost-shares Medicaid DSH expenditures based upon the applicable federal medical assistance percentage. States report DSH expenditures on CMS Form-64, the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.

In Texas, the Health and Human Services Commission (state) administers the DSH program according to the CMS approved state plan. Prior to the beginning of the SFY, the state surveys Texas hospitals and obtains the latest available hospital fiscal year (HFY) data to determine which hospitals meet the eligibility criteria to receive DSH payments. For hospitals that are deemed eligible, the state calculates a hospital specific limit that is the sum of the Medicaid shortfall and the cost of services to uninsured patients.

The amount of payment to be made to the eligible hospitals is based on an adjusted hospital specific limit. The adjusted hospital specific limit is the hospital specific limit trended forward by an inflation update factor since the base year. For example, the adjusted hospital specific limit for 1998 was calculated by the state on a prospective basis during 1997 by applying an inflation update factor to the 1996 hospital specific limit.

The state plan specifies that state-owned teaching, mental, and chest hospitals receive DSH payments equal to 100 percent of their adjusted hospital specific limits. Payments for all other hospitals are apportioned from remaining DSH funds based on weighted Medicaid and low-income days, not to exceed individual adjusted hospital specific limits. The state distributes DSH payments monthly during the SFY.

Cost of services to uninsured patients is calculated from charge and payment data for the latest available HFY. This data is certified and submitted annually by the hospitals to the state. For hospitals that do not submit or are unable to accurately determine charges for uninsured patients, the state plan specifies a proxy methodology for the state to calculate uninsured charges. In applying the proxy methodology, the state uses information submitted by similar facilities to determine the proxy cost of services provided to uninsured patients.

A detailed explanation of the state's DSH payment calculation methodology is included as Appendix A.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of the audit were to (1) review the Texas DSH program and determine that DSH payment limits were calculated in accordance with the approved state plan and (2) verify that payments to individual hospitals did not exceed the hospital specific limits imposed by OBRA 1993.

To accomplish the objectives, we performed the following:

(1) Discussed the state plan with CMS and state officials to obtain an understanding of the DSH program.

(2) Obtained from the state the hospital specific limit for each hospital that received DSH payments during any of HFYs 1996 through 1998. The hospital specific limit is the sum of the Medicaid shortfall and the cost of services to uninsured patients. The information used to compute the cost of services to uninsured patients is furnished by the hospitals and is not audited or verified by the state. The data used to determine the hospital specific limit is not available until after the close of the applicable HFY.

(3) Compared the methodology used by the state in computing the adjusted hospital specific limits used for payment purposes to the methodology contained in the state plan. The adjusted hospital specific limit is a hospital specific limit trended forward to account for inflation. The state limited the negative Medicaid shortfall amounts to zero and did not offset the negative amounts from the uninsured patient costs in computing these hospital specific limits. However, we did offset the negative Medicaid shortfall amounts in our calculation of the hospital specific limits.

(4) Compared the total DSH payments for each hospital that received payments during HFYs 1996 through 1998 to the hospital specific limit as calculated by the state for each of these years and adjusted for the Medicaid negative shortfall when applicable. We made additional adjustments for the three hospitals selected for detailed review of documentation supporting the self-reported data used by the state to calculate the hospital specific limit.

(5) Selected three hospitals for review to determine the accuracy of their respective HFY 1998 hospital specific limits. These hospitals were Baptist Health System (BHS), Harris County Hospital District (HCHD), and Terrell State Hospital (TSH). Other than adjusting the hospital specific limits for any negative Medicaid shortfall for the other hospitals that received DSH payments during HFYs 1996 through 1998, we did not do any additional work.

Total DSH payments (federal allotment plus state-match) of $4.49 billion were made during the HFYs 1996 through 1998 period as shown in the following table:

HFYs	NUMBER OF HOSPITALS RECEIVING PAYMENTS	TOTAL DSH PAYMENTS
1996	178	$1.44 billion
1997	181	1.51 billion
1998	165	1.54 billion
		$4.49 billion

The audit was performed in accordance with generally accepted government auditing standards. Internal control review was limited to obtaining an understanding of how the state administers the DSH program. Internal controls related to individual hospital overall accounting systems were not reviewed.

Fieldwork was performed at the state office in Austin, Texas and at the selected hospitals in San Antonio (BHS), Houston (HCHD), and Terrell (TSH), Texas.

RESULTS OF AUDIT

Our review showed that the state calculated the DSH payment limits in accordance with the state plan with the exception of handling the negative Medicaid shortfall. However, we believe that the approved state plan does not comply with the apparent purpose of OBRA 1993. As a result, DSH payments totaling approximately $511.4 million ($319.2 million federal share) were paid to hospitals throughout the state in excess of the hospital specific limits for HFYs 1996 through 1998. This occurred because the state made DSH payments on a prospective basis as required by the state plan, but did not have controls in place to ensure that the payments did not exceed the actual cost incurred by the hospitals as required under section 1923(g). According to section 1923(g)(1)(A) of the Act,

> "A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) with respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services…by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year…."

The state plan required that the total Medicaid shortfall and the uninsured patient cost be considered in calculating the hospital specific limit. However, the state limited negative Medicaid shortfall amounts to zero and did not offset these amounts against uninsured patient cost. This caused the hospital specific limits to be overstated for each hospital that had a negative Medicaid shortfall.

