Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

TEXAS COULD NOT SUPPORT THE PERMISSIBILITY OF THE FUNDS USED AS THE STATE SHARE OF THE MEDICAID DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM

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Office of Inspector General

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

Texas Could Not Support the Permissibility of the Funds Used as the State Share of the Medicaid Delivery System Reform Incentive Payment Program

Why OIG Did This Audit

Delivery System Reform Incentive Payment (DSRIP) Program payments are incentive payments made to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality and cost-effectiveness of care, and improve the health of patients and families served. These incentive payments have significantly increased funding to providers for their efforts related to the quality of services. Texas made DSRIP Program payments totaling almost $10 billion for demonstration years 1 through 5.

Our objective was to determine whether Texas used permissible funds as the State share of DSRIP Program payments.

How OIG Did This Audit

Our audit covered the State share of $294.1 million of $694.2 million in total DSRIP Program payments made to one provider for December 12, 2011, through September 30, 2016. We calculated the DSRIP payments and required State share and traced them to the financial records to determine the source and amount of funds used as the State share for the DSRIP payments.

What OIG Found

Texas could not support that the $294.1 million in funds that it used as the State share of Parkland Hospital's (Parkland's) DSRIP Program payments were derived from permissible sources.

This occurred because Texas did not provide any guidance to the Dallas County Hospital District, dba Parkland Health & Hospital System (Hospital District) for identifying and documenting the funding sources used for the DSRIP intergovernmental transfers (IGTs). Consequently, the Hospital District did not put controls in place to identify the source of funds or maintain documentation to support the permissibility of the funds used for the DSRIP IGTs.

The State has the burden to document the allowability and allocability of its claims for Federal Financial Participation, and this burden is based on the requirement in Federal cost principles that costs claimed must be documented adequately and on grant administration requirements, including the requirement that grantees maintain accounting records supported by source documentation. Without such documentation, we could not determine whether Texas was entitled to the full $400.1 million Federal share Texas received for Parkland's DSRIP Program payments.

What OIG Recommends and Texas Comments

We recommend that Texas (1) work with CMS to determine how much of the $294.1 million transferred by the Hospital District and used by the State agency as the State share of Parkland's DSRIP Program payments were derived from impermissible sources and refund up to the $400.1 million Federal share received and (2) provide its IGT entities with guidance on identifying and documenting the permissibility of the funds they transfer to cover the State share of Medicaid expenditures, emphasizing that the State is required to maintain records that adequately identify the source and application of funds for federally funded activities.

In written comments on our draft report, Texas did not concur with our recommendations. However, Texas did describe the actions it planned to take to address each of our recommendations. After reviewing Texas' comments, we maintain that our finding and recommendations are valid.

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INTRODUCTION

WHY WE DID THIS AUDIT

Under Texas' section 1115 waiver,[1] incentive payments made to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality and cost-effectiveness of care, and improve the health of patients and families served are made through the Delivery System Reform Incentive Payment (DSRIP) Program. DSRIP Program payments are not direct reimbursement for expenditures or payments for services. Paying providers to incentivize improvements to their health care delivery systems is a relatively new practice in Texas. These incentive payments have significantly increased funding to providers for their efforts related to the quality of services. Texas made DSRIP Program payments totaling almost $10 billion for demonstration years (DYs) 1 through 5 (December 12, 2011, through September 30, 2016).

States may use funds transferred by any unit of State or local government (such as a public hospital, hospital district, county, city, or any State agency) to fund the State share of Medicaid expenditures if the funds are permissible under Federal requirements. A past OIG audit found that Texas relied on impermissible funds for the State share of DSRIP Program payments.[2] This audit of the Texas Health and Human Services Commission (the State agency) focuses on Parkland Hospital (Parkland), a component of the Dallas County Hospital District, dba Parkland Health & Hospital System (Hospital District). Parkland received one of the highest total amounts of DSRIP Program payments in Texas.

OBJECTIVE

Our objective was to determine whether the State agency used permissible funds as the State share of DSRIP Program payments.

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, the Centers for Medicare & Medicaid Services (CMS) administers the program. In Texas, the State agency administers the Medicaid program. Although the State

[1] Section 1115 of the Social Security Act (the Act) gives the Secretary of the Department of Health and Human Services (the Secretary) the authority to approve experimental, pilot, or demonstration projects that are likely to assist in promoting the objectives of the Medicaid program. Texas' waiver was effective Dec. 12, 2011.

