DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION II
JACOB K. JAVITS FEDERAL BUILDING
26 FEDERAL PLAZA, ROOM 3900
NEW YORK, NY 10278

April 2, 2012

Report Number: A-02-10-01006

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., and National Government 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-02-10-01006 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., AND NATIONAL GOVERNMENT SERVICES, INC.

Daniel R. Levinson
Inspector General

April 2012
A-02-10-01006

Office of Inspector General

http://oig.hhs.gov

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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.

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 training time those residents spend working at that 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 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.

National Government Services, Inc. (NGS) is a MAC under contract with CMS to administer the Medicare Part A program for MAC Jurisdiction 13, which consists of two States—New York and Connecticut. For FY ended 2006, 139 hospitals in MAC Jurisdiction 13 collected and reported information to the IRIS on residents. In FY ended 2007, the figure was 137 hospitals.

OBJECTIVE

The objective of our review was to determine whether hospitals in MAC Jurisdiction 12 claimed Medicare GME reimbursement for residents also claimed by hospitals in MAC Jurisdiction 13 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, 36 hospitals in MAC Jurisdiction 12 overstated direct and/or indirect FTE counts on cost reports covering FYs 2006 and 2007 for residents who were also included in the FTE counts on cost reports submitted by hospitals in MAC Jurisdiction 13. As a result, 29 of these 36 hospitals received excess Medicare GME reimbursement totaling $221,772 for residents who were also claimed by hospitals in MAC Jurisdiction 13 for the same period and counted in the IRIS as more than one FTE. For the remaining seven 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 compare IRIS data submitted by hospitals in its jurisdiction to IRIS data submitted by hospitals in other MAC jurisdictions to detect whether a resident had overlapping rotational assignments. As a result, Highmark did not have procedures to ensure that residents working at hospitals in different MAC jurisdictions were not counted as more than one FTE in the calculation of Medicare GME payments.

RECOMMENDATIONS

We recommend that Highmark:

- recover $221,772 in excess Medicare GME reimbursement paid to 29 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 did always claim Medicare GME reimbursement in accordance with Federal requirements,

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

- consider working with NGS to identify and recover any additional overpayments made to hospitals in MAC Jurisdiction 12 for residents also claimed by hospitals in MAC Jurisdiction 13 and for whom the 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 did not concur with our findings and partially agreed with our recommended financial disallowance. Specifically, Highmark agreed that the FTE counts on 68 cost reports (out of a total of 85 cost reports with overpayments) should be adjusted for duplicate residents. However, it described multiple reasons for why its

determinations of final overpayment amounts and FTE counts may differ from ours and indicated that, without CMS approval to adjust workloads, it will not have the resources to review and incorporate our findings into the settlement of the 68 cost reports. Highmark stated that it will not reopen 17 settled cost reports (with excess reimbursement totaling $31,021) because the overpayment amounts do not meet Highmark's materiality thresholds for reopening settled cost reports. Further, Highmark indicated that there is no requirement in the MAC Jurisdiction 12 statement of work to identify duplicate residents in other MAC jurisdictions and that CMS does not provide funding for this. Highmark stated that it would continue to review FTEs in accordance with CMS instructions but that it would not change its procedures or expand review efforts unless CMS issues a contract modification and/or technical direction letter.

After reviewing Highmark's comments, we maintain that our findings and recommendations are valid. Highmark's comments are included in their entirety as the Appendix.

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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 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 the hospitals 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 submit, with each annual Medicare cost report, IRIS data files that contain information on their

[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.

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 2006, 133 hospitals in Jurisdiction 12 collected and reported information to the IRIS on residents. In FY ended 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.

National Government Services, Inc.

National Government Services, Inc. (NGS), is a MAC under contract with CMS to administer the Medicare Part A program for MAC Jurisdiction 13, which consists of two States—New York and Connecticut. For FY ended 2006, 139 hospitals in Jurisdiction 13 collected and reported information to the IRIS on residents. In FY ended 2007, the figure was 137 hospitals.

For FYs 2006 and 2007, hospitals in MAC Jurisdiction 13 claimed GME reimbursement totaling $1.5 billion for direct GME and $2.6 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 also claimed by hospitals in MAC Jurisdiction 13 in accordance with Federal requirements.

[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.

Scope

We reviewed IRIS data that hospitals in MAC Jurisdictions 12 and 13 submitted to support resident training costs claimed on annual Medicare cost reports covering FYs 2006 and 2007. We previously issued a report (A-02-09-01019) to Highmark on resident data reported in the IRIS by hospitals within its jurisdiction. In addition, we will be issuing a separate report (A-02-10-01007) to NGS on hospitals in MAC Jurisdiction 13 that claimed Medicare GME reimbursement for residents also claimed by hospitals in MAC Jurisdiction 12.

