January 3, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Review of Resident Data Reported in the Intern and Resident Information System for Medicare Cost Reports Submitted to Highmark Medicare Services, Inc. (A-02-09-01019)

Attached, for your information, is an advance copy of our final report on resident data reported in the Intern and Resident Information System for Medicare cost reports submitted to Highmark Medicare Services, Inc. (Highmark). We will issue this report to Highmark within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through email at James.Edert@oig.hhs.gov. Please refer to report number A-02-09-01019.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region II
Jacob Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

January 5, 2012

Report Number: A-02-09-01019

Mr. Patrick Kiley
President
Highmark Medicare Services, Inc.
1800 Center Street
P.O. Box 890089
Camp Hill, PA 17089

Dear Mr. Kiley:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Resident Data Reported in the Intern and Resident Information System for Medicare Cost Reports Submitted to Highmark Medicare Services, Inc.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Brenda Tierney, Audit Manager, at (518) 437-9390, extension 222, or through email at Brenda.Tierney@oig.hhs.gov. Please refer to report number A-02-09-01019 in all correspondence.

Sincerely,

/James P. Edert/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, MO 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF RESIDENT DATA REPORTED IN THE INTERN AND RESIDENT INFORMATION SYSTEM FOR MEDICARE COST REPORTS SUBMITTED TO HIGHMARK MEDICARE SERVICES, INC.

Daniel R. Levinson
Inspector General

January 2012
A-02-09-01019

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

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.

EXECUTIVE SUMMARY

BACKGROUND

Since its inception in 1965, the Medicare program has shared in the costs of educational activities incurred by participating hospitals. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, makes two types of payments to teaching hospitals to support graduate medical education (GME) programs for physicians and other practitioners. Direct GME payments are Medicare's share of the direct costs of training interns and residents, such as salaries and fringe benefits of residents and faculty and hospital overhead expenses. (In this report, "resident" includes hospital interns.) Indirect GME payments cover the additional operating costs that teaching hospitals incur in treating inpatients, such as the costs associated with using more intensive treatments, treating sicker patients, using a costlier staff mix, and ordering more tests.

A hospital claims reimbursement for both direct and indirect GME, in part, based on the number of full-time equivalent (FTE) residents that the hospital trains and the portion of time those residents spend working at the hospital. Pursuant to 42 CFR §§ 412.105(f)(1)(iii)(A) and 413.78(b), no resident may be counted as more than one FTE.

CMS makes available the Intern and Resident Information System (IRIS), a software application that hospitals use to collect and report information on residents working in approved residency training programs at teaching hospitals. According to 67 Fed. Reg. 48189 (July 23, 2002), the primary purpose of the IRIS is to ensure that no resident is counted by the Medicare program as more than one FTE employee in the calculation of payments for the costs of direct and indirect GME.

Highmark Medicare Services, Inc. (Highmark) is a Medicare Administrative Contractor (MAC) under contract with CMS to administer the Medicare Part A (hospital insurance) program. Highmark administers the program for MAC Jurisdiction 12, which consists of four States—Pennsylvania, Maryland, New Jersey, and Delaware—and the District of Columbia. For fiscal year (FY) ended in 2006, 133 hospitals in MAC Jurisdiction 12 collected and reported information to the IRIS on residents. In FY ended 2007, the figure was 132 hospitals.

OBJECTIVE

The objective of our review was to determine whether hospitals in MAC Jurisdiction 12 claimed Medicare GME reimbursement for residents in accordance with Federal requirements.

SUMMARY OF FINDING

Hospitals in MAC Jurisdiction 12 did not always claim Medicare GME reimbursement for residents in accordance with Federal requirements. Specifically, 66 hospitals overstated direct and/or indirect FTE counts on cost reports covering FYs 2006 and 2007. As a result, 50 of those 66 hospitals received excess Medicare GME reimbursement totaling $1,915,825 for residents who were claimed by more than 1 hospital for the same period and counted in the IRIS as more

than 1 FTE. For the remaining 16 hospitals, the FTE overstatements did not have an effect on the hospitals' Medicare GME reimbursement.

The overstated FTE counts and excess reimbursement occurred because there was no Federal requirement for Highmark to review IRIS data that hospitals in MAC Jurisdiction 12 submitted to detect whether a resident had overlapping rotational assignments at more than one hospital. As a result, Highmark did not have procedures to adequately ensure that no resident was counted as more than one FTE in the calculation of Medicare GME payments.

