

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**TEXAS CLAIMED OR MAY HAVE
CLAIMED MORE THAN \$30
MILLION OF \$9.89 BILLION IN
FEDERAL FUNDS FOR MEDICAID
UNCOMPENSATED CARE
PAYMENTS THAT DID NOT MEET
FEDERAL AND STATE
REQUIREMENTS**

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September 2022
A-06-19-09002

Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

Report in Brief

Date: September 2022
Report No. A-06-19-09002

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

In 2011, the Centers for Medicare & Medicaid Services (CMS) approved the Texas Healthcare Transformation and Quality Improvement Program demonstration waiver (the waiver). As a part of the waiver, Texas established uncompensated care (UC) payments to offset eligible UC costs hospitals and other providers incurred. UC payments help defray uncompensated costs of care provided to Medicaid-eligible and uninsured individuals. The waiver established a maximum amount, \$17.58 billion, that would be paid under the UC program during the first 5 demonstration years (Dys). UC payments have a significant financial impact on Texas health care providers. Further, a previous Office of Inspector General audit identified substantial unallowable payments Florida made under a similar type of program.

Our objective was to determine whether Texas claimed UC payments in accordance with applicable Federal and State requirements.

How OIG Did This Review

We reviewed \$16.95 billion (\$9.89 billion Federal share) in UC payments distributed for UC costs incurred from December 12, 2011, through September 30, 2016 (Dys 1 through 5).

Texas Claimed or May Have Claimed More Than \$30 Million of \$9.89 Billion in Federal Funds for Medicaid Uncompensated Care Payments That Did Not Meet Federal and State Requirements

What OIG Found

Texas claimed \$16.90 billion (\$9.86 billion Federal share) in UC payments in accordance with applicable Federal and State requirements. However, Texas incorrectly claimed \$18.90 million (\$11.05 million Federal share). Specifically, Texas claimed (1) \$12.91 million (\$7.51 million Federal share) because it did not refund the full Federal share of overpayments and (2) \$5.99 million (\$3.54 million Federal share) because it did not collect overpayments it identified.

Additionally, the State agency may have incorrectly claimed \$33.78 million (\$19.66 million Federal share) because it did not reduce hospitals' actual UC costs by Medicare payments the hospitals received.

What OIG Recommends and Texas Comments

We recommend that Texas (1) work with CMS to determine whether the \$33.78 million in UC payments hospitals retained because costs were not reduced by the Medicare payments they received should be recouped and, if so, either refund the related Federal share of \$19.66 million to the Federal Government or redistribute the recouped funds to hospitals that had unmet UC costs; (2) refund \$11.05 million to the Federal Government for the underreported UC overpayments; (3) follow the CMS-approved methodology for calculating actual UC costs when reconciling initial UC payments with providers' actual UC costs, including reducing UC costs by Medicare payments providers receive; and (4) establish review procedures for overpayments to ensure that they are accurately entered into the State agency's accounting system and returned to the Federal Government.

Texas concurred with our second, third, and fourth recommendations, and provided information on actions it had taken or planned to take in relation to these recommendations. Texas did not concur with our first recommendation because it said there was no valid requirement in place for costs to be offset by Medicare payments. After review and consideration of Texas' comments, we maintain that our finding, as modified, is valid, but adjusted our first recommendation from a recoupment of funds to working with CMS to determine the correct course of action.

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INTRODUCTION

WHY WE DID THIS AUDIT

In 2011, the Centers for Medicare & Medicaid Services (CMS) approved the Texas Healthcare Transformation and Quality Improvement Program demonstration waiver (the waiver). As a part of the waiver, the Texas Health and Human Services Commission (State agency) established uncompensated care (UC) payments to offset eligible UC costs hospitals and other providers incurred. UC payments help defray uncompensated costs of care provided to Medicaid-eligible and uninsured individuals. The waiver established a maximum amount, \$17.58 billion, that would be paid under the UC program during the first 5 demonstration years (DYs). UC payments have a significant financial impact on Texas health care providers. Further, a previous Office of Inspector General audit identified substantial unallowable payments Florida made under a similar type of program.¹

OBJECTIVE

Our objective was to determine whether the State agency claimed UC payments in accordance with applicable Federal and State requirements.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Federal Government pays its share of a State's medical assistance costs based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. In Texas, the State agency administers the Medicaid program.