[2] *Texas Relied on Impermissible Provider-Related Donations To Fund the State Share of the Medicaid Delivery System Reform Incentive Payment Program* (A-06-17-09002).

agency 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 Medicaid expenditures based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. The State is responsible for funding the remainder of its expenditures, or the State share.

States may use funds transferred by any unit of State or local government (such as a public hospital, hospital district, county, city, or any State agency) to fund the State share of Medicaid expenditures if the funds are permissible under Federal requirements. The process by which funds are transferred to the State agency by another unit of government is known as an intergovernmental transfer (IGT).

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.

Texas' Medicaid Delivery System Reform Incentive Payment Program

The DSRIP Program provides incentive payments that the State agency makes to hospitals and other types of providers. The DSRIP Program operates as part of Texas' section 1115 waiver. The waiver states that DSRIP Program payments are available for the development of a program that supports hospitals' efforts to enhance access to health care, increase the quality of care, and improve the health of the patients and families they serve.

The waiver established 20 regional health care partnerships (RHPs) throughout Texas. Under these RHPs, providers within the same geographic boundary are grouped together. Each RHP is anchored by a public hospital or local government entity that, as explained below, financially supports the DSRIP Program within its geographic boundaries and has the authority to make IGTs.

The Hospital District is a component unit of Dallas County and anchors the Region 9 RHP (RHP 9), which encompasses Dallas, Denton, and Kaufman Counties. As the entity anchoring RHP 9, the Hospital District controlled the level of DSRIP Program payments that an RHP 9 provider could receive. Additionally, the Hospital District was an IGT entity and transferred funds for the State share of some RHP 9 providers' DSRIP Program payments.[3] Parkland is an RHP 9 DSRIP provider, and the Hospital District transferred funds to the State agency to cover the State share of Parkland's DSRIP payments.

[3] An IGT entity is a governmental entity (such as a public hospital, hospital district, county, city, or any State agency) that provides funding to the State agency, which will then have those funds "matched" by the Federal Government for Medicaid expenditures and sent to the Medicaid provider designated by the funding governmental entity.

For DYs 1 through 5, the State agency made $694.2 million in DSRIP payments to Parkland, for which the Hospital District transferred the State share of $294.1 million to the State agency. In addition to those transferred funds, the Hospital District also transferred $133 million in funds to cover the State share of RHP 9 DSRIP payments totaling $313.1 million made to private providers.[4]

Federal and State Requirements for the State Share of Medicaid Payments

In accordance with the Act, to receive Federal Financial Participation (FFP) in its medical assistance expenditures, a State must cover its assigned share of those expenditures (State share), which varies from State to State based on each State's FMAP.[5] The Act further states that funds transferred from units of government within a State and derived from State and local taxes may be used by States as the State share of expenditures, unless the government entity's transferred funds are from donations or taxes that would not otherwise be recognized as the State share.[6]

Federal regulations state that public funds may be considered as the State's share in claiming FFP if the public funds are (1) appropriated directly to the State agency, transferred from other public agencies to the State agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP and, (2) not Federal funds or are Federal funds authorized by Federal law to be used to match other Federal funds.[7]

In Decision No. 2886, dated August 7, 2018, the Department of Health and Human Services Departmental Appeals Board (DAB) reaffirmed that a State has the burden to document the allowability and allocability of its claims for FFP, and this burden is based on the requirement in Federal cost principles that costs claimed must be documented adequately and on grant administration requirements, including the requirement that grantees maintain accounting records supported by source documentation.[8]

The Federal cost principles are used to determine whether costs are allowable, reasonable, and allocable under Federal awards. To be allowable, costs must be necessary for the performance of the Federal award, not be used to meet cost sharing for another federally financed program, and be adequately documented.[9] To be reasonable, consideration must be given to whether

[4] The private providers were private hospitals and private medical centers.

[5] The Act § 1902(a)(2) and § 1903(a)(1).

[6] The Act § 1903(w)(6).

[7] 42 CFR § 433.51.

[8] DAB No. 2886, (2018), Page 17.

