TEXAS HEALTH AND HUMAN SERVICES COMMISSION
Austin, Texas

Independent Accountant's Report on Program Operation as Related to Disproportionate Share Hospital Payments Final Rule for Medicaid State Plan Rate Year 2007

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INDEPENDENT ACCOUNTANT'S REPORT

To the Executive Commissioner of the Texas Health and Human Services Commission (HHSC)
Austin, Texas

We have examined management's assertion that the operation of the Disproportionate Share Hospital (DSH) Program in the State of Texas (State) for the Medicaid State Plan (MSP) rate year 2007 meets the requirements of each of the six verifications set forth in Title 42 Code of Federal Regulations (CFR) Part 455 relating to the Medicaid Program for Disproportionate Share Hospital Payments Final Rule (DSH Rule). The Texas Health and Human Services Commission's (HHSC) management is responsible for the assertion. Our responsibility is to express an opinion on the assertion for each of the six verifications set forth in the DSH Rule based on our examination.

Except as described below, our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants (AICPA) and the standards applicable to attestation engagements contained in *Government Auditing Standards*, issued by the Comptroller General of the United States and, accordingly, included examining, on a test basis, evidence supporting management's assertion and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion.
Our examination considered management's assertion on the following six verifications:

(1) *Verification 1:* Each hospital that qualifies for a DSH payment in the State is allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the MSP rate year to Medicaid-eligible individuals and individuals with no source of third-party coverage for the services in order to reflect the total amount of claimed DSH expenditures.

(2) *Verification 2:* DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. For each audited MSP rate year, the DSH payments made in that audited MSP rate year are measured against the actual uncompensated care cost in that same audited MSP rate year.

(3) *Verification 3:* Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals and individuals with no third-party coverage for the inpatient and outpatient hospital services they received as described in section 1923(g)(1)(A) of the Social Security Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share payment limit, as described in section 1923(g)(1)(A) of the Social Security Act.

(4) *Verification 4:* For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals, which are in excess of the Medicaid-incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third-party coverage for such services.

(5) *Verification 5:* Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments; and any payments made on behalf of the uninsured from payment adjustments have been separately documented and retained by the State.

(6) *Verification 6:* The information specified in the preceding verification (Verification 5) includes a description of the methodology for calculating each hospital's payment limit under section 1923(g)(1) of the Social Security Act. Included in the description of the methodology, the State has specified how it defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the inpatient hospital and outpatient hospital services they received.

Verification 1

Our examination disclosed that three out of 181 hospitals participating in the DSH program in the State during MSP rate year 2007 did not meet the qualification requirements defined in Social Security Act section 1923(d) but received DSH payments.

Because eight additional hospitals did not provide adequate documentation, we were unable to determine whether these eight hospitals met the Federal qualification requirements set forth in Social Security Act section 1923(d). Of these eight hospitals, two were no longer operating during the period covered by our examination.

In our opinion, except for the effects discussed in the preceding paragraphs and except for the matters we might have discovered had we been able to apply adequate procedures to the eight hospitals that did not provide documentation, each hospital that qualifies for a DSH payment in the State is allowed to retain that payment received in accordance with Title 42 CFR Part 455.304 (d)(1) relating to the Medicaid Program's DSH Rule.

Verification 2

Our examination disclosed that 56 out of 181 hospitals exceeded their hospital-specific DSH payment limit, computed based on the final DSH Rule effective as of January 19, 2009. The reason they exceeded their hospital-specific DSH payment limit was because the methodology for calculating the hospital-specific limit as specified in the Centers for Medicare and Medicaid Services (CMS) approved MSP effective for 2007, is not in compliance with the final DSH Rule. Specifically, the 2007 MSP allowed the costs of care for providing hospital services for patients who were considered to be insured under the definitions in the final DSH Rule in calculating the hospital-specific DSH payment limits. The DSH Rule states that only uncompensated care cost for furnishing hospital services to Medicaid-eligible individuals and individuals with no third-party coverage are eligible for inclusion in the calculation of the hospital-specific DSH payment limit. Additionally, not all payments the hospitals received for providing care to Medicaid-eligible patients were applied against the cost of care for the purpose of calculating hospital-specific DSH payment limits.