Within 30 days after the end of each quarter, States report expenditures and the associated Federal share on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report). The amounts that States report must represent actual expenditures (42 CFR § 430.30). The State agency uses line items on the CMS-64 report to claim

¹ *Florida Medicaid Paid Hundreds of Millions in Unallowable Payments to Jackson Memorial Hospital Under Its Low Income Pool Program (A-04-17-04058)*, issued in August 2019. Available online at <https://oig.hhs.gov/oas/reports/region4/41704058.asp>. Accessed Apr. 26, 2022.

expenditures based on the type of services provided. When a State agency recovers an expenditure previously reported on the CMS-64 report, it must refund the Federal share by reporting the recovery to CMS at the FMAP used to calculate the amount it originally received.

The State agency operates the waiver, which was approved by CMS under Title XIX, section 1115, of the Social Security Act (the Act). Section 1115 of the Act gives CMS authority to approve experimental, pilot, or demonstration projects that it considers likely to assist in promoting the objectives of the Medicaid program. The purpose of these projects, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate State-specific policy approaches to better serve Medicaid populations.

Texas' Uncompensated Care Program

The UC program's objective is to offset eligible UC costs that hospitals and other providers incurred against the care of Medicaid-eligible and uninsured individuals. In the waiver, the State agency established a limit on UC payments totaling \$17.58 billion over the first 5 DYs, as shown in Table 1.

Table 1: Limits on Uncompensated Care Payments in Billions of Dollars by Demonstration Year

DY	Limit
1	\$3.70
2	3.90
3	3.53
4	3.35
5	3.10
Total	\$17.58

The State agency made initial UC payments to participating hospitals based on the hospitals' historical UC costs. The waiver required the State agency to reconcile those initial UC payments with hospitals' actual UC costs for each DY to ensure that hospitals did not receive UC payments that exceeded their actual UC costs. The State agency calculated each hospital's actual costs using cost and payment information from the hospital's cost reports. On January 30, 2020, the State agency submitted to CMS its reconciliations of hospitals' initial UC payments with their actual UC costs for DYs 1 through 5.

When a hospital's initial UC payments exceeded its actual UC costs, the State agency identified the excess as an overpayment. Often, hospitals voluntarily returned the overpayments that the State agency identified. When hospitals did not return overpayments, the State agency sent them letters that identified the amount of the overpayment and requested repayment. When the State agency recovered an overpayment, it was required to return the Federal share of the overpayment to the Federal Government on the CMS-64 report.

HOW WE CONDUCTED THIS AUDIT

We reviewed \$16.95 billion (\$9.89 billion Federal share) in UC payments distributed for UC costs incurred from December 12, 2011, through September 30, 2016 (DYs 1 through 5). We reconciled the UC payments the State agency claimed on the CMS-64 report with the State agency's detailed lists of UC payments and recoupments. We then compared the claimed UC payments and recoupments with the amounts captured in the State agency's reconciliations of hospitals' and other providers' initial UC payments with their actual UC costs. For selected providers, we compared the actual cost and payment information with the supporting cost report information.² Finally, we determined whether the State agency returned the Federal share of overpayments it identified in its reconciliations to the Federal Government on the CMS-64 report.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

The State agency claimed \$16.90 billion (\$9.86 billion Federal share) in UC payments in accordance with applicable Federal and State requirements. However, the State agency incorrectly claimed \$18.90 million (\$11.05 million Federal share).³ Specifically, the State agency claimed:

- \$12.91 million (\$7.51 million Federal share) because it did not refund the full Federal share of overpayments⁴ and
- \$5.99 million (\$3.54 million Federal share) because it did not collect overpayments it identified.⁵

² We judgmentally selected payments based on provider type and the relative amount of UC costs and payments.

³ The exact Federal share amount of incorrectly claimed UC payments was \$11,058,256. The difference between \$11,058,256 and the \$11.05 million to which the bulleted Federal share amounts sum is due to rounding.

⁴ The exact Federal share amount was \$7,514,250.

⁵ The exact Federal share amount was \$3,544,007.