[9] 45 CFR § 75.403.

the costs are generally recognized as ordinary and necessary for the operation of the non-Federal entity or the proper and efficient performance of the Federal award.[10] To be allocable, costs must be incurred specifically for the Federal award, and must be necessary to the overall operation of the non-Federal entity.[11]

States must expend and account for Federal awards in accordance with State laws and procedures for expending and accounting for the State's own funds. The State's financial management systems must be sufficient to permit preparation of required reports and the tracing of expenditures to a level adequate to establish that award funds have not been used in violation of Federal statutes, regulations, and the terms and conditions of Federal awards. Additionally, States' financial management systems must provide for records that adequately identify the source and application of funds for federally funded activities. These records must contain information pertaining to authorizations, assets, income, and expenditures and be supported by source documentation.[12]

Texas' 1115 Medicaid waiver provides for supplemental funding to certain Medicaid providers in Texas through the DSRIP program. A governmental entity makes IGTs for the State share before providers receive DSRIP Program payments. Funds may be transferred to the State agency by any unit of local government (including, but not limited to, a public hospital, hospital district, county, city, or Local Mental Health Authority) or by another State agency. There are State and Federal restrictions on the types of funds that may be transferred for State share purposes. A governmental entity may transfer funds to the State agency as the State share if (1) the funds are in the entity's control, (2) the funds are not Federal funds, (3) the funds are public funds, and (4) the funds are not impermissible provider-related donations.[13] A provider-related donation is a donation or other voluntary payment (in cash or in kind) made directly or indirectly to a State or unit of local government by or on behalf of a health care provider or related entity.[14]

Additionally, the Texas Administrative Code (TAC), Title 1, section 355.8203, states that public funds are funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.[15]

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[10] 45 CFR § 75.404.

[11] 45 CFR § 75.405.

[12] 45 CFR § 75.302.

[13] State agency IGT Guidelines; 42 CFR §§ 433.51, 433.57.

[14] 42 CFR § 433.52.

[15] 1 TAC § 355.8203(b)(8).

HOW WE CONDUCTED THIS AUDIT

Our audit covered $294.1 million in funds used as the State share of $694.2 million in total DSRIP Program payments made to Parkland for December 12, 2011, through September 30, 2016 (i.e., waiver DYs 1 through 5), which the State agency paid and claimed during fiscal years (FYs) 2013 through 2017. We calculated the DSRIP payments and required State share and traced them to the financial records to determine the source and amount of funds used as the State share of the DSRIP payments. Additionally, we selected 47 of 18,927 bank deposit transactions on the bank statements for the 9 months in which DSRIP IGTs were made for the State share. For those 47 deposit transactions, we requested and reviewed source documentation to support the amount, date, and source of each deposit.

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.

FINDING

We could not determine whether the State agency used permissible funds as the State share of DSRIP Program payments because the State agency could not support that the $294.1 million[16] in funds that it used as the State share of Parkland's DSRIP Program payments were derived from permissible sources. This occurred because the State agency did not provide any guidance to the Hospital District for identifying and documenting the funding sources used for the DSRIP IGTs. Consequently, the Hospital District did not put controls in place to identify the source of funds or maintain documentation to support the permissibility of the funds used for the DSRIP IGTs. Without such documentation, we could not determine whether the State agency was entitled to the full $400.1 million Federal share[17] the State agency received for Parkland's DSRIP Program payments.

THE STATE AGENCY COULD NOT SUPPORT THE PERMISSIBILITY OF FUNDS USED AS THE STATE SHARE OF PAYMENTS

The Federal Government pays its share of a State's Medicaid expenditures based on the FMAP,

[16] The exact amount of the State share the State agency could not support as permissible funds was $294,094,985.

[17] The exact amount of the full Federal share the State agency received for Parkland's DSRIP Program payments was $400,090,187.

and the State is responsible for funding the remainder of its expenditures, or the State share.[18] States may use funds transferred by any unit of State or local government (such as a public hospital, hospital district, county, city, or any State agency) to fund the State share if the funds are permissible under Federal requirements. A governmental entity may transfer funds to the State agency as the State share if (1) the funds are in its control, (2) the funds are not Federal funds, (3) the funds are public funds, and (4) the funds are not impermissible provider-related donations.[19]

State public funds are funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.[20] Public funds may be considered as the State's share in claiming FFP if the public funds are (1) appropriated directly to the State agency, transferred from other public agencies to the State agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP, and (2) are not Federal funds or are Federal funds authorized by Federal law to be used to match other Federal funds.[21]