RECOMMENDATIONS

We recommend that Highmark:

- recover $1,915,825 in excess Medicare GME reimbursement paid to 50 hospitals in MAC Jurisdiction 12,

- adjust the direct and indirect FTE counts claimed on the Medicare cost reports covering FYs 2006 and 2007 for each of the hospitals that did not always claim Medicare GME reimbursement in accordance with Federal requirements,

- consider developing procedures to ensure that no resident is counted as more than one FTE in the calculation of Medicare GME payments, and

- consider identifying and recovering any additional overpayments made to hospitals in MAC Jurisdiction 12 for residents whose FTE count exceeded one on Medicare cost reports submitted after FY 2007.

HIGHMARK MEDICARE SERVICES, INC., COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Highmark generally concurred with our first and second recommendations, partially concurred with our fourth recommendation, and disagreed with our third recommendation. Specifically, Highmark agreed with the FTE overstatements and excess Medicare GME reimbursement identified. However, Highmark agreed to adjust only the FTE counts on 117 cost reports (out of a total of 152 cost reports with errors) and recover $1,814,426 in excess Medicare GME reimbursement. Highmark stated that it will not reopen 35 settled cost reports (with excess reimbursement totaling $101,399) because the overpayment amounts do not meet Highmark's materiality thresholds for reopening settled cost reports.

Highmark stated that it partially concurred with our fourth recommendation. Highmark indicated that it would continue to follow instructions contained in the MAC Jurisdiction 12 statement of work and make FTE adjustments based on the review of rotation schedules prepared by the hospitals. However, Highmark will not change its procedures or expand review efforts unless CMS issues a contract modification and/or technical direction letter. Similarly, Highmark disagreed with our third recommendation because there is no requirement for reviewing IRIS

data in the MAC Jurisdiction 12 statement of work and CMS provides no funding to perform additional reviews of FTEs "outside the contracted desk review and audit programs."

After reviewing Highmark's comments, we maintain that our findings and recommendations are valid. We have revised our report and first recommendation to reflect that, of the 66 hospitals with overstated FTEs, the overstatements for 50 of those hospitals had an effect on Medicare GME reimbursement. Highmark's comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicare Payments for Graduate Medical Education

Since its inception in 1965, the Medicare program has shared in the costs of educational activities incurred by participating hospitals. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, makes two types of payments to teaching hospitals to support graduate medical education (GME) programs for physicians and other practitioners. Direct GME payments are Medicare's share of the direct costs of training interns and residents, such as salaries and fringe benefits of residents and faculty and hospital overhead expenses.[1] Indirect GME payments cover the additional operating costs that teaching hospitals incur in treating inpatients, such as the costs associated with using more intensive treatments, treating sicker patients, using a costlier staff mix, and ordering more tests.

A hospital claims reimbursement for both direct and indirect GME, in part, based on the number of full-time equivalent (FTE) residents that the hospital trains and the portion of time those residents spend working at the hospital. Pursuant to 42 CFR § 412.105(f)(1)(iii)(A), FTE status is based on the total time necessary to fill a residency slot. The regulation states: "If a resident is assigned to more than one hospital, the resident counts as a partial [FTE] based on the proportion of time worked in any areas of the hospital listed in paragraph (f)(1)(ii) of this section to the total time worked by the resident. A hospital cannot claim the time spent by residents training at another hospital."[2]

For payment purposes, the total number of FTE residents is the 3-year "rolling average" of the hospital's actual FTE count for the current year and the preceding two cost-reporting periods (42 CFR §§ 412.105(f) and 413.79(d)(3)). Pursuant to 42 CFR §§ 412.105(f)(1)(iii)(A) and 413.78(b), no individual may be counted as more than one FTE. Each time a hospital claims GME reimbursement for a resident it must provide CMS with information on the resident's program, year of residency, dates and locations of training (including training at other hospitals), and percentage of time working at those locations (42 CFR §§ 412.105(f) and 413.75(d)).

For fiscal year (FY) 2009 (the most current data available), teaching hospitals nationwide claimed GME reimbursement totaling $3 billion for direct GME and $6.5 billion for indirect GME.

Intern and Resident Information System

CMS makes available the Intern and Resident Information System (IRIS), a software application that hospitals use to collect and report information on residents working in approved residency programs at teaching hospitals. Hospitals receiving direct and/or indirect GME payments must

[1] In this report, "resident" includes hospital interns.

[2] When referring to the time a resident spends at a hospital, the terms "working" and "training" are interchangeable.

submit, with each annual Medicare cost report, IRIS data files that contain information on their residents, including, but not limited to, the dates of each resident's rotational assignment. According to 67 Fed. Reg. 48189 (July 23, 2002), the primary purpose of the IRIS is to ensure that no resident is counted by the Medicare program as more than one FTE employee in the calculation of payments for the costs of direct and indirect GME.

Highmark Medicare Services, Inc.