Additionally, the State agency may have incorrectly claimed \$33.78 million (\$19.66 million Federal share) because it did not reduce hospitals' actual UC costs by Medicare payments the hospitals received.⁶

THE STATE AGENCY DID NOT REFUND THE FULL FEDERAL SHARE OF OVERPAYMENTS IT MADE TO THREE PUBLIC HOSPITALS

According to Federal law, States must refund to CMS the Federal share of Medicaid overpayments.^{7,8} The waiver also requires the State agency to refund to the Federal Government its share of overpayments. Regulations require that credits received from a non-Federal entity be credited to the Federal Government as a cost reduction or cash refund, as appropriate.^{9,10}

The State agency identified \$30.89 million (\$17.99 million Federal share) in overpayments made to three public hospitals. Because the public hospitals had provided the State share of their payments, the hospitals returned only the \$17.99 million Federal share of the overpayments.¹¹ The State agency inadvertently recorded \$17.99 million received from the hospitals as the total overpayment amount and refunded \$10.47 million to the Federal Government. An official at the State agency explained that officials made the mistake of recording a portion of the overpayment, \$17.99 million, in the accounting system rather than the full \$30.89 million. The accounting system then calculated the Federal share based on \$17.99 million rather than the full \$30.89 million. This error was not detected because the State agency does not have procedures to review the overpayments returned to the Federal Government, so it returned \$10.47 million to the Federal Government rather than \$17.99 million.

As a result, the State agency underreported total overpayments by \$12.91 million and did not return the additional \$7.51 million Federal share to the Federal Government.

⁶ The exact Federal share amount was \$19,661,532.

⁷ Section 1903(d)(2)(A) of the Act.

⁸ 42 CFR § 433.312.

⁹ 45 CFR § 75.406.

¹⁰ Credits are transactions that offset or reduce expenditures allocable to Federal awards.

¹¹ States may use funds transferred from another government entity (such as a county hospital) to fund the State share of Medicaid expenditures.

THE STATE AGENCY DID NOT COLLECT OVERPAYMENTS IT IDENTIFIED FOR EIGHT HOSPITALS OR RETURN THE RELATED FEDERAL SHARE

States must refund to CMS the Federal share of Medicaid overpayments.^{12, 13} The waiver also requires the State agency to refund to the Federal Government its share of overpayments. Regulations require that credits received from a non-Federal entity be credited to the Federal Government as a cost reduction or cash refund, as appropriate.¹⁴

The State agency failed to collect and return \$5.99 million (\$3.54 million Federal share) in overpayments it identified that were made to eight hospitals. The State agency normally records overpayment amounts due from hospitals in its accounting system. However, for these eight hospitals, the State agency inadvertently did not record the amount in its accounting system. During and after DYs 1 through 5, the State agency experienced high personnel turnover; the new employees did not know that the overpayment amounts due had not been recorded.

As a result, the State agency never requested the overpayments from the hospitals and did not return \$5.99 million (\$3.54 million Federal share) in program overpayments.

THE STATE AGENCY DID NOT REDUCE HOSPITALS' UNCOMPENSATED CARE COSTS BY MEDICARE PAYMENTS RECEIVED

Hospitals that qualify as a Disproportionate Share Hospital (DSH) may receive both DSH payments and UC payments.¹⁵ Hospital UC costs that were not paid through the DSH program, can be paid for through the UC program. The total amount of a hospital's DSH and UC payments each year is limited to the UC costs for Medicaid-eligible and uninsured individuals (i.e., the hospital-specific limit (HSL)). In calculating the HSL, all revenue related to services provided to Medicaid-eligible and uninsured patients is subtracted from the respective costs to determine net UC costs.¹⁶

In January 2010, CMS issued two Frequently Asked Questions (FAQs) that instructed States to decrease hospital provider costs by private insurance and Medicare payments when calculating

¹² Section 1903(d)(2)(A) of the Act.

¹³ 42 CFR § 433.312.

¹⁴ 45 CFR § 75.406.

¹⁵ Hospitals that serve a high number of Medicaid beneficiaries and uninsured individuals qualify for DSH payments. Those payments are designed to pay qualifying hospitals' UC costs of providing services to such individuals; however, DSH payments are limited to a State's DSH allotment (§ 1923 of the Act).