The funding for the Hospital District's DSRIP IGTs came from its operating revenue account. All of the Hospital District's operating funds go into one operating revenue account. The operating revenue account included funding sources such as tax revenues, Medicare and Medicaid payments for services provided to beneficiaries, commercial insurance payments for services provided to patients with private health care coverage, payments from patients for services provided, private grants from foundations to fund specific tasks to be performed as designated in the agreements, and other grant funds from State agencies to fund specific programs. The Hospital District also uses funds from its operating revenue account to make IGTs for the State share of many other Medicaid payments, which included Medicaid Disproportionate Share Hospital (DSH) payments and Uncompensated Care Program (UC) payments.

Hospital District officials claimed that the IGTs for Medicaid payments were made from its tax revenue. IGTs the Hospital District transferred for DSRIP and UC payments represented 44.67 percent of the Hospital District's tax revenue in 2013; however, by 2016, those IGTs represented 95.70 percent of its tax revenue. As stated above, the Hospital District made additional IGTs for the State share of many other Medicaid payments. Therefore, the Hospital District may have needed to use funds other than tax revenue for its IGTs. The table (next page) shows the growing percentage of the Hospital Districts' tax revenue that the State share

[18] The Act § 1903(a)(1).

[19] State agency IGT Guidelines; 42 CFR §§ 433.51, 433.57.

[20] 1 TAC § 355.8203(b)(8).

[21] 42 CFR § 433.51.

of DSRIP and UC payments consumed. The table does not represent all IGTs the Hospital District made to cover the State share of all Medicaid payments for our audit period. Instead, the table shows the IGTs for just two types of Medicaid payments (i.e., the DSRIP Program and UC payments) and that these payments increasingly represented a larger share of the Hospital District's tax revenue.

Table: Two Types of Medicaid Payments' State Shares Transferred Compared With the Hospital Districts' Tax Revenue by Fiscal Year

Hospital District's Fiscal Year	Total Transferred for DSRIP and UC Payments	Tax Revenue	State Share Transferred as a Percentage of Tax Revenue
2013	$189,337,084	$423,889,000	44.67%
2014	262,805,312	449,537,000	58.46%
2015	323,806,175	496,300,000	65.24%
2016	512,627,987	535,646,000	95.70%
Total	**$1,288,576,558**	**$1,905,372,000**	**67.63%**

Tax revenues are the primary source of the Hospital District's funding and, according to its officials, would cover the funding for the DSRIP IGTs. However, the Hospital District was unable to support that it used only tax revenue to fund the DSRIP IGTs. A Hospital District official told us that the Hospital District could not support which operating funds were used to fund the DSRIP IGTs because of the diverse revenue streams that went into the one operating revenue account.

We determined that the Hospital District did not have enough tax revenue to cover its January 2016 DSRIP IGT and used $15 million from an investment portfolio account to help cover the $90 million DSRIP IGT. Hospital District officials told us that the investment portfolio account was funded from its operating revenue account. Because all of the Hospital District's operating funds go into one operating revenue account, we could not determine whether the funds from the investment portfolio account used to help cover its DSRIP IGT were permissible.

The Hospital District could not provide documentation to support the funding source of the $294.1 million used for its DSRIP IGTs because of the many different revenue streams that went into the operating revenue account. Specifically, the Hospital District did not have documentation to support that it used only public funds for its DSRIP IGTs.

For FYs 2013 through 2017, the Hospital District made DSRIP IGTs for the $294.1 million State share in 9 different months from its operating revenue account. There were 18,927 deposits totaling almost $3.2 billion documented in the bank statements for the Hospital District's operating revenue account for these 9 months. Due to the size of the Hospital District's

operations, it would not be feasible for us to review all of the Hospital District's operating funds to validate the permissibility of the funds used for its DSRIP IGTs. Instead, we judgmentally selected and reviewed 47 bank deposits from the Hospital District's operating revenue account for the 9 months in which DSRIP IGTs were made for the State share.