This shortfall finding was included as part of our overall calculation of the DSH payments that exceeded the hospital specific limits. Our audit did not specifically quantify the effect these

shortfalls had on specific hospitals because our audit scope was initially designed to determine the overall impact of reconciling the budgeted hospital specific limits to actual costs.

The hospital specific limit was based on historical data and was trended forward to account for inflation. This then became the adjusted hospital specific limit. As an example, the state DSH payments for 1998 were based on the 1996 hospital specific limit and trended forward to account for inflation as provided for in the state plan, but were never reconciled to the 1998 hospital specific limit. Therefore, our calculations are comprised of the reconciliation for all hospitals and any additional adjustments at the three hospitals reviewed. Also, the state did not verify the accuracy of the self-reported data submitted by the hospitals using the proxy method.

There was also an internal control weakness in the use of the proxy method in calculating the uninsured patient charges by the state. One person performs the proxy calculations with no independent review or approval of the calculations. This methodology was used regularly for some hospitals, but we believe the proxy method should be used on an exception-only basis.

Three hospitals were selected for review to determine the accuracy of their respective HFY 1998 hospital specific limits. Our review identified unallowable costs that resulted in additional excess DSH payments for BHS totaling approximately $1.7 million ($1.1 million federal share). Overpayments decreased for HCHD and TSH by a total of $5.7 million ($3.6 million federal share).[2]

$511.4 Million Paid In Excess of Hospital Specific Limits

A total of approximately $511.4 million ($319.2 million federal share) was paid in excess of hospital specific limits for HFYs 1996 through 1998. This occurred because the state calculated DSH payments on a prospective basis in accordance with the state plan, but did not have controls in place to ensure that the payments were in accordance with the apparent purpose of federal law. According to section 1923(g)(1)(A) of the Act, DSH payments cannot exceed the cost incurred during the year of furnishing hospital services to individuals who are either eligible for medical assistance under the state plan or have no health insurance (or other source of third-party coverage). Also, the state did not verify the accuracy of the self-reported data submitted by the hospitals.

STATE PAYMENT METHODOLOGY

Hospital Specific Limits As Computed by State At Close of HFYs		Inflation Factor		Adjusted Hospital Specific Limit For HFYs
1994	X		=	1996
1995				1997
1996				1998

[2] *These amounts were included as adjustments in our calculation of the $511.4 million.*

OFFICE OF INSPECTOR GENERAL (OIG) RECONCILIATION OF DSH PAYMENTS TO HOSPITAL SPECIFIC LIMITS

DSH Payments For HFYs		Hospital Specific Limits for HFYs		Payments in Excess of Hospital Specific Limits
1996		1996		
1997	−	1997	=	$511.4 Million
1998		1998		

We obtained the DSH payment and hospital specific limit data from the state. The DSH payments were compared to the hospital specific limits for each hospital for HFYs 1996 through 1998 to arrive at the amount of excess DSH payments. The state did not offset negative Medicaid shortfalls against uninsured patient cost in calculating hospital specific limits. Instead, the state set negative amounts to zero, thus overstating the hospital specific limit for each hospital that had a negative Medicaid shortfall. We used the negative Medicaid shortfalls to offset the uninsured patient cost in our calculation of excess DSH payments. In instances where the state used the proxy method to calculate uninsured patient cost, we used their results for the comparison.

Of the $511.4 million of excess payments, approximately 62.6 percent ($320 million) went to 14 state-owned teaching, mental, and chest hospitals. The state plan specified that DSH payments for these hospitals be set at 100 percent of their adjusted hospital specific limits. (See Schedule A.)

Medicaid Shortfall Calculation

The state calculated the Medicaid shortfall component of the hospital specific limit using Medicaid charge and payment totals provided by the Texas Medicaid contractor, National Heritage Insurance Company (NHIC), and participating health maintenance organizations. The totals were obtained from reports containing all Medicaid claims for the HFY filed up to 7 months after the close of the HFY. The accuracy of the Medicaid charge and payment totals could not be verified because the detailed reports for HFYs 1996 through 1998 were not retained. Because supporting detail was unavailable and the Medicaid shortfall comprised less than 7 percent of the hospital specific limit for HFYs 1996 through 1998, we used these totals in the Medicaid shortfall calculation.

Use of Proxy Method to Calculate Cost of Services to Uninsured Patients

The state plan described a proxy method to be used to calculate uninsured patient charges. This proxy method was used by the state when: (1) the hospital did not report uninsured patient data or (2) the uninsured charges submitted by a hospital exceeded the sum of its bad debt and charity

charges by a threshold percentage determined by the state. The reported uninsured patient payments were disregarded when the proxy method was used. (See Appendix B for detailed description of proxy method.)

There is an internal control weakness in the use of the proxy method to calculate uninsured patient charges. One person controlled the proxy calculations and there was no independent review or approval of the calculations.

Although the state plan provided for use of the proxy method, we believe this method should be used as an exception-only basis. Our review of the use of the proxy method for HFYs 1996 through 1998 indicated that some hospitals regularly utilized this alternative methodology. Specifically, we identified the following:

- The proxy method was used 68 times to calculate $257 million of uninsured patient charges for the 3-year period.

- In 37 of the 68 instances, hospitals reported uninsured patient data that was deemed inaccurate by the state.