¹⁶ The waiver, Attachment H; 1 Texas Administrative Code § 355.8066.

HSLs.¹⁷ However, hospitals challenged the FAQs in Federal courts, and CMS eventually withdrew them in December 2018. Even though CMS withdrew the FAQs, the State agency sought, in connection with unspent UC funds, and received CMS approval in July 2020 to calculate the HSL by reducing hospital provider costs by Medicare payments but not by private insurance payments for DYs 3 through 5. (See Appendix B for Federal and State requirements related to the calculation of actual uncompensated care costs.)

However, the State agency did not reduce hospitals' UC costs by Medicare payments received for dually eligible individuals from October 1, 2013, through September 30, 2016 (DYs 3 through 5).¹⁸ Because the State agency did not reduce costs by Medicare payments, some hospitals received payments that exceeded the net UC cost of services provided to Medicaid and uninsured patients. As a result, hospitals may have inappropriately retained \$33.78 million (\$19.66 million Federal share) in UC payments for DYs 3 through 5. Table 2 shows our calculation of additional DY 3 UC payments the State agency potentially should have recovered from four hospitals after reducing the hospitals' UC costs by Medicare payments received.

Table 2: Examples of Additional Payments the State Agency Potentially Should Have Recovered After Medicare Payment Reductions in Demonstration Year 3

-A-	-B-	-C-	-D-	-E-	-F-	-G-
	State Agency-Calculated UC Costs	Initial UC Payments Received	State Agency-Calculated Recovery ¹⁹	Medicare Payments Received	UC Costs Reduced by Medicare Payments ²⁰	Additional Recovery ²¹
Hospital 1	\$30,559,115	\$13,809,572	\$-	\$20,218,143	\$10,340,972	\$3,468,600
Hospital 2	3,599,845	3,592,248	-	1,291,857	2,307,988	1,284,260
Hospital 3	16,709,388	14,376,744	-	3,368,818	13,340,570	1,036,174
Hospital 4	1,760,908	1,798,176	37,268	1,013,214	747,694	1,013,214

¹⁷ CMS, "Additional Information on the DSH Reporting and Audit Requirements," FAQs 33 and 34.

¹⁸ Dually eligible individuals are patients who are entitled to both Medicare and Medicaid benefits.

¹⁹ When a hospital's initial UC payments received exceeded its State agency-calculated UC costs, the State agency calculated a recovery amount (i.e., column C less column B).

²⁰ We calculated this amount by reducing the State agency-calculated UC costs by Medicare payments received (i.e., column B less column E).

²¹ When a hospital's initial UC payments exceeded its UC costs reduced by Medicare payments, we calculated an additional recovery amount (i.e., column C less columns F and D).

RECOMMENDATIONS

We recommend that the Texas Health and Human Services Commission:

- work with CMS to determine whether the \$33,776,649 in UC payments hospitals retained because costs were not reduced by the Medicare payments they received should be recouped and, if so, either:
 - refund the related Federal share of \$19,661,532 to the Federal Government or
 - redistribute the recouped funds to participating hospitals that had UC costs that were not covered by the UC payments from the State;
- refund \$11,058,256 to the Federal Government for the underreported UC overpayments;²²
- follow its CMS-approved methodology for calculating actual UC costs when reconciling initial UC payments with providers' actual UC costs, including reducing UC costs by Medicare payments providers receive; and
- establish review procedures for overpayments to ensure that they are accurately entered into the State agency's accounting system and returned to the Federal Government.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not concur with our first recommendation. The State agency concurred with our second, third, and fourth recommendations and provided information on actions it had taken or planned to take in relation to these recommendations. Those actions included refunding \$11.05 million to the Federal Government for underreported UC overpayments and identifying any other underreported overpayments, following the CMS-approved methodology for calculating actual UC costs, and reviewing existing procedures for entering overpayments into its accounting system to ensure overpayments are accurately entered.

Regarding our first recommendation, the State agency stated that CMS's July 10, 2020, letter approving a methodology for the State agency to calculate the HSL by reducing hospital provider costs by Medicare payments for DYs 3 through 5 applied only to the withheld UC payments and not to the full UC payments for those DYs and that the HSL calculation described in the letter relates only to the HSL applied to the withheld payments.