Highmark Medicare Services, Inc. (Highmark) is a Medicare Administrative Contractor (MAC)[3] under contract with CMS to administer the Medicare Part A (hospital insurance) program. Highmark administers the program for MAC Jurisdiction 12, which consists of four States—Pennsylvania, Maryland, New Jersey, and Delaware—and the District of Columbia.[4] For FY ended in 2006, 133 hospitals in MAC Jurisdiction 12 collected and reported information to the IRIS on residents. In FY ended in 2007, the figure was 132 hospitals.

For FYs 2006 and 2007, hospitals in MAC Jurisdiction 12 claimed GME reimbursement totaling $650 million for direct GME and $1.5 billion for indirect GME.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether hospitals in MAC Jurisdiction 12 claimed Medicare GME reimbursement for residents in accordance with Federal requirements.

Scope

We reviewed IRIS data that hospitals in MAC Jurisdiction 12 submitted to support resident training costs claimed on annual Medicare cost reports covering FYs 2006 and 2007. This review is part of a nationwide series of Office of Inspector General reviews of Medicare GME payments to hospitals for residents counted as more than one FTE.

We did not assess Highmark's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our audit, which did not require an understanding of all internal controls over the Medicare program.

[3] Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer to MACs, between October 2005 and October 2011, the functions of fiscal intermediaries and carriers. For each MAC jurisdiction, the legal fiscal intermediaries and carriers continue to service the providers in those States until the MAC assumes responsibility for the workload.

[4] CMS awarded the MAC contract for Jurisdiction 12 to Highmark on October 24, 2007. However, because of a protest of the award, the transition was delayed. In December 2008, Highmark assumed full responsibility for the workload in Jurisdiction 12. Therefore, Highmark is responsible for collecting any overpayments and resolving the issues related to this audit.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- held discussions with Highmark officials to gain an understanding of Highmark's procedures for reviewing IRIS data submitted by hospitals in MAC Jurisdiction 12;
- obtained FYs 2006 and 2007 IRIS data from Highmark for all hospitals in MAC Jurisdiction 12;
- analyzed the IRIS data to identify residents claimed by more than one hospital for the same rotational assignment (e.g., weekly rotation schedule) and for whom the total FTE count exceeded one;[5]
- obtained and reviewed rotation schedules and other documentation from each hospital in MAC Jurisdiction 12 for each resident for whom the total FTE count exceeded one to determine which hospital should have claimed Medicare GME reimbursement for the resident during an overlapping period;
- adjusted the claimable direct and/or indirect FTE counts for hospitals that should not have claimed GME reimbursement for residents during an overlapping period or provided conflicting documentation that did not resolve the overlapping rotation dates;[6] and
- determined the net dollar effect of the adjustments to the direct and indirect FTE counts by recalculating each hospital's Medicare cost report(s).[7]

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 objective. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objective.

[5] The FTE count for a resident exceeded one FTE when the total direct GME percentage and/or the total indirect GME percentage for overlapping rotational assignments, as reported in the IRIS, was greater than 100 percent.

[6] According to Highmark guidance, the resolution of overlaps or duplicate rotations is the responsibility of each individual hospital. When hospitals cannot reach an agreement on which hospital should claim a resident, no hospital can count the FTE or claim reimbursement for the resident.

[7] We used Worksheet E-3, Part IV, to recalculate direct GME reimbursement and Worksheet E, Part A, for indirect GME reimbursement.

FINDING AND RECOMMENDATIONS

RESIDENT FULL-TIME EQUIVALENT COUNT EXCEEDED ONE

Pursuant to 42 CFR § 412.105(f)(1)(iii)(A), if a resident is assigned to more than one hospital, the resident counts as a partial FTE based on the proportion of time worked in the hospital to the total time worked by the resident. A hospital cannot claim the time spent by residents training at another hospital. In addition, pursuant to 42 CFR §§ 412.105(f)(1)(iii)(A) and 413.78(b), no individual may be counted as more than one FTE in the calculation of Medicare GME payments.

For Medicare cost reports covering FYs 2006 and 2007, 66 hospitals[8] in MAC Jurisdiction 12 claimed GME reimbursement for residents who were claimed by more than 1 hospital for the same period and whose total FTE count exceeded 1. Specifically, those 66 hospitals overstated FTE counts for direct GME reimbursement by a total of 32.67 FTEs for FY 2006 and 28.36 FTEs for FY 2007. In addition, the 66 hospitals overstated FTE counts for indirect GME reimbursement by a total of 37.38 FTEs for FY 2006 and 29.43 FTEs for FY 2007.