We requested that the Hospital District provide source documentation as support for the deposit amounts, deposit dates, and source of the deposits in our judgmental sample. The selected bank deposits from the Hospital District's operating revenue account from FY 2013 through FY 2017 totaled more than $343.7 million and contained both public and non-public funds (e.g., grants conditioned on supplying a benefit solely to the grantor of the funds). The Hospital District was able to provide documentation to support the bank deposit amounts, dates, and sources (such as patient invoices, canceled checks from individual patients, and third-party administrators for commercial insurance companies, grant payments from private foundations and State agencies, deposit wire transfers, bank statements for fund transfers, and grant contracts and agreements). However, the Hospital District could not provide documentation to show how all the sampled deposits made to the operating revenue account were used or that the total amount of public funds in its operating revenue account was sufficient to cover all IGTs the Hospital District made. Thus, the Hospital District could not support that it used only public funds for its DSRIP IGTs.

The Hospital District could not provide documentation of the funding sources for its DSRIP IGTs because the State agency did not provide any guidance to the Hospital District for identifying and documenting the funding sources used for the DSRIP IGTs. Consequently, the Hospital District did not put controls in place to identify the source of funds or maintain documentation to support the permissibility of the funds used for the DSRIP IGTs.

CONCLUSION AND RECOMMENDATIONS

The State has the burden to document the allowability and allocability of its claims for FFP, and this burden is based on the requirement in Federal cost principles that costs claimed must be documented adequately and on grant administration requirements, including the requirement that grantees maintain accounting records supported by source documentation. With no guidelines for the Hospital District to document the funding sources for its DSRIP IGTs, the State agency may have used impermissible funds as the State share and may not have been entitled to related Federal funds for Parkland's DSRIP Program payments. Therefore, we recommend that the Texas Health and Human Services Commission:

- work with CMS to determine how much of the $294,094,985 transferred by the Hospital District and used by the State agency as the State share of Parkland's DSRIP Program payments were derived from impermissible sources and refund up to the $400,090,187 Federal share received and

- provide its IGT entities with guidance on identifying and documenting the permissibility of the funds they transfer to cover the State share of Medicaid expenditures, emphasizing that the State is required to maintain records that adequately identify the source and application of funds for federally funded activities.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not concur with our recommendations. However, the State agency did describe the actions it planned to take to address each of our recommendations.

Regarding our first recommendation, the State agency stated that all funds utilized for the non-Federal share of Parkland's DSRIP Program payments were permissible. Specifically, the State agency believed that the Hospital District used permissible public funds to support the Medicaid program and that it may utilize any permissible source of public funds for use of the non-Federal share of Medicaid payments. The State agency also believed that our review primarily covered the Hospital District's tax revenue and that our analysis indicated that the Hospital District had sufficient tax revenue to cover the amount of its DSRIP IGTs. The State agency also stated that our use of the definition of public funds contained in the TAC, Title 1, section 355.8202(b)(9) was improper. The State agency contended that this provision was under the UC program and inapplicable to payments made to hospitals under the DSRIP program.

Even though the State agency disagreed with our first recommendation, it stated that it would provide CMS documentation that confirms the permissibility of all funding sources of the State share of Parkland's DSRIP Program payments. Additionally, the State agency will hold a discussion with CMS's Financial Management Group if, and when, CMS initiates further action.

Regarding our second recommendation, the State agency claimed that the Hospital District maintained appropriate records to document the source of public funds that are utilized as IGTs. The State agency further contended that these records clearly identified the source of all deposits to the Hospital District's operating account and detailed the transactions between its other accounts and its Medicaid IGTs and payments. The State agency said that it believed no additional guidance was necessary because (1) we did not identify any impermissible funds used in Parkland's DSRIP Program payments and (2) the Hospital District's records were sufficiently detailed and maintained. The State agency also stated that if additional record retention was necessary, it did not have the authority to issue record retention schedules or instructions because that authority is expressly conferred on the Texas State Library and Archives Commission.

The State agency claimed that our second recommendation was not appropriate because it was premised on the faulty idea that the Hospital District erred by not maintaining a dedicated

account for Medicaid permissible funds. The State agency stated that there were no Federal statutes or regulations specific to the Medicaid program that required that the State share of the Medicaid portion must be held in a dedicated account prior to being used. The State agency further claimed it could identify which governmental entity supplied public funds and confirmed that each governmental entity had sufficient public funding to cover the amount of IGTs in support of the Medicaid program. The State agency also stated that we seemingly suggested that the Hospital District limit the public funds it chooses to contribute to tax revenue. The State agency stated that it does not agree with the public fund limit and that there is no statutory or regulatory basis for such a limitation.