²² These overpayments are not eligible for redistribution because their total amounts were correctly captured in the State agency's reconciliation of UC payments with actual costs or were used to decrease the UC limits to resolve overpayments the State agency made earlier.

Further, the State agency said that it reduced hospital provider costs by Medicare payments when distributing unspent funds, consistent with its July 10, 2020, communication to CMS. It contends that it was not required to reduce the HSL by Medicare payments (or third-party commercial insurance payments) during DYs 3 through 5 because there was no valid requirement in place that would have mandated such an HSL calculation and that costs were not required to be offset by Medicare payments or third-party commercial insurance payments during this time.

Finally, the State agency said that CMS withdrew the issued FAQs 33 and 34 and that the current version of 42 CFR § 447.299, which requires costs to be offset by Medicare and private insurance payments, was not effective until June 2017.

The State agency's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our finding, as modified, regarding hospitals' UC costs that were not reduced by Medicare payments for DYs 3 through 5 is valid. However, we adjusted our first recommendation from a recoupment of funds to working with CMS to determine the correct course of action.

Regarding our first recommendation, we acknowledge that the July 10, 2020, letter applied to the withheld UC payments. However, we would also note that this letter refers to CMS's approval for "calculat[ing] revised hospital-specific limits for 2014-2017 without the application of [the FAQ requiring offset of private insurance payments] and expend[ing] the unspent DSH funds for 2014-2017 in accordance with the methodologies described in [a 2019] letter," and seeks similar approval for the unspent UC funds. Thus, we believe there is some ambiguity as to whether CMS intended for the State agency to calculate revised HSLs that reduced hospital provider costs by Medicare payments (but not private insurance) for 2014 through 2017 generally, which includes DYs 3 through 5. In addition, the State agency's approved SPA (effective October 2013), which is listed in Appendix B, stated that the State agency should reduce costs by total payments from all payor sources when calculating HSL, including Medicare payments.²³ CMS also later disapproved a proposed SPA that would have excluded Medicare payments from the HSL calculation. While this occurred prior to CMS's withdrawal of FAQs 33 and 34, the 2013 approved SPA remains in the current State plan. The July 10, 2020, letter did not offset hospital costs by private insurance payments but still reduced costs by Medicare payments.

As the State agency noted, the language in the July 10, 2020, letter does discuss the methodology in relation to the disbursement of unspent UC funds, so we defer to CMS about

²³ A subsequently approved SPA (14-042), which was effective September 1, 2014, revised the methodology for calculating HSLs but maintained that the State agency would reduce hospital costs by total payments from all payor sources.

whether it intended that the UC payments we reviewed be reconciled to UC costs that were not reduced by Medicare payments.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed \$16.95 billion (\$9.89 billion Federal share) in UC payments distributed for December 12, 2011, through September 30, 2016 (DYS 1 through 5). We focused on payments made for that period because the State agency completed the reconciliations of those DYs' initial UC payments with actual UC costs soon after we initiated this audit.

We limited our review of the State agency's internal controls to those related to claiming UC payments and reconciling initial UC payments with actual UC costs because our objective did not require an understanding of the State agency's overall internal control structure.

We conducted our fieldwork at the State agency's offices in Austin, Texas. We conducted our audit from April 2019 through June 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal and State requirements applicable to UC payments, including requirements in the CMS-approved waiver;
- interviewed State agency officials to gain an understanding of the State agency's policies and procedures related to UC payments and reviewed the State agency's written policies and procedures;
- reconciled the UC payments the State agency claimed on the CMS-64 report with the State agency's detailed list of UC payments and recoupments;
- compared the State agency's detailed list of UC payments and recoupments with the State agency's reconciliations of initial UC payments with hospitals' and other providers' actual UC costs to determine whether all claimed initial UC payments were accurately captured in those reconciliations;
- selected 10 hospital providers and 1 physician group provider and compared the actual cost and payment information captured in the reconciliation for those providers with supporting cost report information;
- determined whether the State agency returned the Federal share of overpayments it identified in its reconciliations;

- calculated the Federal share the State agency received for the finding amounts identified; and
- discussed the results of our audit with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: FEDERAL AND STATE REQUIREMENTS RELATED TO THE CALCULATION OF ACTUAL UNCOMPENSATED CARE COSTS