As a result, 45 qualified hospitals, three unqualified hospitals, and eight hospitals for whom we could not verify their qualification status in MSP rate year 2007 received DSH payments that exceeded their hospital-specific DSH payment limits, calculated based on the final DSH Rule.

In our opinion, except for the effects discussed in the preceding paragraphs, DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit in accordance with Title 42 CFR Part 455.304 (d)(2) relating to the Medicaid Program's DSH Rule.

Verification 3

Our examination disclosed that the 2007 MSP, which was approved by CMS, allowed the charges for those patients who were considered to be insured under the definitions in the final DSH Rule in the calculation of hospital-specific DSH payment limits. Additionally, the plan did not allow for the inclusion of the dual-eligible clients in the calculation of the hospital-specific DSH payment limits. The 2007 MSP, as approved, was not in compliance with the final DSH Rule as effective on January 19, 2009. We tested the uninsured data for 27 hospitals and found that 22 of these 27 hospitals included patients with insurance or third-party coverage in their self-reported uninsured data. The remaining five hospitals did not provide any supporting documentation, thus we were unable to make a determination.

In our opinion, because of the effects discussed in the preceding paragraph and except for the matters we might have discovered had we been able to apply adequate procedures to the five hospitals that did not provide documentation, management did not include only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals and individuals with no third-party coverage for the inpatient and outpatient hospital services as eligible costs in the calculation of the hospital-specific DSH payment limit in accordance with Title 42 CFR Part 455.304 (d)(3) relating to the Medicaid Program's DSH Rule.

Verification 4

Our examination disclosed that the CMS-approved 2007 MSP is silent on the treatment of other Medicaid payments such as supplemental or enhanced Medicaid payments, or Medicare payments for dual-eligible patients. As a result, certain supplemental or enhanced Medicaid payments and Medicare payments for dual-eligible patients that disproportionate share hospitals received for providing inpatient and outpatient hospitals services to Medicaid-eligible individuals which were in excess of the Medicaid incurred costs of such services, were not applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third-party coverage for such services.

In our opinion, because of the effects discussed in the preceding paragraph, not all Medicaid payments, that are in excess of the Medicaid-incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third-party coverage for such services in accordance with Title 42 CFR Part 455.304 (d)(4) relating to the Medicaid Program's DSH Rule.

Verification 5

The State has separately documented and retained a record of all its costs under the Medicaid program. The State maintains a document retention policy, which states the retention period for files, but does not identify the particular records that are required to be maintained / retained in the file. The State has retained the following documents pertaining to the DSH program: State Plan, DSH applications received from the hospitals, correspondence received from the hospitals, HHSC-prepared DSH worksheets, and the Medicaid Management Information System (MMIS) data. Our examination disclosed that the responsibility for retention of source documentation was accepted by the hospitals under their signed and attested DSH surveys. Eight hospitals did not retain or make available to us during the course of this examination, information or records of their inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under Title 42 CFR Part 455.304; and any payments made on behalf of the uninsured from payment adjustments. An additional nine facilities only provided limited information that allowed us to only verify their qualification status.

In our opinion, except for the effects discussed in the preceding paragraph, management separately documented and retained information and records of costs and payments related to the DSH program in accordance with Title 42 CFR Part 455.304 (d)(5) relating to the Medicaid Program's DSH Rule.

Verification 6

Our examination disclosed that the MSP for 2007 provides the methodology for calculating each hospital's payment limit under section 1923(g)(1) of the Social Security Act, and included in the description of the methodology, the State has specified how it defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the inpatient hospital and outpatient hospital services they received.