Fifty of the sixty-six hospitals with overstated FTEs in MAC Jurisdiction 12 received excess Medicare GME reimbursement totaling $1,915,825. Specifically, we determined that these hospitals overstated, on Medicare cost reports for 2006 through 2009,[9] FTE counts for FYs 2006 and 2007. We determined this by using CMS's 3-year rolling average formula. The 50 hospitals overstated:

- direct GME reimbursement by $725,318 and

- indirect GME reimbursement by $1,190,507.

For the remaining 16 hospitals, the overstated FTEs did not have a dollar effect on Medicare GME reimbursement because 14 hospitals were still over their FTE caps[10] after adjusting the claimable direct and/or indirect FTE counts and the FTE adjustments for the remaining 2 hospitals were equal to 0 when rounded to the nearest hundredth.

The overstated FTE counts and excess reimbursement occurred because there was no Federal requirement for Highmark to review IRIS data that hospitals in MAC Jurisdiction 12 submitted to detect whether a resident had overlapping rotational assignments at more than one hospital. As a result, Highmark did not have procedures to adequately ensure that no resident was counted as more than one FTE in the calculation of Medicare GME payments.

[8] For FYs 2006 and 2007, the 66 hospitals claimed GME reimbursement totaling $486 million for direct GME and $1.1 billion for indirect GME.

[9] The 2006 FTE overstatements affected GME costs claimed on FYs 2007 and 2008 Medicare cost reports. The FY 2007 FTE overstatements affected GME costs claimed on FYs 2008 and 2009 Medicare cost reports.

[10] Section 1886 of the Social Security Act established caps on the number of residents that a hospital may claim for Medicare direct and indirect GME reimbursement.

RECOMMENDATIONS

We recommend that Highmark:

- recover $1,915,825 in excess Medicare GME reimbursement paid to 50 hospitals in MAC Jurisdiction 12,

- adjust the direct and indirect FTE counts claimed on the Medicare cost reports covering FYs 2006 and 2007 for each of the hospitals that did not always claim Medicare GME reimbursement in accordance with Federal requirements,

- consider developing procedures to ensure that no resident is counted as more than one FTE in the calculation of Medicare GME payments, and

- consider identifying and recovering any additional overpayments made to hospitals in MAC Jurisdiction 12 for residents whose FTE count exceeded one on Medicare cost reports submitted after FY 2007.

HIGHMARK MEDICARE SERVICES, INC., COMMENTS

In written comments on our draft report, Highmark generally concurred with our first and second recommendations, partially concurred with our fourth recommendation, and disagreed with our third recommendation. Specifically, Highmark agreed with the FTE overstatements and excess Medicare GME reimbursement identified. However, Highmark agreed to adjust only the FTE counts on 117 cost reports (out of a total of 152 cost reports with errors) and recover $1,814,426 in excess Medicare GME reimbursement. Highmark stated that it will not reopen 35 settled cost reports (with excess reimbursement totaling $101,399) because the overpayment amounts do not meet Highmark's materiality thresholds for reopening settled cost reports. Highmark cited a portion of section 2931.2 of CMS's *Provider Reimbursement Manual – Part 1* (CMS Publication 15-1) that addresses reopening cost reports based upon new and material evidence and stated that CMS allows contractors to establish their own reopening thresholds to determine if a potential reopening is considered material.

Highmark stated that it partially concurred with our fourth recommendation. Highmark indicated that it would continue to follow instructions contained in the MAC Jurisdiction 12 statement of work and make FTE adjustments based on the review of rotation schedules prepared by the hospitals. However, Highmark will not change its procedures or expand review efforts unless CMS issues a contract modification and/or technical direction letter. Similarly, Highmark disagreed with our third recommendation because there is no requirement for reviewing IRIS data in the MAC Jurisdiction 12 statement of work and CMS provides no funding to perform additional reviews of FTEs "outside the contracted desk review and audit programs."

Highmark's comments appear in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing Highmark's comments, we maintain that our findings and recommendations are valid. We have revised our report and first recommendation to reflect that, of the 66 hospitals with overstated FTEs, the overstatements for 50 of those hospitals had an effect on Medicare GME reimbursement.

The excess Medicare GME reimbursement amounts that we identified, including the $101,399 for 35 cost reports that Highmark has refused to reopen, are based upon FTE overstatements that are inconsistent with Federal regulations. Therefore, we maintain that Highmark should adjust the direct and indirect FTE counts claimed on all of the 152 cost reports and recover any excess Medicare reimbursement. CMS's *Provider Reimbursement Manual – Part 1* (CMS Publication 15-1) Section 2931.2 states:

> Reopening Final Determination.—Whether or not the intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions.