Even though the State agency disagreed with our second recommendation, it stated that it was in the process of implementing additional procedures related to its local funds monitoring. The State agency concurred that the tracking of the use and application of federally funded activities is a critical part of financial stewardship. Additionally, the State agency said that it will hold a discussion with CMS's Financial Management Group if, and when, CMS initiates further action.

The State agency's comments are included as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our finding and recommendations are valid. Regarding our first recommendation, the State agency and the Hospital District did not provide sufficient documentation or evidence to support that all funds used for the non-Federal share of Parkland's DSRIP payments were from permissible sources only. In our discussions with the Hospital District, Hospital District officials told us that tax revenues were the primary source of the Hospital District's funding and that that revenue would cover the funding for the DSRIP IGTs. However, the Hospital District was unable to support that it used only tax revenue to fund the DSRIP IGTs.

Additionally, our review was not primarily focused on the Hospital District's tax revenue. According to Hospital District officials, the funding for the Hospital District's DSRIP IGTs came from its operating revenue account, which contained all of the Hospital District's operating funds. In addition to tax revenues, the operating revenue account included funding sources such as Medicare and Medicaid payments for services provided to beneficiaries, commercial insurance payments for services provided to patients with private health care coverage, payments from patients for services provided, private grants from foundations to fund specific tasks to be performed as designated in the agreements, and other grant funds from State agencies to fund specific programs. We reviewed these funding sources in addition to the tax revenue. A Hospital District official told us that the Hospital District could not support which operating funds were used to fund the DSRIP IGTs because of the diverse revenue streams that went into the one operating revenue account. Because the operating revenue account included both public and non-public funds, and the Hospital District could not provide documentation to support that the amount of public funds in the account was sufficient to

cover all IGTs the Hospital District made, it could not support that it used only public funds for its DSRIP IGTs.

The State agency was correct that the definition of public funds contained in the TAC, Title 1, section 355.8202(b)(9), is inapplicable to payments made to hospitals under the DSRIP program. However, the definition of public funds contained in the TAC, Title 1, section 355.8203(b)(8), is the same as the definition in section 355.8202(b)(9) and is applicable to the DSRIP program. We've corrected this citation where appropriate.

Regarding our second recommendation, the Hospital District was able to provide documentation for the source of all deposits to the Hospital District's operating account in our judgmental sample. However, the Hospital District could not provide documentation to show how all the sampled deposits made to the operating revenue account were used or that the total amount of public funds in its operating revenue account was sufficient to cover all IGTs the Hospital District made. Thus, the Hospital District could not support that it used only public funds for its DSRIP IGTs.

The State agency believed that additional guidance was not necessary and that it does not have the authority to issue record retention schedules and instructions. However, we are not recommending that the State agency issue record retention schedules or instructions. Rather, we recommend that the State agency provide guidance regarding documentation that would adequately support the permissibility of the funds IGT entities may transfer to cover the State share of Medicaid expenditures. Additional guidance is necessary because the Hospital District did not have controls in place to identify the source of funds or maintain documentation to support the permissibility of the funds used for the DSRIP IGTs.

We did not tell the State agency that the Hospital District erred by not maintaining a dedicated account for Medicaid permissible funds. Furthermore, we did not suggest that the Hospital District should limit the public funds it chooses to contribute to tax revenue.

OTHER MATTERS

FEDERAL FUNDS RECEIVED FOR PRIVATE PROVIDER PAYMENTS MAY ALSO BE AT RISK

In addition to the funds the Hospital District transferred to cover the State share of Parkland's DSRIP Program payments, the Hospital District used the same operating revenue account to cover the State share of $133.0 million related to RHP 9 private providers' DSRIP Program payments totaling $313.1 million. Because the Hospital District did not have controls to identify the source of funds or maintain documentation to support the permissibility of the funds used for the DSRIP IGTs, the $180.1 million Federal share it received for the RHP 9 private providers' DSRIP Program payments are at risk.

In DAB No. 2886 (2018), the DAB upheld CMS's disallowance of $25.3 million in Federal funds Texas received related to certain private hospitals' Medicaid payments.[22] Funds the Hospital District transferred were at issue in CMS's disallowance. CMS disallowed FFP in supplemental Medicaid payments made to certain private hospitals because the State share of the payments was derived from impermissible provider-related donations from private hospitals (through entities they created and owned) undertaking contracts to provide physician services in two public county hospital districts.[23] When the private hospitals assumed the county hospital contract costs, which were previously paid from the Hospital District's operating revenue account, funds within that account were freed up to allow the Hospital District to make IGTs on the private hospitals' behalf.