- In 31 of the 68 instances, hospitals did not report uninsured patient data. In the most extreme example, the state calculated $61 million in uninsured charges.

- For 20 hospitals, the proxy method was used to calculate uninsured patient charges for at least 2 of the 3 years. Six of these hospitals had uninsured patient charges calculated by the proxy method all 3 years. Three of the hospitals did not report uninsured patient data all 3 years.

The state officials explained that hospitals are aware of the availability of the proxy method and sometimes call to inquire what their uninsured charges would be if the proxy method was used. By not reporting uninsured charges and payments, a hospital was relieved of its responsibility to maintain accurate records. Also, a hospital could increase its hospital specific limit over what it would have been if it had reported charges and payments.

Review of Three Selected Hospitals for HFY 1998

We selected three hospitals for review to determine the accuracy of the calculation of the HFY 1998 hospital specific limits. Our review included an examination of the calculation of the uninsured patient cost and the cost-to-charge ratio. Hospitals selected for review included a private not-for-profit hospital, a public hospital, and a state mental hospital.

Our review of the three hospitals resulted in an additional overpayment for BHS and a reduction in the overpayments for HCHD and TSH. The results of the review of the three hospitals are shown in the schedule below:

HOSPITAL (TYPE)	AMOUNT PAID IN EXCESS OF HOSPITAL SPECIFIC LIMIT	ADJUSTMENTS BASED ON REVIEW AT THE HOSPITALS	RECALCULATION OF AMOUNT PAID IN EXCESS OF HOSPITAL SPECIFIC LIMIT	See Schedule
BHS (Private)	$4,303,512	$1,728,814	$6,032,326	B-1
HCHD (Public)	$5,637,179	($4,937,219)	$ 699,960	C-1
TSH (State Mental)	$5,397,099	($ 812,541)	$4,584,558	D-1

At the time of the detailed review, BHS and HCHD provided updated uninsured patient charge and payment data that we used in calculating the hospital specific limits. However, unallowable charges and payments were included in hospital-reported uninsured patient data, which was not verified by the state. In addition, the cost-to-charge ratio included unallowable cost centers for separately licensed entities. The issues related to adjustments made for the hospital specific limit recalculation for each hospital are described below in the sections entitled, "Uninsured Patient Cost" and "Cost-to-Charge Ratio."

Uninsured Patient Cost

The uninsured charges and payment information used to calculate the uninsured patient cost of the hospital specific limit was reported to the state by each hospital. This information was not verified by the state. The following items were inappropriately included in the uninsured patient data that the three selected hospitals reported and certified to the state:

- Elective cosmetic surgery (see Schedule B)
- Skilled nursing facility (SNF) patients (see Schedule B)
- Insured patients (see Schedules B and C)
- Incorrect cost report Worksheet (see Schedule D)
- Bad debts (see Schedule D)
- Insured patient charges (understated, see Schedule D)
- Uninsured patient payments (overstated, see Schedule D)

Cost-to-Charge Ratio

The cost-to-charge ratios for BHS and HCHD were calculated in accordance with the state plan. However, the calculations were based on total costs and charges that included cost centers for separately licensed or certified entities that provided non-hospital services (SNF, home health agency, rural health clinic, and air ambulance service). In a January 1998 letter to state Medicaid agencies, the Health Care Financing Administration (HCFA, (now CMS)) instructed that hospital specific limits should not include costs or revenues for services provided by a separately licensed or certified entity, even if that entity is owned by the same institution. Therefore, we removed

costs and charges for these cost centers, and recalculated the cost-to-charge ratios for BHS (see Schedule B-2) and HCHD (see Schedule C-2). The revised cost-to-charge ratios were used in the adjustments to the hospital specific limits for BHS (see Schedule B-1) and HCHD (see Schedule C-1).

RECOMMENDATIONS

We recommended that the state:

- Work with CMS to address and resolve the $511.4 million ($319.2 million federal share) of DSH payments made in excess of hospital specific limits. Although the state plan was silent on the use of, or reconciliation to, incurred costs and payments, we believe that the apparent purpose of section 1923 of the Act was to limit the state's reimbursement to hospitals to the cost of providing hospital services for each year.

- Issue guidance requiring that the negative Medicaid shortfall be used in determining the hospital specific limit.

- Establish procedures to assure that the uninsured data submitted by hospitals is accurate and supported.

- Review the calculations of uninsured patient cost for all other state mental hospitals to determine if similar incorrect information was used, and if so, make appropriate adjustments and refunds.

- Establish procedures to limit the use of the proxy method for calculating uninsured patient charges. Also, establish internal controls to have the proxy calculations independently approved and reviewed.

- Provide guidance for calculating the cost-to-charge ratio. Non-allowable cost centers of separately licensed or certified entities should not be included.

AUDITEE'S COMMENTS AND OIG'S RESPONSE

The state disagreed that it made excess DSH payments. It contends that the payments were made in accordance with the approved state plan and that the plan made no provision for retrospective settlements. It also contends that the congressional intent was not to require reconciliation of DSH payments to final costs. Further, CMS did not require such a provision in the approved state plan.

We have not made specific recommendations on the allowability of the excess DSH payments. Instead we recommend that CMS and the State work to address and resolve the issue. We note

that section 1923 (g)(1) (A) of the Act states *"…A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) with respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services… by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance… for services provided during the year."* We agree with the state that the state plan did not address a specific action to limit the payments to the costs of services, but we continue to believe that the apparent Congressional purpose was to limit the state's reimbursement to the cost of providing hospital services.