In our opinion, management included in the information and records it retained a description of the methodology for calculating each hospital's DSH payment limit and definitions of incurred inpatient and outpatient costs in accordance with Title 42 CFR Part 455.304 (d)(6) relating to the Medicaid Program's DSH Rule.

In accordance with *Government Auditing Standards*, we have also issued our report dated December 13, 2010, on our consideration of HHSC's internal controls over the DSH Program in the State for MSP rate year 2007 as it relates to the six verifications set forth in Title 42 CFR Part 455 relating to the Medicaid Program's DSH Rule and on compliance and other matters. The purpose of that report is to describe the scope of our testing of internal controls over the DSH Program in the State for MSP rate year 2007 as it related to the aforementioned six verifications set forth in the DSH Rule and the results of that testing, and not to provide an opinion on the internal controls over compliance with the DSH Rule. That report is an integral part of an examination performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our examination.

This report is intended solely for the information and use of HHSC, the Texas State Legislature, hospitals participating in the Texas State DSH program, and CMS and is not intended to be, and should not be, used by anyone other than these specified parties.

Clifton Gunderson LLP

Austin, Texas
December 13, 2010

Clifton Gunderson LLP
Certified Public Accountants & Consultants

INDEPENDENT ACCOUNTANT'S REPORT ON INTERNAL CONTROL OVER THE DISPROPORTIONATE SHARE HOSPITAL PROGRAM IN THE STATE OF TEXAS FOR THE MEDICAID STATE PLAN RATE YEAR 2007 AS IT RELATES TO THE SIX VERIFICATIONS SET FORTH IN TITLE 42 CFR PART 455 RELATING TO THE MEDICAID PROGRAM FOR DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FINAL RULE AND ON COMPLIANCE AND OTHER MATTERS

Texas Health and Human Services Commission:
Austin, Texas

We have examined the assertion of HHSC management that operation of the DSH Program in the State for the MSP rate year 2007 followed the requirements of the six verifications set forth in Title 42 CFR Part 455.304 relating to the DSH Rule and have issued our report thereon dated December 13, 2010. Our report was modified because of exceptions and because we were unable to obtain certain information. Except as discussed in the preceding sentence, we conducted our examination in accordance with the attestation standards established by AICPA and the standards applicable to attestation engagements contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

In planning and performing our examination, we considered HHSC's internal controls over the DSH Program, in order to determine our examination procedures for the purpose of expressing our opinion on management's assertion related to the six verifications set forth in the DSH Rule and not to provide an opinion on the internal controls over compliance with the DSH Rule. Accordingly, we do not express an opinion on the effectiveness of HHSC's internal control over compliance with the DSH Rule.

A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to initiate, authorize, record, process, or report data reliably such that there is more than a remote likelihood that management's inability to follow the requirements of the six verifications set forth in the DSH Rule, that is more than inconsequential, will not be prevented or detected by the entity's internal control. We consider the deficiencies described in the accompanying Schedule of Findings to be significant deficiencies in internal control in relation to the six verifications set forth in the DSH Rule.

A material weakness is a significant deficiency, or combination of significant deficiencies that results in more than a remote likelihood that a material deviation from the requirements of the six verifications set forth in the DSH Rule will not be prevented or detected by the entity's internal controls. Of the significant deficiencies described above, we consider findings 1 through 5 to be material weaknesses.

Our consideration of internal control relating to the six verifications set forth in the DSH Rule was for the limited purpose described in the first paragraph of this section and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses.

Compliance and Other Matters

As part of our examination of the assertion of HHSC that operation of the DSH Program in the State for the MSP rate year 2007 followed the requirements of the six verifications set forth in Title 42 CFR Part 455.304 relating to the DSH Rule, we performed tests of its compliance with certain provisions of laws, regulations, and contracts, noncompliance with which could have a direct and material effect on management's assertion that they met the requirements of the six verifications set forth in the DSH Rule. However, providing an opinion on compliance with those provisions was not an objective of our examination, and accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and which are described in the accompanying Schedule of Findings as findings 1 through 5.