Contrary to 42 CFR §§ 412.105(f)(1)(iii)(A) and 413.78(b), which state that no individual may be counted as more than 1 FTE in the calculation of Medicare GME payments, the cost reports for the 66 hospitals included residents whose total FTE count exceeded 1. Because the excess Medicare GME reimbursement amounts for 35 cost reports that Highmark will not reopen are material and based upon FTE overstatements that are inconsistent with Federal regulations, we recommend that Highmark reopen the 35 cost reports and recover the $101,399 in excess Medicare GME reimbursement. In addition, Highmark's thresholds for reopening settled cost reports are guidelines and not Federal regulations.

APPENDIX

APPENDIX: HIGHMARK MEDICARE SERVICES, INC., COMMENTS

Medicare
Part A

September 8, 2011

Mr. James P. Edert
Regional Inspector General for Audit Services
Office of Inspector General – Region II
Jacob Javits Federal Building
26 Federal Plaza – Room 3900
New York, NY 10278

RE: A-02-09-01019

Dear Mr. Edert:

We received your draft report (A-02-09-01019) dated August 12, 2011, regarding the review of data reported in the Intern and Resident Information System (IRIS) for Medicare cost reports submitted to Highmark Medicare Services, Inc. (HMS). Detailed below are the four recommendations contained in your report, and HMS' responses.

First OIG recommendation: Recover $1,915,825 in excess Medicare GME reimbursement paid to 66 hospitals in Jurisdiction 12.

HMS response: HMS concurs with the recommendation with the following clarifications.

1. The OIG tested 66 hospitals within Jurisdiction 12 for potential overpayments related to resident FTEs. Each of the 66 hospitals were reviewed for reporting periods from 2006 through 2009, in total the OIG reviewed 264 (66 X 4) cost reports. Of the 264 cost reports subject to the OIG review, 112 were not overpaid according to the OIG's testing results. Additionally, the overpayment amounts identified by the OIG were for both IME and GME reimbursement. As a result the OIG recommendation should be revised as follows; Recover $1,915,825 in excess Medicare IME and GME reimbursement on 152 of 264 cost reports tested in Jurisdiction 12.

2. Of the 264 cost reports tested, 109 have not been final settled (i.e. The Notice of Program Reimbursement – NPR has not been issued to the hospital), these cost reports are not subject to reopening thresholds and will be settled with the resident adjustments identified by the OIG regardless of materiality. HMS is holding these cost reports from settlement based on CMS instructions related to the national SSI ratios and NJ disproportionate share (DSH) issues. Based on the schedule attached, 109 cost reports will be settled with an expected recovery of approximately $1,594,065. HMS will process these settlements timely in accordance with CMS instructions including instructions related specifically to settling SSI and NJ DSH cost reports. To date CMS has not issued instructions relating to the settlement of open cost reports with SSI/DSH reimbursement.

3. Of the 264 cost reports, eight cost reports (that were not held open due to the SSI/DSH noted above), have been final settled and the OIG overpayment amount exceeds the HMS' reopening thresholds. These cost reports will be reopened and adjusted for the OIG recommendation. The eight cost reports that will be reopened total $220,361 of the total OIG overpayment.

HIGHMARK.
MEDICARE SERVICES
A CMS CONTRACTOR
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Camp Hill, PA 17089
www.highmarkmedicareservices.com

4. Of the 264 cost reports, 35 cost reports (that were not held open due to the SSI/DSH noted above), have been final settled. For these cost reports the OIG overpayment amount does not meet HMS' reopening thresholds (materiality levels) and will not be adjusted for the OIG recommendation. The 35 cost reports that will not be reopened total $101,399 of the total OIG overpayment. CMS Publication 15-1, Section 2931.2, states "Whether or not the intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted..." CMS allows contractors to establish their own reopening thresholds to determine if a potential reopening is considered material. HMS has defined material reopening evidence as follows:

Hospitals, SNFs and Specialties:	
Total Medicare Reimbursement	Reimbursement Impact of reopening
$5,000,000 and over	At least $10,000
$1,000,000 to $4,999,999	At least $5,000
$500,000 to $999,999	At least $3,500
Up to $499,999	At least $750

As an example, a hospital with $5;000,000 and over in total Medicare reimbursement for a cost report period would have to have a reopening that impacts Medicare reimbursement by at least $10,000. In this example, any potential reopening under $10,000 would not meet HMS' threshold for reopening, therefore, no reopening would be processed.

Summary (See attached schedule for details):

	Recovery	Cost Reports
OIG Recommendation	$1,915,825	152
HMS expected impact – open settlements	$1,594,065	109
HMS expected impact – reopenings (above threshold)	$ 220,361	8
Total HMS expected impact/collections	$1,814,426	117
Reopenings below HMS threshold (will not be processed)	$ 101,399	35
Totals agree with OIG recommendation	$1,915,825	152
Cost reports that had no overpayments per the OIG	0	112
Total of all cost reports reviewed	$1,915,825	264

Second OIG recommendation: Adjust the direct and indirect FTE counts claimed on the Medicare cost reports covering FYs 2006 and 2007 for each of the 66 hospitals that did not always claim Medicare GME reimbursement in accordance with Federal requirements.