The state disagreed with the finding in the draft report on the procedure of offsetting a surplus in one calculation with a negative in the other. However, the state did agree that revisiting this issue was a reasonable recommendation and would be willing to do so for DSH calculations in future years.

The state plan defined the Medicaid shortfall as "…the cost of services (inpatient and outpatient) furnished to Medicaid patients, less the amount paid under the nondisproportionate share hospital payment method under this plan." The plan did not provide for limiting the amount to "zero" when the Medicaid payments exceed the cost of services. We made the adjustments to the calculations of the hospital specific limits, where appropriate. We noted this in our report. We agree that this issue should be addressed and the negative amounts be included in the hospital specific limit calculations when applicable.

The state agreed with the findings regarding the accuracy of self-reported information submitted by the hospitals, the utilization of the proxy method, and the issue addressed for the calculation of the cost-to-charge ratio. The state expressed a willingness to work with CMS to resolve these issues.

The state did not respond to the recommendation pertaining to reviewing the calculations of the uninsured patient cost for all the other state mental hospitals and make appropriate adjustment and refunds. We continue to believe that the state should address this recommendation.

The full text of the state's response is included in Appendix C.

APPENDICES

TEXAS DSH PAYMENT CALCULATION METHODOLOGY

In Texas, the Health and Human Services Commission (state) administers the DSH program according to the CMS approved state plan. Prior to the beginning of the SFY, the state surveys Texas hospitals to determine which hospitals, based on the latest available HFY data, meet the state conditions of participation. The state then determines DSH payments for the coming SFY for hospitals deemed eligible.

The state calculates the hospital specific limit for each eligible hospital based on the latest available HFY data. For example, the DSH payments for SFY 1998 are computed in SFY 1997 and are based on HFY 1996 data.

The hospital specific limit is the sum of the Medicaid shortfall and the cost of services to uninsured patients. The state plan further defines these two components of the hospital specific limit:

(1) Medicaid shortfall is the cost of services (inpatient and outpatient) furnished to Medicaid patients, less the amount paid under the non-disproportionate share hospital payment method.

(2) Cost of services to uninsured patients is inpatient and outpatient charges to patients who have no health insurance or other source of third party payment for services provided during the year, multiplied by the hospital's ratio of cost to charges (inpatient and outpatient), less the amount of payments made by or on behalf of those patients. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment.

The Medicaid shortfall is calculated from Medicaid charge and payment data supplied to the state by NHIC, the Texas Medicaid contractor and by health maintenance organizations participating in the Texas Medicaid program. The data is based on Medicaid claims (based on admission date) for the latest available HFY, and includes claims filed up to 7 months after the HFY.

Cost of services to uninsured patients is calculated from charge and payment data for the latest available HFY. This data is certified and submitted annually by the hospitals to the state. The state plan specifies a proxy methodology for the state to calculate uninsured patient charges for hospitals that do not submit, or are unable to accurately determine, charges and payments for uninsured patients.

The state converts the Medicaid and uninsured patient charges to cost using the hospital's overall cost-to-charge ratio. The ratio is based on the latest available Medicare cost report (total cost per Worksheet B, Part 1, Column 25, divided by total charges per Worksheet C, Part 1, Column 6). Medicaid and uninsured patient payments are then

TEXAS DSH PAYMENT CALCULATION METHODOLOGY

subtracted from the respective calculated costs, and the net results are summed to constitute the hospital specific limit.

The state then applies an appropriate inflation factor to each hospital specific limit to obtain an adjusted hospital specific limit for the upcoming SFY, the period for which DSH payments are then calculated.

After determining the adjusted hospital specific limit for each eligible hospital, the state determines payments based on total DSH funds available for the upcoming SFY. The state of Texas has historically utilized its entire annual federal allotment of DSH funds.

The state plan specifies that state-owned teaching, mental, and chest hospitals receive DSH payments equal to 100 percent of their adjusted hospital specific limits. Payments for all other hospitals are apportioned from remaining DSH funds based on weighted Medicaid and low-income days, not to exceed individual adjusted hospital specific limits. The state distributes DSH payments monthly during the SFY.

The OBRA 1993 specifies that DSH payments should not exceed hospital specific limits for the period in which received. However, the state plan contains no provision for subsequent reconciliation of DSH payments to actual hospital cost incurred during the payment period. Based on discussions with a state official, DSH payments are considered final and reconciliations have not been performed.

TEXAS DSH PROXY METHODOLOGY

Hospitals that do not respond to the annual survey, or that are unable to determine accurately the charges attributed to patients without insurance, shall have their bad debt charges and charity charges as defined in the state plan, reduced by a percentage derived from a representative sample of hospitals determined annually by the state. The state calculates the percentage in the following manner for each specific category of hospitals:

- The state sums the total amount of charges for patients without health insurance or other third party payments.
- The state sums the charity and bad debt charges.
- The state calculates a ratio by dividing the sum of charges for patients without health insurance by the sum of charity and bad debt charges.
- The state then uses the resulting ratio for each of the specific category of hospitals. Individual hospitals that did not respond to the survey, or that are unable to accurately determine uninsured patient charges, have their hospital's individual sum of bad debt and charity charges multiplied by the appropriate ratio for the specific hospital category.
- This calculates a value for the charges for patients without health insurance or other third party payments for each individual hospital.
- The state multiplies each hospital's calculated value by that hospital's cost-to-charge ratio to obtain the proxy cost for services delivered to uninsured patients at each hospital.