This report is intended solely for the information and use of HHSC, the Texas State Legislature, the hospitals participating in the Texas State DSH program, and CMS and is not intended to be, and should not be, used by anyone other than these specified parties.

Clifton Gunderson LLP

Austin, Texas
December 13, 2010

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
SCHEDULE OF FINDINGS RELATING TO THE SIX VERIFICATIONS OF THE DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FINAL RULE FOR THE MEDICAID STATE PLAN RATE YEAR 2007

Finding 1 –

Criteria
Social Security Act section 1923(d) requires that, unless exempt, a hospital must have at least two obstetricians, or two physicians if the hospital is located in a rural area, who have staff privileges at the hospital, as well as a Medicaid inpatient utilization rate (MIUR) of not less than one percent to qualify as a disproportionate share hospital.

Condition
Three hospitals out of 181 did not meet the Federal DSH requirements, as effective on January 19, 2009, to qualify as a DSH hospital. Two of the 181 hospitals that received DSH payments in MSP rate year 2007 did not have at least two obstetricians or two physicians if the hospital is located in a rural area, who have staff privileges at the hospital. One facility did not have an MIUR of at least one percent.

Additionally, due to the lack of documentation, we were not able to determine whether eight other hospitals for MSP rate year 2007 met the requirements set forth in Social Security Act section 1923(d).

Cause
The State does not require that the hospital report obstetricians on the DSH application, but instead only requires a Medical Doctor (MD) or Doctor of Osteopathy (DO), regardless of the urban or rural classification of the hospital. The State does not perform any review of the MIUR data that is used in the DSH calculation.

Recommendation

We recommend that HHSC implement a review process to ensure hospitals that receive DSH payments meet the qualification requirements to be deemed as a disproportionate share hospital. We recommend that HHSC update its MSP to ensure that it requires two obstetricians, or two physicians if the hospital is located in a rural area, as prescribed in the Social Security Act section 1923(d).

Finding 2 –

Criteria
Social Security Act section 1923(g)(1)(A) specified that DSH payments to a hospital shall not exceed the cost incurred (net of the payments received) during the MSP rate year. Title 42 CFR Part 455.304(d)(2) further clarified that DSH payments made to each qualifying hospital shall comply with the hospital-specific DSH payment limit.

Condition
We found that 181 hospitals in the State received DSH payments in MSP rate year 2007. Except for the eleven hospitals discussed in Finding 1, we found that 45 of the remaining 170 hospitals received DSH payments exceeding their hospital-specific DSH payment limits calculated based on the DSH Rule, as effective on January 19, 2009.

Cause
The state-estimated hospital-specific DSH limit differs from the DSH limit calculated based on the DSH Rule because the MSP describes a calculation of the DSH limit that is different than the calculation required by the DSH Rule. The MSP did not include certain supplemental/enhanced Medicaid payments or payments for dual-eligible clients.

Recommendation
We recommend that HHSC propose an MSP amendment to allow for a reconciliation process between the prospective data and actual data, use the methodology specified in the DSH Rule for calculating hospital-specific DSH payment limits, and prepare a Data Reporting Schedule (DRS) for audit purposes for MSP 2011 and thereafter. Any overpayments identified in the reconciliation process should be recouped and redistributed, as allowed by a CMS-approved MSP.

Finding 3 –

Criteria
Social Security Act section 1923(g)(1)(A) states that with respect to a disproportionate share hospital, the DSH payment limit is subject to uncompensated costs, which include costs incurred (net of payments) during the MSP rate year for furnishing hospital services to individuals who either are eligible for medical assistance under the MSP or have no health insurance (or other source of third-party coverage) for services provided during the MSP rate year.

Additionally, Title 42 CFR Part 455.304(d)(3) requires that only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals and individuals with no third-party coverage for the inpatient and outpatient hospital services are eligible for inclusion in the calculation of the hospital-specific DSH payment limit.