The Act requires that payment for services be consistent with efficiency, economy, and quality of care.²⁴ Also, Federal regulations state that, for costs to be allowable under Federal awards, they must be reasonable and explain that a cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost.²⁵

Providers receiving both DSH and UC payments under the State plan and the waiver cannot receive total payments that exceed the hospital's total eligible UC costs.²⁶ All UC payments to providers and all expenditures described as UC-permissible expenditures must not exceed the cost of services provided to Medicaid and uninsured patients. UC payments are calculated using the same methodology that is used to calculate the DSH HSL. The waiver applies the same methodology in the DSH and UC programs to calculate the hospital's UC costs. DSH and UC program payments cannot cover the same UC costs.

The waiver requires the State agency to offset UC revenue with all applicable inpatient and outpatient hospital UC payments received by a hospital. The State agency uses the hospital's actual data reported on the reconciliations and best available cost reports to ensure that the hospital's payments do not exceed its eligible costs. The State agency determines the hospital's Medicaid DSH and UC costs.

The reconciliation process employs the same cost-finding methodology the State agency uses to determine UC costs. The best available cost report or reports covering the DY is also used in the reconciliation process. If at the end of the reconciliation process the State agency determines that a provider received an overpayment, the amount of the overpayment should be recouped from the provider and may be redistributed to hospitals that still have UC costs. Alternatively, the Federal share of the overpayment must be properly credited to the Federal Government through an adjustment shown on the CMS-64 report.²⁷

The State agency submitted a State Plan Amendment (SPA) to CMS and received approval to change its State plan, effective October 2013, to calculate the HSLs using actual charges and payments and to reduce costs by total payments from all payor sources. The actual charges

²⁴ Section 1902(a)(30)(A) of the Act.

²⁵ 45 CFR §§ 75.403(a) and 75.404.

²⁶ The waiver, page 49 STC 45. Uncompensated Care (UC) Pool.

²⁷ The waiver, page 187 Attachment H, UC Claiming Protocol and Application.

include Medicaid and Medicare charges and payment data, as appropriate, for dually eligible individuals.²⁸

Further, the State agency sought CMS approval to calculate the HSL for unspent UC funds by offsetting costs by Medicare payments but not private insurance payments for DYs 3 through 5. CMS approved the State agency's proposed methodology.²⁹

²⁸ SPA 13-042, effective Oct. 4, 2013, DSH Reimbursement Methodology, Calculating a hospital-specific limit, section(e).

²⁹ Letter from the State agency to CMS on July 10, 2020, and subsequent approval from CMS on July 29, 2020.

APPENDIX C: STATE AGENCY COMMENTS

Texas Health and Human Services Commission (HHSC)
August 25, 2022, Management Response to the
U.S. Department of Health and Human Services Office of Inspector General
Draft Report dated June 24, 2022 - A-06-19-09002

Medicaid Uncompensated Care Payments

Management Response Recommendation 1

Recommendation 1: We recommend that Texas recoup \$33.78 million in UC payments hospitals retained because costs were not reduced by the Medicare payments they received and either refund the related Federal share of \$19.66 million to the Federal Government or redistribute the recouped funds to hospitals that had unmet UC costs.

Statement of Concurrence or Nonconcurrence

HHSC does not concur with this finding.

DHHS-OIG states, “[T]he State agency sought and received CMS approval in July 2020 to calculate the HSL by reducing hospital provider costs by Medicare payments but not by private insurance payments for DYs 3 through 5. (See Appendix B.)...However, the State agency did not reduce hospitals’ UC costs by Medicare payments received for dually eligible individuals from October 1, 2013, through September 30, 2016 (DYs 3 through 5).”