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

Don A.Gilbert, M.B.A.
COMMISSIONER

October 25, 2002

Gordon L. Sato
Department of Health & Human Services
Office of Inspector General
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

RE: Comments on the draft report, "Audit of Texas Medicaid Inpatient Disproportionate Share Hospital Program for Hospital Fiscal Years 1996 through 1998," prepared by the Office of Inspector General, September 2002

Dear Mr. Sato:

Thank you for the opportunity to comment on the draft report cited above. We agree with the general finding that Texas calculated the Disproportionate Share Hospital (DSH) payment limits in accordance with the approved state plan. However, we disagree with the exception noted in the report regarding the handling of negative Medicaid shortfall. We have consistently treated the cap as the sum of two separate calculations: (1) the determination of a hospital's cost of treating the uninsured; and (2) the determination of a hospital's Medicaid shortfall. We did not think it appropriate to use a surplus in one calculation to offset a deficit in the other. Under our current state plan, if we were to reduce uninsured costs by the amounts a hospital's Medicaid payments exceeded its Medicaid costs, as suggested by the draft report, several hospitals would qualify for DSH but would be unable to receive funds. This would represent a serious problem, since we have no provisions in our current state plan to address a situation where a hospital cannot receive DSH funds after it has qualified. Nevertheless, we concede that revisiting this issue is a reasonable recommendation, and would be willing to do so for DSH calculations in future years.

We further disagree with the finding that we made excess payments of approximately $511.4 million ($319.2 million federal share) for hospital fiscal years 1996 through 1998. The Texas Medicaid state plan for the DSH program describes a prospective system in which payments for any given year are based on the most accurate data currently available for a previous year. The approved DSH plan makes no provision for retrospective settlements. We are unaware of any specific Congressional intent to require reconciliation of DSH payments under a prospective payment system against final cost reporting, and your draft report offers no direction in this regard. Had the intent of Congress in OBRA 1993 been to require retrospective settlements, we believe the legislation would have more clearly required such action. Further, if this had been Congress' intent, we think the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services [CMS]) would have required the State the opportunity to include such settlements in the state plan at the time the plan was approved.

P. O. Box 13247 • Austin, Texas 78711 • 4900 North Lamar, Fourth Floor, Austin, Texas 78751

We share OIG concerns regarding the accuracy of self-reported uninsured charges and payments submitted by the hospitals, and would be happy to discuss with the CMS ways to verify the accuracy of these data. We also share the concerns expressed regarding utilization of the proxy method, and would be happy to explore with CMS procedures to review and regulate its use for calculating uninsured patient charges. Finally, we are willing to work with CMS to develop additional guidance for calculating the cost-to-charge ratio, including more specific information on non-allowable cost centers.

Because of its importance in the context of this draft report, we must reemphasize the fact that the Texas Medicaid DSH state plan describes a prospective system, without provision for cost settlements. Although we certainly would be willing to amend the plan to improve the program, we feel that any changes must be implemented on a prospective basis, considering the State's reliance on the approval of the responsible federal agency and, in turn, the hospitals' reliance on the State's implementation of the approved state plan.

Thank you for again for the opportunity to comment on the draft audit report. If you have questions about our response, please call Scott Reasonover at (512) 338-6464.

Sincerely,

Don A. Gilbert

DAG:sl

c: Scott Reasonover

SCHEDULES

Schedule A

SCHEDULE OF DSH PAYMENTS
IN EXCESS OF HOSPITAL SPECIFIC LIMITS
HFYs 1996-1998

HFY	Number of Hospitals	Payments in Excess of Hospital Specific Limit	FMAP	Federal Share
1996	44	$213,318,750	62.30%	$132,897,581
1997	45	$221,264,478	62.56%	$138,423,057
1998	65	$ 80,862,651	62.28%	$ 50,361,259
		$515,445,879		**$321,681,897**
Adjustments Per Review of Three Selected Hospitals for HFY 1998				
Adjustment to excess payment				
BHS (**See Schedule B**)		$ 1,728,814	62.28%	$ 1,076,705
HCHD (**See Schedule C**)		$ (4,937,219)	62.28%	$ (3,074,900)
TSH **(See Schedule D**)		$ (812,541)	62.28%	$ (506,051)
Net Adjustment		$ (4,020,946)		$ (2,504,246)
Total DSH Payments in Excess of Hospital Specific Limits		**$511,424,933**		**$319,177,651**

DETAIL OF AUDIT ADJUSTMENTS- BAPTIST HEALTH SYSTEM (BHS)

Elective Cosmetic Surgery Charges and Payments Included in Uninsured Data

The HFY 1998 uninsured patient data for BHS included $7,249,242 in charges and $1,143,976 in payments for plastic surgery accounts. Admissions staff and nurse auditors stated that essentially all BHS plastic surgeries were elective cosmetic procedures. An official at BHS stated that these patients were classified as self-pay and considered uninsured because health insurance did not cover these services.