Condition
We identified 22 hospitals for MSP rate year 2007 that included charges and consequently costs for furnishing hospital services to individuals who had insurance or other third-party coverage as uninsured charges. While the CMS-approved MSP effective for the period reviewed correctly defines the uninsured costs as "the inpatient and outpatient charges to patients who have no health insurance or other source of third party payment for services provided during the year…", it also states "Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment." This definition is inconsistent with that of the Social Security Act, which states that payment adjustments are for "…furnishing hospital services by the hospital to individuals who…have no health insurance (or other source of third party coverage) for services provided during the year."

Cause
The State does not require that supporting documentation accompany the self-reported uninsured data provided by the hospitals on their DSH applications. The State does not perform any verification of the self reported data.

Recommendation
We recommend that HHSC propose an MSP amendment to ensure that only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals and individuals with no third-party coverage for the inpatient and outpatient hospital services they received as described in section 1923(g)(1)(A) of the Social Security Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit.

Finding 4 –

Criteria
Social Security Act section 1923(g)(1)(A) specifies that the hospital-specific DSH payment limit should be subject to costs net of all non-DSH section payments received under Title XIX of the Social Security Act. Title 42 CFR Part 455.304(d)(4) echoes this requirement and states that all Medicaid payments should be applied against uncompensated care costs for the purposes of hospital-specific limit calculation.

Condition
The CMS-approved 2007 State MSP defines Medicaid inpatient days as "the total number of Title XIX inpatient days based on the latest available State fiscal year data for patients eligible for Title XIX benefits. The term excludes days for patients who are covered for services which are fully or partially reimbursable by Medicare." The MSP defines the Medicaid shortfall as "the cost of services …furnished to Medicaid patients, less the amount paid under the nondisproportionate share hospital payment method under this state plan." This definition is silent on the treatment of dual-eligible payments from Medicare and other primary insurance payers and supplemental/enhanced payments made by HHSC such as cost report settlements. As a result, HHSC did not apply all costs and payments made on behalf of dual-eligible Medicaid individuals in the calculation of the hospital-specific DSH payment limit and did not include cost report settlements.

Cause
The State MSP does not include out-of-state Medicaid or Medicare crossover (dual-eligible) payments or costs in the DSH limit calculation. Additionally, the State MSP did not consider cost settlements in the DSH limit calculation.

Recommendation
We recommend that HHSC propose an MSP amendment which specifies that, for purposes of hospital-specific limit calculation, in addition to regular Medicaid fee-for-service rate payments, out-of-state Medicaid payments, and Medicaid managed care organization payments, the following payments against the uncompensated care costs should be applied as well:

- All supplemental/enhanced payments made by HHSC,
- Medicare and other payer payments for furnishing inpatient and outpatient hospital services to Medicaid-eligible patients.

HHSC should then:

- Require disproportionate share hospitals to report all Medicaid payments, including Medicare payments for dual-eligible patients, and
- Revise its hospital-specific DSH payment limit calculation model to include these payments, as required in the Social Security Act and the DSH Rule.

Finding 5 –

Criteria

Title 42 CFR Part 455.304(d)(5) requires that states separately document and retain a record of the following: all of costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining DSH payments; and any payments made on behalf of the uninsured.

Condition

In its DSH application with disproportionate share hospitals, HHSC required these hospitals to allow state or federal personnel access to the hospital and its records. We found that eight hospitals in MSP rate year 2007 did not provide any information or records of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments; and any payments made on behalf of the uninsured from payment adjustments. An additional nine hospitals only provided limited data that allowed us to only calculate their qualification status.

Cause

The State did not identify specific items for the hospitals to maintain related to the DSH program. Although the State's document retention policy contains a retention period, this information is not included in the DSH application instructions.

Recommendation

We recommend that HHSC implement periodic monitoring procedures to ensure disproportionate share hospitals maintain complete and accurate data and records to support all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments; and any payments made on behalf of the uninsured from payment adjustments under Title 42 CFR Part 455.304(d).