The July 10, 2020, communication cited by the auditors states that “The Texas Health and Human Services Commission (HHSC) seeks written approval to use the methodology described in this letter to distribute the unspent funds from its Uncompensated care (UC) pool for federal fiscal years 2014 through 2017” (emphasis added). The request, which was granted by CMS on July 29, 2020, related only to the withheld UC payments, not the full UC payments for those demonstration years, and the HSL calculation described in the communication with CMS above relates only to the HSL applied to the withheld payments. Consistent with the July 10, 2020, communication, the state reduced hospital provider costs by Medicare payments when distributing unspent funds. Outside of the voluntary agreement with regard to the distribution of unspent funds, the state was not required to reduce the HSL by Medicare payments (or third-party commercial insurance payments) during DYs 3 through 5 because there was no valid requirement in place that would have mandated such an HSL calculation. During DYs 3 through 5 costs were not required to be offset by Medicare payments or third-party commercial insurance payments. Although

FAQs 33 and 34 had been issued, the FAQs were later invalidated, and CMS withdrew them.

Further, the current version of 42 C.F.R. 447.299, requiring costs to be offset by Medicare and private insurance payments, was not effective until June 2017.

Management Response to Recommendation 2

Recommendation 2: We recommend that Texas refund \$11.05 million to the Federal Government for the underreported UC overpayments.

Statement of Concurrence or Nonconcurrence

Concur

Actions Taken and/or Planned

This recommendation combines two findings:

- The State Agency Did Not Refund the Full Federal Share of Overpayments It Made to Three Public Hospitals - \$12.91 million (\$7.51 million Federal share) because the State agency did not refund the full Federal share of overpayments it made to three public hospitals, and
- The State Agency Did Not Collect \$5.99 Million in Overpayments It Identified for eight Hospitals or Return the Related Federal Share of \$3.54 Million - \$5.99 million (\$3.54 million Federal share) because the State agency did not collect overpayments it identified for eight hospitals.

The first finding was resolved during the fieldwork portion of this audit.

For the second finding, the HHSC Provider Finance Department Payments team has identified the cash sweep transactions that will need to be reversed in our State agency accounting system to refund the Federal government for underreported UC overpayments. The Payments team is

currently performing additional quality assurance steps to ensure we are not missing any transactions that could impact the final delivery of overpayments to the Federal government.

Responsible Manager

██████████

Target Implementation Date

HHSC was notified in writing of this overpayment on 07/07/2022. Per 42 CFR 433.312, HHSC has one year from the date of discovery to refund the overpayment amount to the Federal government; therefore, the target implementation date is 07/07/2023.

Management Response to Recommendation 3

Recommendation 3: We recommend that Texas follow the CMS-approved methodology for calculating actual UC costs when reconciling initial UC payments with providers' actual UC costs, including reducing UC costs by Medicare payments providers receive.

Statement of Concurrence or Nonconcurrence

Concur

Actions Taken and/or Planned

HHSC follows the CMS-approved methodology to calculate actual Uncompensated Care costs when reconciling the initial Uncompensated Care payments against providers' actual Uncompensated Care costs. This includes reducing Uncompensated Care costs by Medicare payments a provider may have received.

This UC Reconciliation includes two calculations for UC costs in the UC Reconciliation final report. The first calculation is 'UC Payments in Excess of Cost Including Other Insurance and Medicare Payments'. The second

calculation is 'UC Payment in Excess of UC Cost Excluding Other Insurance and Medicare Payments'. Both calculations are available in the final UC Reconciliation report because during the CHAT Lawsuit, Myers and Stauffer sent reports with both calculations so HHSC would have the correct Uncompensated cost regardless of the outcome of the lawsuit.

Responsible Manager

██████████

Target Implementation Date

Completed on 12/4/2019

Management Response to Recommendation 4

Recommendation 4: We recommend that Texas establish review procedures for overpayments to ensure that they are accurately entered into the State agency's accounting system and returned to the Federal Government.

Statement of Concurrence or Nonconcurrence

Concur

Actions Taken and/or Planned

HHSC currently has a documented process to review entries made by the HHSC Accounting team into the State agency's accounting system to ensure that there are no duplicates or missing entries compared to the payment vouchers that were submitted to HHSC Accounting by the HHSC Provider Finance Department Payments team. The HHSC Provider Finance Department Payments team will review this existing process documentation to ensure it addresses when overpayments are identified to ensure they are accurately entered into the State agency's accounting system and returned to the Federal government.

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Responsible Manager

██████████

Target Implementation Date

12/31/2022

Office of Inspector General Note - The deleted text has been redacted from this Appendix because it contains personally identifiable information.