HMS response: HMS concurs with the recommendation with the following clarifications.

The HMS response given for the first OIG recommendation applies also to this second OIG recommendation. For all years (2006 – 2009), HMS will adjust the FTE counts for 117 cost reports with an expected recovery of $1,814,426.

Third OIG recommendation: Consider developing procedures to ensure that no resident is counted as more than one FTE in the calculation of Medicare GME payments.

HMS response: HMS does not concur with this recommendation.

We appreciate the OIG statement on page ii of the draft report which states: "The overstated FTE counts and excess reimbursement occurred because there was no Federal requirement for Highmark to review IRIS data that hospitals in MAC Jurisdiction 12 submitted to detect whether a resident had overlapping rotational assignments at more than one hospital." HMS as a Medicare Administrative Contractor (MAC) follows CMS instructions as contained in the J12 contracted Statement of Work (SOW).

Further, the J12 SOW item C.5.11.3.3.11 states; "The Contractor shall implement and notify providers that train residents in approved graduate medical education (GME) programs of all Intern and Resident Information System (IRIS) updates in accordance with CMS instructions provided in periodic change requests (CRs)." Again, there is no requirement in the J12 SOW and CMS provides no funding for HMS to perform additional FTE reviews outside the contracted desk review and audit programs.

HMS will continue to review FTEs in accordance with CMS expectations and instructions but will not change our procedures or expand our review efforts unless CMS issues a contract modification and or technical direction letter from the CMS-Contracting Officer's Technical Representative (COTR).

Fourth OIG recommendation: Consider identifying and recovering any additional overpayments made to hospitals in MAC Jurisdiction 12 for residents whose FTE count exceeded one on Medicare cost reports submitted after FY 2007.

HMS response: HMS partially concurs with this recommendation.

HMS is contracted by CMS to follow the instructions contained in the J12 Statement of Work (SOW). HMS testing of FTEs is based on the review of rotation schedules as prepared by the hospitals (not IRIS data). During the testing of rotation schedules, we do identify duplicates and other issues that require us to adjust the FTE counts. When we identify an issue, we will continue to follow CMS instructions and make FTE adjustments as contracted, but will not change or expand our review efforts unless CMS issues a contract modification and or technical direction letter from the CMS-COTR.

If you have any questions or comments concerning this response, please contact me at 443-886-2808 or through email at adam.weber@highmarkmedicareservices.com.

Sincerely,

Adam Weber
Director, Provider Audit
Highmark Medicare Services, Inc.

Summary of OIG Adjustments After Exit Conference
Incorporates Revisions Made Based on Information Provided by Highmark