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.

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 other MAC jurisdictions;
- obtained FYs 2006 and 2007 IRIS data from Highmark and NGS for all hospitals in MAC Jurisdictions 12 and 13, respectively;
- analyzed the IRIS data to identify residents claimed by at least one hospital in MAC Jurisdiction 12 and at least one hospital in MAC Jurisdiction 13 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 hospitals in MAC Jurisdictions 12 and 13 for each resident whose total FTE count exceeded one to determine which hospital should have claimed Medicare GME reimbursement for the resident during the 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

[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.

- 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 findings and conclusions based on our audit objective.

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, 36[8] hospitals in MAC Jurisdiction 12 claimed GME reimbursement for residents who were also claimed by at least one hospital in MAC Jurisdiction 13 for the same period and whose total FTE count exceeded one. Specifically, these 36 hospitals overstated FTE counts for direct GME reimbursement by a total of 2.93 FTEs for FY 2006 and 4.70 FTEs for FY 2007. In addition, the 36 hospitals overstated FTE counts for indirect GME reimbursement by a total of 3.05 FTEs for FY 2006 and 5.39 FTEs for FY 2007.

Twenty-nine of the thirty-six hospitals with overstated FTEs received excess Medicare GME reimbursement totaling $221,772. 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 29 hospitals overstated:

- direct GME reimbursement by $120,621, and

- indirect GME reimbursement by $101,151.

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

[8] For FYs 2006 and 2007, the 36 hospitals claimed GME reimbursement totaling $348 million for direct GME and $827 million 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.

For the remaining seven hospitals, the overstated FTEs did not have a dollar effect on Medicare GME reimbursement because five hospitals were still over their FTE caps[10] after adjusting the claimable direct and/or indirect FTE counts and the FTE adjustments for the other two hospitals was 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 compare IRIS data submitted by hospitals in its jurisdiction to IRIS data submitted by hospitals in other MAC jurisdictions to detect whether a resident had overlapping rotational assignments. As a result, Highmark did not have procedures to ensure that residents working at hospitals in different MAC jurisdictions were not counted as more than one FTE in the calculation of Medicare GME payments.

RECOMMENDATIONS

We recommend that Highmark:

- recover $221,772 in excess Medicare GME reimbursement paid to 29 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 working at hospitals in different MAC jurisdictions is counted as more than one FTE in the calculation of Medicare GME payments, and

- consider working with NGS to identify and recover any additional overpayments made to hospitals in MAC Jurisdiction 12 for residents also claimed by hospitals in MAC Jurisdiction 13 and for whom the 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 did not concur with our findings and partially agreed with our recommended financial disallowance. Specifically, Highmark agreed that the FTE counts on 68 cost reports (out of a total of 85 cost reports with overpayments) should be adjusted for duplicate residents. However, it described multiple reasons for why its determinations of final overpayment amounts and FTE counts may differ from ours and indicated that, without CMS approval to adjust workloads, it will not have the resources to review and incorporate our findings into the settlement of the 68 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.

Highmark indicated that its determinations of final overpayment amounts and FTE counts may differ because: (1) we used IRIS data as source documentation and a review of the hospital's rotation schedules and the FTEs claimed on cost reports may differ from the FTEs reported in IRIS, (2) any change in the resident counts may impact the resident-to-bed ratio and could result in changes to the overpayment amounts we identified, (3) the hospitals may provide new evidence that could change the overpayment, and (4) of the 85 cost reports with overpayments, 68 have not been final settled and the savings may change when they are settled.

Although Highmark agreed that the FTE counts on the 68 cost reports that have not been settled should be adjusted for duplicate residents, it stated that it will not reopen 17 settled cost reports (with excess reimbursement totaling $31,021) 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.

In response to our last two recommendations, Highmark indicated that there is no requirement in the MAC Jurisdiction 12 statement of work to identify duplicate residents in other MAC jurisdictions and that CMS does not provide funding for this. Highmark stated that it would continue to review FTEs in accordance with CMS instructions but that it would not change its procedures or expand review efforts unless CMS issues a contract modification and/or technical direction letter.

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 also acknowledge that Highmark's final overpayment amounts and FTE counts may differ from ours when it settles the cost reports for hospitals in MAC Jurisdiction 12. However, the excess Medicare GME reimbursement we identified was based on adjusting the claimable direct and/or indirect FTE counts for hospitals that claimed a resident in excess of one FTE. In addition, we only used IRIS data to identify residents claimed by at least one hospital in MAC Jurisdiction 12 and at least one hospital in MAC Jurisdiction 13 for the same rotational assignment (i.e., IRIS data was not the sole source for our FTE adjustments). Rather, our FTE adjustments were based on reviewing rotation schedules and other documentation from hospitals in MAC Jurisdictions 12 and 13 for each resident whose total FTE count exceeded one. Accordingly, each hospital that claimed a resident in excess of one FTE has been notified and given the opportunity to provide information as to which hospital should have claimed the resident.