Fifteen plastic surgery accounts were judgmentally selected and presented to the BHS nurse audit staff for medical record review. The hospital staff could not locate the medical records for two of the selected accounts. The nurse auditors concluded that all 13 accounts reviewed had charges for elective cosmetic procedures. These charges were for procedures such as breast augmentations, face-lifts, and liposuctions.

The state plan specifies that patients may be considered uninsured for DSH purposes if their health insurance does not cover the services provided. However, because Medicaid does not cover elective cosmetic surgery, we believe that these services should not be included in calculating limits for DSH payments. Because BHS did not identify or support any plastic surgeries as medically necessary, we removed all plastic surgery charges and payments in recalculating the HFY 1998 hospital specific limit for BHS. **(See Schedule B-1.)**

SNF Charges Included in Uninsured Data

The uninsured patient data submitted by BHS for HFY 1998 included charges of $149,858 for three SNF patients. The SNF was operated as a separately licensed entity by BHS during HFY 1998. In January 1998, the HCFA (now CMS) issued Medical Services Letter No. 98-002 which clarified that the cost of such services could not be included for DSH purposes:

> "...a state may not include costs or revenues in the hospital-specific DSH limit which are attributable to services rendered in a separately licensed/certified entity, even if that entity is owned by the same overall institution."

Therefore, we removed these charges in recalculating the HFY 1998 hospital specific limit for BHS. **(See Schedule B-1.)**

Insured Patient Charges and Payments Included in Uninsured Data

Charges of $198,245 and payments of $102,399 for patients with health insurance were included in the uninsured charges and payments. This occurred because the previous information system used by BHS automatically reclassified insured patients to self-pay (uninsured) status after insurance payments were posted to reflect the balance due from

DETAIL OF AUDIT ADJUSTMENTS- BAPTIST HEALTH SYSTEM (BHS)

the patients. According to the state plan, patients with health insurance may be considered for DSH purposes only when their health insurance does not cover the services provided. Therefore, we removed these amounts in recalculating the HFY 1998 hospital specific limit for BHS. **(See Schedule B-1.)**

Cost-to-Charge Ratio

The cost-to-charge ratio for BHS was calculated in accordance with the state plan. However, the calculation was based on total costs and charges that included cost centers for separately licensed or certified entities that provided non-hospital services (SNF, home health agency, rural health clinic, and air ambulance service). In a January 1998 letter to state Medicaid agencies, the HCFA (now CMS) instructed that hospital specific limits should not include costs or revenues for services provided by a separately licensed or certified entity, even if that entity is owned by the same institution. Therefore, we removed costs and charges for these cost centers, and recalculated the cost-to-charge ratios for BHS (**see Schedule B-2**). We used the revised cost-to-charge ratio in the adjustments to the hospital specific limit for BHS**. (See Schedule B-1).**

BAPTIST HEALTH SYSTEM
HOSPITAL FISCAL YEAR 1998
PAYMENTS EXCEEDING HOSPITAL SPECIFIC LIMIT

Calculation Based on Reported Data	$4,303,512
OIG Adjustments Per Hospital Review	1,728,814
Final Adjusted OIG Calculation	$6,032,326

EXPLANATION OF AUDIT ADJUSTMENTS

	Calculation Based on Reported Data		OIG Adjustments Per Hospital Review		Final Adjusted OIG Calculations	
DSH Payments		$13,688,340		$ - 0 -		$ 13,688,340
Hospital Specific Limit Calculation						
Medicaid Shortfall *(see page 2)*	1,136,812		(794,185)		342,627	
Uninsured Patient Cost *(see page 2)*	8,248,016		(934,629)		7,313,387	
Total Hospital Specific Limit		9,384,828		(1,728,814)		7,656,014
Payments Exceeding Hospital Specific Limit		$ 4,303,512		$1,728,814		$6,032,326

BAPTIST HEALTH SYSTEM
HOSPITAL FISCAL YEAR 1998
PAYMENTS EXCEEDING HOSPITAL SPECIFIC LIMIT

Detailed Summary of Medicaid Shortfall and Uninsured Patient Cost Calculations

	Calculations Based on Reported Data	OIG Adjustments Per Hospital Review	Final Adjusted OIG Calculations
Medicaid Shortfall			
Medicaid Charges	$ 71,315,160		$ 71,315,160
Cost-to-Charge Ratio[1]	.3981		.3870
Medicaid Cost	28,393,151		27,598,967
Less: Medicaid Payments	(27,256,339)		(27,256,340)
Total Medicaid Shortfall	$ 1,136,812	($ 794,185)	$ 342,627
Uninsured Patient Cost			
Uninsured Charges	$ 33,622,525		$ 37,814,379
Less: Plastic Surgery Charges	-0-		(7,249,242)
Less: Insured Patient Charges	-0-		(198,245)
Less: SNF Patient Charges	-0-		(149,858)
Total Uninsured Charges	33,622,525		30,217,034
Cost-to-Charge Ratio[1]	.3981		.3870
Cost of Charges	13,386,346		11,693,992
Less:			
Total Uninsured Payments	5,138,330		5,626,980
Plastic Surgery Payments	-0-		(1,143,976)
Insured Payments	-0-		(102,399)
Net Uninsured Payments	5,138,330		4,380,605
Total Uninsured Patient Cost	$ 8,248,016	($ 934,629)	$7,313,387