	FTE Audit Adjustment				GME EFFECT				IME EFFECT								
Prov #	GME 2006	IME 2006	GME 2007	IME 2007	2006	2007	2008	2009	2006	Total 2006	2007	Total 2007	2008	Total 2008	2009	Total 2009	Total Overpayments
080001	2.1973	2.1972	0.1395	0.1395	$100,046	$7,611	$1,391	$460	$108,673	$208,719	$0	$7,611	$0	$1,391	$0	$460	$218,121
083300	1.6899	2.6137	0.0959	0.0959	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
090003	0.2765	0.4671	0.0808	0.0822	$3,867	$4,328	$4,628	$836	$0	$3,867	$11,957	$15,925	$5,090	$9,718	$0	$836	$30,346
090004	1.2342	1.2342	1.7474	1.7573	$1,322	$2,318	$2,791	$1,387	$0	$1,223	$0	$2,318	$0	$2,791	$0	$1,287	$7,719
090005	0.0014	0.0027	0.0014	0.0027	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
090006	0.0244	0.0744	0.4688	0.4688	$0	$7,825	$8,150	$7,153	$0	$0	$1,322	$9,147	$12,057	$20,207	$0	$7,153	$36,507
090011	1.2227	1.0356	1.0397	0.4395	$20	$211	$0	$0	$0	$20	$0	$211	$0	$0	$0	$0	$231
093025	0.0849	0.0849	0.6130	0.8236	$1,054	$7,949	$8,657	$7,065	$0	$1,054	$0	$7,949	$0	$8,657	$0	$7,065	$24,725
093300	0.4332	0.0000	1.0590	0.0000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
094001	0.0600	0.0000	0.0101	0.0000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
310001	3.4685	4.0959	1.0658	1.2192	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
310002	0.0411	0.0411	0.5348	0.5553	$0	$261	$259	$263	$0	$0	$0	$261	$0	$259	$0	$263	$783
310010	3.1858	3.7578	2.2274	2.4137	$2,604	$3,404	$3,395	$1,383	$34,895	$37,499	$0	$3,404	$0	$3,395	$0	$1,383	$45,681
310014	2.1249	2.2907	1.6416	1.8951	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
310015	0.0110	0.0110	0.0767	0.0767	$0	$444	$450	$0	$0	$0	$0	$444	$0	$450	$0	$0	$894
310019	0.6247	0.7479	-	-	$21,677	$0	$0	$0	$0	$21,677	$0	$0	$0	$0	$0	$0	$21,677
310021	-	-	0.0247	0.0247	$0	$928	$0	$393	$0	$0	$957	$1,885	$0	$0	$0	$393	$2,278
310022	0.1192	0.1192	-	-	$1,991	$1,961	$2,189	$0	$1,424	$5,415	$10,211	$12,172	$3,930	$6,119	$0	$0	$22,706
310027	0.0212	0.0212	0.2110	0.4219	$318	$0	$0	$0	$0	$318	$0	$0	$0	$0	$0	$0	$318
310029	0.0016	0.0016	0.0031	0.0031	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
310031	0.0068	0.0127	0.0438	0.0877	$0	$760	$1,600	$774	$0	$0	$1,424	$2,184	$11,942	$13,542	$0	$774	$16,500
310038	2.0000	2.1726	1.4055	1.5205	$917	$892	$945	$726	$0	$917	$0	$892	$0	$945	$0	$726	$3,480
310039	0.0424	0.0836	0.1203	0.1556	$821	$5,012	$4,148	$3,212	$0	$821	$6,854	$11,866	$13,818	$17,966	$0	$3,212	$33,865
310040	0.2027	0.2027	0.2055	0.2055	$0	$8,168	$4,647	$1,210	$0	$0	$9,175	$17,242	$2,458	$7,105	$1,192	$2,402	$26,850
310048	0.0959	0.0959	0.1178	0.1933	$1,320	$2,262	$3,302	$1,876	$0	$1,320	$0	$3,262	$0	$3,302	$0	$1,876	$9,760
310051	-	-	0.0767	0.0767	$0	$1,227	$1,904	$1,220	$0	$0	$0	$1,227	$0	$1,904	$0	$1,220	$4,351
310054	0.0022	0.0959	-	-	$7,440	$2,512	$2,787	$0	$0	$7,440	$0	$2,512	$0	$2,787	$0	$0	$7,739
310057	0.5248	0.5666	0.0051	0.0051	$8,244	$8,447	$7,994	$464	$16,546	$24,790	$19,412	$27,859	$3,126	$9,120	$0	$464	$62,233
310061	-	-	0.0849	0.0849	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
310070	0.3562	0.3562	0.9808	1.0192	$3,299	$14,694	$14,443	$9,715	$0	$3,299	$22,827	$37,521	$66,037	$80,480	$0	$9,715	$131,013
310073	1.2685	1.4767	2.0658	2.5945	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
310075	0.5863	0.5863	0.3247	0.3260	$4,859	$7,847	$8,221	$2,827	$0	$4,859	$19,628	$27,475	$18,488	$26,709	$6,778	$9,605	$68,648
310086	0.1286	0.1286	0.0463	0.0463	$54	$0	$80	$28	$0	$54	$0	$0	$0	$80	$0	$28	$362
310093	0.0301	0.0301	-	-	$558	$530	$0	$0	$0	$558	$0	$530	$0	$0	$0	$0	$1,088
310052	0.0849	0.0849	0.0164	0.0164	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