[22] On Oct. 2, 2019, DAB declined a request the State agency made for reconsideration of DAB No. 2886. On Dec. 2, 2019, the State agency filed a civil action in Federal court seeking judicial review of DAB No. 2886.

[23] DAB No. 2886, (2018), pages 1 and 17.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $294,094,985 in funds used as the State share of $694,185,172 in total DSRIP Program payments made to Parkland for December 12, 2011, through September 30, 2016 (i.e., waiver DYs 1 through 5), which the State agency paid and claimed during FYs 2013 through 2017.

We limited our review of the State agency's internal controls to those related to the DSRIP Program 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 and Hospital District offices in Austin, Texas, and Dallas, Texas, respectively.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, requirements, and guidance governing the source of the State share of Medicaid expenditures;

- reviewed the State agency's approved 1115 waiver;

- interviewed State agency officials to gain an understanding of the State agency's policies and procedures related to DSRIP Program payments and reviewed the State agency's written policies and procedures;

- identified all providers that received DSRIP Program payments for DYs 1 through 5 by tracing DSRIP Program expenditures the State agency claimed on the CMS-64 reports to detailed supporting payment data;

- selected Parkland's DSRIP Program payments for validation of the related State share funds' source;

- interviewed Hospital District officials to gain an understanding of the Hospital District's policies and procedures related to obtaining and transferring the State share of DSRIP Program payments and reviewed its written policies and procedures;

- reviewed the Hospital District's financial statements;

- obtained the operating revenue account's bank statements for the 9 months in which the Hospital District transferred the State share of DSRIP payments, which included a total of 18,927 deposits totaling almost $3,187,188,284 and analyzed those bank deposit transactions;

- judgmentally selected 47 bank deposit transactions from the operating revenue account's bank statements totaling $343,714,360[24] and requested and reviewed source documentation to support the amount, date, and source of each deposit;

- identified UC payments for which the Hospital District transferred the State share of funds;[25] and

- discussed the results of our audit with the State agency and the Hospital District's 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.

[24] We designed our selection to provide coverage of the types of deposits consistently made into the bank account and to capture various deposit sizes, from small to large. The amounts for 31 of the selected deposits exceeded $50,000.

[25] We identified the UC payments from another audit that focused specifically on UC payments (A-06-18-09002).

APPENDIX B: STATE AGENCY COMMENTS

HHSC Management Response Template to
U.S. Department of Health and Human Services Office of Inspector General
Draft Report date October 7, 2022 - A-06-17-09004 and Titled
"Texas Could Not Support the Permissibility of the Funds Used as the State Share of the Medicaid Delivery System Reform Incentive Payment Program"

Recommendation 1: The Texas Health and Human Services Commission (HHSC) should work with CMS to determine how much of the $294,094,985 transferred by the Hospital District and used by the State agency as the State share of Parkland's DSRIP Program payments were derived from impermissible sources and refund up to $400,090,187 Federal share received.

Management Response

Statement of concurrence/nonconcurrence

Although HHSC disagrees with Recommendation 1, HHSC will provide CMS with documentation that confirms the permissibility of all funding sources of the State share of Parkland's DSRIP Program payments. All funds utilized for the non-federal share of Parkland's DSRIP Program payments were permissible, and, HHSC does not concur with the premise that Parkland's use of an operational account into which a variety of sources of public funds were deposited indicates a violation of any known federal statute or regulation that would render their legitimate public funds impermissible for the use in Medicaid. Nor does HHSC agree that a presumption of impermissibility should underpin discussions between CMS and the state. More specifically, HHSC disagrees for the following reasons:

1. Dallas County Hospital District (d/b/a Parkland), one of the largest public hospitals in the country and a unit of local government, used permissible public funds, as contemplated by 42 C.F.R. § 433.51, to support the Medicaid program.

2. As a unit of local government, Parkland may utilize ***any permissible*** source of public funds for use as the non-federal share of Medicaid payments. Examples of impermissible public funds include federal funds described by 42 C.F.R. § 433.51(c), provider-related donations not described by 42 C.F.R. § 433.66, and health care-related taxes not described

by 42 C.F.R. § 433.68. The OIG has not indicated that Parkland used any impermissible *funding* source, including those indicated above.