[1] *State used 15 decimal places in original hospital specific limit calculation, and we limited to 4 decimal places in our adjusted calculation. (See Schedule B-2).*

Schedule B-2

BAPTIST HEALTH SYSTEM
ADJUSTMENTS TO COST-TO-CHARGE RATIO
HOSPITAL FISCAL YEAR 1998

	Calculations Based on Reported Data	OIG Adjustments Per Hospital Review	Final Adjusted OIG Calculations
Total Costs	$320,476,992	$ -0-	$320,476,992
Less:			
SNF Costs	-0-	(5,428,963)	(5,428,963)
Home Health Costs	-0-	(4,450,236)	(4,450,236)
Rural Health Costs	-0-	(320,258)	(320,258)
Air Ambulance Costs	-0-	(4,107,383)	(4,107,383)
Net Costs	$320,476,992	($14,306,840)	$306,107,152
Total Charges	$804,942,989	$ -0-	$804,942,989
Less:			
SNF Charges	-0-	(5,104,535)	(5,104,535)
Home Health Charges	-0-	(3,920,575)	(3,920,575)
Rural Health Charges	-0-	(125,330)	(125,330)
Air Ambulance Charges	-0-	(4,643,353)	(4,643,353)
Net Charges	$804,942,989	($ 13,793,793)	$791,149,196
Cost-to-Charge Ratio (Costs ÷ Charges) =	.398136261051402		.3870[1]

[1] *Rounded to 4 decimal places. The state used 15 decimal places in the original calculation.*

DETAIL OF AUDIT ADJUSTMENTS-- HARRIS COUNTY HOSPITAL DISTRICT (HCHD)

Insured Patient Charges and Payments Included in Uninsured Data

The HCHD provided an updated summary schedule of HFY 1998 charges and payments for uninsured patients, which we used in our comparison. This updated report increased the uninsured charges and payments over the amount originally reported to the state. However, the updated summary schedule contained charges of $1,067,562 and payments of $1,006,845 for patients with health insurance. According to the state plan, patients with health insurance may be considered for DSH purposes only when their health insurance does not cover the services provided. Therefore, we removed these amounts in recalculating the HFY 1998 hospital specific limit for HCHD. **(See Schedule C-1.)**

Cost-to-Charge Ratio

The cost-to-charge ratio for HCHD was calculated in accordance with the state plan. However, the calculation was based on total costs and charges that included an SNF cost center that was a separately licensed or certified entity that provided non-hospital services. In a January 1998 letter to state Medicaid agencies, the HCFA (now CMS) instructed that hospital specific limits should not include costs or revenues for services provided by a separately licensed or certified entity, even if that entity is owned by the same institution. Therefore, we removed costs and charges for the SNF cost center and recalculated the cost-to-charge ratio for HCHD **(see Schedule C-2**). We used the revised cost-to-charge ratio in the adjustments to the hospital specific limit for HCHD. (**See Schedule C-1).**

HARRIS COUNTY HOSPITAL DISTRICT
HOSPITAL FISCAL YEAR 1998
PAYMENTS EXCEEDING HOSPITAL SPECIFIC LIMIT

Calculation Based on Reported Data	$ 5,637,179
OIG Adjustments Per Hospital Review	4,937,219
Final Adjusted OIG Calculations	$ 699,960

EXPLANATION OF AUDIT ADJUSTMENTS

	Calculation Based on Reported Data		OIG Adjustments Per Hospital Review		Final Adjusted OIG Calculations	
DSH Payments		$186,397,139	$ -0-			$186,397,139
Hospital Specific Limit Calculation						
Medicaid Shortfall *(see page 2)*	2,391,068		(184,830)		2,206,238	
Uninsured Patient Cost *(see page 2)*	178,368,892		5,122,049		183,490,941	
Total Hospital Specific Limit		180,759,960		4,937,219		185,697,179
Payments Exceeding Hospital Specific Limit		$ 5,637,179		$4,937,219		$ 699,960

HARRIS COUNTY HOSPITAL DISTRICT
HOSPITAL FISCAL YEAR 1998
PAYMENTS EXCEEDING HOSPITAL SPECIFIC LIMIT

Detailed Summary of Medicaid Shortfall and Uninsured Patient Cost Calculations

	Calculations Based on Reported Data	OIG Adjustments Per Hospital Review	Final Adjusted OIG Calculations
Medicaid Shortfall			
Medicaid Charges	$127,461,770		$127,461,770
Cost-to-Charge Ratio [1]	.5831		.5816
Medicaid Cost	74,316,595		74,131,765
Less: Medicaid Payments	(71,925,527)		(71,925,527)
Total Medicaid Shortfall	$ 2,391,068	($ 184,830)	$ 2,206,238
Uninsured Patient Cost			
Uninsured Charges	$313,557,338		$322,795,890
Less: Insured Charges	-0-		1,067,562
Net Updated Charges	313,557,338		321,728,328
Cost-to-Charge Ratio [1]	.5831		.5816
Cost of Charges	182,819,631		187,117,196
Less:			
Total Uninsured Payments	4,450,739		4,633,100
Insured Payments	-0-		(1,006,845)
Net Uninsured Payments	4,450,739		3,626,255
Total Uninsured Patient Cost	$178,368,892	$5,122,049	$183,490,941