310096	1.1329	1.5945	0.7548	0.9232	$15,803	$25,841	$27,311	$19,555	$59,985	$75,788	$168,415	$195,256	$93,324	$120,635	$54,123	$44,678	$436,357
310108		-	0.0055	0.0055	$0	$741	$0	$0	$0	$0	$0	$741	$1,180	$1,180	$1,324	$1,324	$3,245
310119	1.2301	1.1507	1.3877	1.6904	$496	$0	$0	$0	$0	$496	$0	$0	$0	$0	$0	$0	$496
390001	0.0767	0.0767	0.0767	0.0767	$3,256	$1,134	$1,229	$1,275	$3,434	$6,690	$2,520	$3,653	$3,581	$3,812	$0	$1,275	$15,430
390002	0.0479	0.0479	-	-	$2,691	$0	$0	$0	$2,252	$4,943	$0	$0	$0	$0	$0	$0	$4,943
390006	0.1781	0.1781	-	-	$1,968	$1,975	$2,020	$0	$5,026	$7,994	$5,275	$7,250	$0	$2,020	$0	$0	$16,864
390024	0.0435	0.0435	-	-	$360	$0	$0	$0	$946	$1,306	$0	$0	$0	$0	$0	$0	$1,306
390027	0.0877	0.0877	0.0110	0.0110	$864	$1,150	$886	$292	$0	$864	$0	$1,150	$0	$886	$0	$292	$3,192
390028	1.4802	1.4700	0.5561	0.5561	$27,266	$38,329	$19,594	$10,754	$0	$27,266	$92,090	$130,419	$20,532	$40,126	$0	$10,754	$208,965
390042	0.0767	0.0767	0.1699	0.1699	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
390046	0.0438	0.0274	0.1315	0.1725	$0	$0	$0	$60	$0	$0	$4,904	$4,904	$18,200	$18,200	$0	$60	$23,164
390049	0.0151	0.0301	-	-	$483	$451	$504	$0	$0	$483	$0	$481	$0	$504	$0	$0	$1,468
390050	0.9005	0.9506	1.1080	1.2190	$1,077	$964	$1,013	$273	$0	$1,077	$0	$964	$0	$1,013	$0	$273	$3,327
390063	-	-	0.3315	0.3315	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
390066	0.0477	0.0477	-	-	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
390067	0.5690	0.6255	0.1145	0.1720	$7,955	$9,612	$9,821	$1,816	$0	$7,955	$60,674	$70,286	$25,170	$35,091	$4,186	$6,002	$119,334
390081	0.2167	0.2093	0.2458	0.2531	$5,637	$10,730	$11,554	$5,811	$5,186	$10,823	$15,416	$26,146	$18,249	$29,803	$8,434	$12,215	$79,987
390090	0.4027	0.4537	0.5012	0.5161	$5,446	$12,137	$12,477	$6,401	$11,071	$16,517	$30,419	$42,556	$19,424	$31,901	$0	$6,401	$97,375
390113	-	-	0.4301	0.4493	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
390115	-	-	0.2521	0.2521	$0	$830	$878	$867	$0	$0	$0	$830	$0	$878	$0	$867	$2,575
390116	0.2438	0.2438	0.5041	0.4192	$3,541	$11,553	$12,169	$7,619	$7,301	$10,842	$22,893	$34,446	$22,776	$34,895	$0	$7,619	$87,802
390133	0.1267	0.2514	-	-	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
390142	0.0066	0.0066	0.5159	0.5159	$0	$544	$560	$523	$0	$0	$0	$544	$0	$560	$0	$523	$1,627
390156	0.0384	0.0384	-	-	$628	$618	$1,273	$0	$0	$628	$3,197	$3,815	$894	$2,167	$0	$0	$6,610
390164	0.0270	0.0421	0.1672	0.1744	$309	$0	$467	$979	$0	$309	$0	$0	$0	$467	$0	$979	$1,955
390180	0.3178	0.3589	0.2260	0.2260	$473	$463	$0	$0	$0	$473	$0	$463	$0	$0	$0	$0	$936
390196	0.0585	0.1036	0.8000	0.8000	$0	$1,616	$1,317	$1,669	$0	$0	$0	$1,616	$0	$1,317	$0	$1,669	$4,602
390198	-	-	0.7096	0.7096	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
390256	2.7329	4.2329	2.3167	2.5027	$0	$0	$0	$1,925	$0	$0	$0	$0	$0	$0	$0	$1,925	$1,925
390267	0.0767	0.0767	0.0110	0.0110	$1,317	$1,323	$2,076	$711	$0	$1,317	$6,938	$8,261	$2,076	$4,752	$0	$711	$13,041
393302	0.2356	0.3041	0.4968	0.5738	$0	$0	$0	$12	$0	$0	$0	$0	$0	$0	$0	$12	$12
66	**32.6663**	**37.3751**	**28.3565**	**29.4278**	**$235,082**	**$210,622**	**$187,130**	**$92,484**	**$259,339**		**$517,157**		**$360,004**		**$54,007**		**$1,915,825**

	Amount Collectible	# of Cost Reports
Cost report not finalized, OIG adjustments will be implemented	$1,594,665	109
Cost report finalized, OIG adjustments meet materiality thresholds, reopening will be performed	$220,361	8
Total to be collected	$1,814,426	117
Cost report settled, OIG adjustments do not meet materiality thresholds, no reopening will be performed	$101,399	35
Cost reports with no overpayment identified by the OIG	$0	112
Total OIG Recommendation	$1,915,825	264 (66 hospitals X 4 years = 264 cost reports)