3. Restricting the definition of "public funds" to the definition of "public funds" contained in 1 Tex. Admin. Code § 355.8202(b)(9) is improper. This provision is applicable only to payment of physician group practices under the uncompensated care program and is, therefore, inapplicable to payments made to hospitals under the DSRIP program.

4. The OIG performed its review primarily on the funds Parkland receives from ad valorem tax revenue. While ad valorem tax revenue is ***one of*** the sources of public funds available to Parkland, it is ***not the only*** source for permissible public funds.[1] Even so, the OIG's analysis indicated that Parkland did, in fact, have sufficient ad valorem tax revenue to cover the amount of its DSRIP IGT.

Action Plan

Engage in discussion with CMS Financial Management Group, if and when further action is initiated by CMS.

Responsible Manager

Victoria Grady, Director of Provider Finance

Target Implementation Date

None.

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[1] There is no federal statute or rule that requires IGT for the non-federal share of Medicaid payments to be derived from a governmental entity's tax revenue. On the contrary, CMS has been clear that states are not limited to tax revenue as the source of the state's share of Medicaid payments. See, e.g., "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership" final rule and comment (72 Fed. Reg. 29748).

CMS proposed limiting the permissible sources of the non-federal share to appropriated funds, IGT derived from state or local taxes, and certified public expenditures in its proposed Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63722, 63776 (Nov. 18, 2019) (revisions to 42 CFR 433.51) but withdrew the proposed rule after commenters pointed out that the proposed regulation would have exceeded CMS's statutory authority.

HHSC Management Response Template to
U.S. Department of Health and Human Services Office of Inspector General
Draft Report date October 7, 2022 - A-06-17-09004 and Titled
"Texas Could Not Support the Permissibility of the Funds Used as the State Share of the Medicaid Delivery System Reform Incentive Payment Program"

Recommendation 2: The Texas HHSC should provide its IGT entities with guidance on identifying and documenting the permissibility of the funds they transfer to cover the State share of Medicaid expenditures, emphasizing that the State is required to maintain records that adequately identify the source and application of funds for federally funded activities.

Management Response

Statement of concurrence/nonconcurrence

HHSC disagrees with Recommendation 2 because Parkland does maintain appropriate records to document the sources of public funds that are utilized as IGT. Further, HHSC guidance is unnecessary because OIG has failed to identify any impermissible funds used in DSRIP payments to Parkland.

Parkland has sufficient records and provided them to both OIG and HHSC upon request. The records maintained by Parkland clearly identify the source of all deposits to their operating account, and also provide records of transactions in detail between and amongst their other accounts (such as their investment account) and their Medicaid IGT and payments. Because the records are maintained and sufficiently detailed, no additional guidance is necessary.

But, even if additional record retention was necessary, Parkland is a local governmental entity and is subject to records retention requirements established by the Texas State Library and Archives Commission (TSLAC). HHSC lacks statutory authority to issue records retention schedules or instructions to a unit of local government, as that authority is expressly conferred to TSLAC by the Texas Legislature.

Moreover, HHSC is in the process of implementing additional procedures related to its monitoring of local funds. CMS has acknowledged that the procedures being implemented by HHSC are a more robust oversight mechanism for local fund permissibility than that of any other state. HHSC concurs that the tracking of the use and application of federally funded activities is a critical part of financial stewardship.

HHSC Management Response Template to
U.S. Department of Health and Human Services Office of Inspector General
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OIG's recommendation is premised on the faulty idea that Parkland erred by not maintaining a dedicated-account for Medicaid permissible funds, but there are no federal statutes or regulations specific to the Medicaid program that state that the state share of the Medicaid portion must be held in a dedicated account prior to being utilized as that state's matching portion. Further, HHSC can identify which governmental entity supplies public funds and confirms that each governmental entity has sufficient public funding to cover the amount of IGT in support of the Medicaid program; however, HHSC does not agree to limit the public funds a unit of local government chooses to contribute to ad valorem tax revenue, as the OIG seems to suggest it should. As explained above, there is no statutory or regulatory basis for such a limitation.

Action Plan

Engage in discussion with CMS Financial Management Group, if and when further action is initiated by CMS.

Responsible Manager

Victoria Grady, Director of Provider Finance

Target Implementation Date

None.