[1] *State used 15 decimal places in original hospital specific limit calculation, and we limited to 4 decimal places in our adjusted calculation. (See Schedule C--2).*

Schedule C-2

HARRIS COUNTY HOSPITAL DISTRICT
ADJUSTMENTS TO COST-TO-CHARGE RATIO
HOSPITAL FISCAL YEAR 1998

	Calculations Based on Reported Data	OIG Adjustments Per Hospital Review	Final Adjusted OIG Calculations
Total Costs	$396,839,281	-0-	$396,839,281
Less:			
SNF Costs	$ -0-	($ 2,476,075)	($ 2,476,075)
Net Costs	$396,839,281	($ 2,476,075)	$394,363,206
Total Charges	$680,626,408	-0-	$680,626,408
Less:			
SNF Charges	$ -0-	($ 2,607,457)	($ 2,607,457)
Net Charges	$680,626,408	($ 2,607,457	$678,018,951
Costs-to-Charge Ratio (Costs ÷ Charges) =	.583050079067752		[1].5816

[1] *Rounded to 4 decimal places. The state used 15 decimal places in the original calculation.*

DETAIL OF AUDIT ADJUSTMENTS – TERRELL STATE HOSPITAL (TSH)

Incorrect Cost Report Worksheet Used

For the state mental hospitals, including TSH, uninsured patient charges were calculated from total cost as reported in the Medicare/Medicaid cost report. Cost is used because actual uninsured charges are based on ability to pay, and, therefore, generally much lower than cost. The Texas Department of Mental Health and Mental Retardation (MHMR) provided the uninsured patient cost information to the state for all state mental hospitals.

For HFY 1998, MHMR used total cost from Worksheet A of the cost report. In our opinion, total reimbursable cost from Worksheet B should be used. Worksheet A total cost includes non-reimbursable cost centers as well as all general service (overhead) cost. Worksheet B reimbursable cost includes only the allocable amount of general service cost. The use of Worksheet A overstated uninsured patient cost by $1,403,754 for TSH. **(See Schedule D-1.)**

An MHMR official stated that the same uninsured patient cost calculation method was used for all the state mental hospitals for HFY 1998. We did not review cost report information for the other state mental hospitals. Therefore, we did not determine overall the effect of using Worksheet A instead of Worksheet B for all state mental hospitals.

Bad Debts Reported

The MHMR included bad debts totaling $40,685 in calculating uninsured patient cost for TSH. According to the state plan, bad debts may not be included in calculating the hospital specific limit. Therefore, we removed this amount in recalculating the HFY 1998 hospital specific limit for TSH. **(See Schedule D-1.)**

Insured Patient Charges Understated

The insured patient charges for TSH were understated by $870,381 because MHMR reported the Medicaid charges from a report prepared by NHIC that is based on paid claims rather than all filed claims. We used the charges from the all filed claims report to recalculate the uninsured patient charges. **(See Schedule D-1.)**

Uninsured Patient Payments Overstated

The MHMR incorrectly calculated and reported $3,456,107 of uninsured patient payments to the state because the calculation methodology did not accurately determine actual private source payments. The correct amount of private source payments totaling $328,746 was identified in the MHMR annual cash reimbursement report. As a result, the uninsured patient payments were overstated by $3,127,361 for TSH.

We discussed the methodology used to determine uninsured patient payments with an MHMR official and he agreed that private source payments totaling $328,746 from the annual cash reimbursement report should be used. **(See Schedule D-1.)**

TERRELL STATE HOSPITAL
HOSPITAL FISCAL YEAR 1998
PAYMENTS EXCEEDING HOSPITAL SPECIFIC LIMIT

Calculation Based on Reported Data	$5,397,099
OIG Adjustment Per Hospital Review	812,541
Final Adjusted OIG Calculation	$4,584,558

EXPLANATION OF AUDIT ADJUSTMENT

	Calculation Based on Reported Data		OIG Adjustment Per Hospital Review		Final Adjusted OIG Calculation	
DSH Payments		$ 37,586,860		$ -0-		$ 37,586,860
Hospital Specific Limit Calculation						
Medicaid Shortfall	1,233,072		-0-		1,233,072	
Uninsured Patient Cost *(see page 2)*	30,956,689		812,541		31,769,230	
Total Hospital Specific Limit		32,189,761		812,541		33,002,302
Payments Exceeding Hospital Specific Limit		$ 5,397,099		$ 812,541		$ 4,584,558

TERRELL STATE HOSPITAL
HOSPITAL FISCAL YEAR 1998
PAYMENTS EXCEEDING HOSPITAL SPECIFIC LIMIT

Detailed Summary of Uninsured Patient Cost Calculation

	Calculation Based on Reported Data	OIG Adjustments Per Hospital Review	Final Adjusted OIG Calculation
Uninsured Patient Cost			
Total Uninsured Charges [1]	$ 38,401,807	($ 1,403,754)	$ 36,998,053
Bad Debts	40,685	(40,685)	-0-
Less:			
Total Insured Patient Charges	4,029,696	870,381	4,900,077
Net Uninsured Charges	34,412,796	(2,314,820)	32,097,976
Less:			
Total Uninsured Patient Payments	3,456,107	3,127,361	328,746
Total Uninsured Patient Cost	$ 30,956,689	$ 812,541	$ 31,769,230

[1] *MHMR used Worksheet A, OIG used Worksheet B.*