The excess Medicare GME reimbursement amounts that we identified, including the $31,021 for 17 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 85 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, cost reports for hospitals in MAC Jurisdiction 12 included residents whose total FTE count exceeded 1. Because the excess Medicare GME reimbursement amounts for 17 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 17 cost reports and recover the $31,021 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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare
Part A

February 22, 2012

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-02-10-01006

Dear Mr. Edert:

We received your draft report (A-02-10-01006) and cover letter dated January 23, 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) and National Government Services, Inc. (NGS). Detailed below are the four recommendations contained in your report, and HMS' responses.

I. **First OIG recommendation:** Recover $221,772 in excess Medicare GME reimbursement paid to 29 hospitals in Jurisdiction 12.

HMS response:
HMS does not concur with this finding, based on the following:

- The OIG's estimated overpayment amount may be different from the final overpayment determined by HMS for the following reasons:
  - A review of the hospital's rotation schedules and the FTEs claimed on the cost report may be different from the FTEs reported on IRIS. Since the source document used by the OIG was the IRIS; we could find differences when comparing to the rotation schedules or the FTEs claimed on the cost report that could result in a different overpayment amount.
  - Any changes in the resident counts can impact the resident to bed ratio that could result in changes to the OIG overpayment amounts.
  - Once HMS presents the audit adjustments for the duplicate residents to the hospitals, the hospitals may provide new evidence that could change the overpayment.
  - Of the 144 cost reports (see summary of cost reports below), there are a total of 68 cost reports that have never been final settled, where the OIG overpayments are based on the as-filed cost report. These savings may change once all the adjustments including updating settlement and payment data are made and the cost report is final settled.

Based on the above, HMS believes the final overpayment determinations will be different from the OIG's overpayment amounts. Therefore, HMS does not concur with the OIG overpayment amounts. Although HMS does not concur with the OIG overpayment amounts, HMS does agree that the 68 cost reports should be adjusted and settled for any duplicate residents.

- Of the 144 cost reports, there are 17 cost reports (that were not held open due to the SSI/DSH issue), 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 as recommended

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by the OIG. The cost reports that will not be reopened total $31,021 of the total OIG estimated 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. As discussed with CMS, HMS does not concur to reopen any cost reports that are under our reopening thresholds.

Timing of settling the 68 cost reports:
As noted above of the 144 cost reports tested, 68 have not been final settled, these cost reports are not subject to reopening thresholds and will be settled with the resident adjustments determined by HMS 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. 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. As a result, HMS is waiting for CMS instruction and cannot commit to a time frame for settling these cost reports.

Resources to settle the 68 cost reports:
To proceed with this additional unplanned work (68 open settlements), HMS will need to obtain CMS approval to reduce the OY 4 audit plan. Without CMS approval to adjust workloads, HMS will not have the resources to review and incorporate the OIG findings into the settlement of the 68 cost reports.

Summary of OIG Overpayments by Cost Reports:
The OIG tested 36 hospitals within MAC Jurisdiction 12 for potential overpayments related to resident FTEs that were also claimed by hospitals in MAC Jurisdiction 13. Each of the 36 hospitals were reviewed for reporting periods 2006 through 2009, in total the OIG reviewed 144 (36 X 4) cost reports. Of the 144 cost reports subject to the OIG review, 59 were not overpaid according to the OIG's testing results. See additional cost report information below:

	Recovery	Cost Reports
OIG Recommendation	$ 221,772	85
Open settlements (cost report not finalized)	$ 190,751	68
Reopenings (above threshold)	$ 0	0
Total OIG expected impact/collections	$ 190,751	68
Reopenings below HMS threshold (will not be processed)	$ 31,021	17
Totals agree with OIG recommendation	$ 221,772	85
Cost reports that had no overpayments per the OIG	0	59
Total of all cost reports reviewed	$ 221,772	144

II. **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 hospitals that did not always claim Medicare GME reimbursement in accordance with Federal requirements.

HMS response:
HMS does not concur with this finding, based on the following:

- The OIG's FTE counts may differ from the final FTE count determined by HMS for the following reasons:
    - A review of the hospital's rotation schedules and the FTEs claimed on the cost report may be different from the FTEs reported on IRIS. Since the source document used by the OIG was the IRIS we could find differences when comparing to the rotation schedules or the FTEs claimed on the cost report that could result in different FTE amounts.

- Any changes in the resident counts can impact the resident to bed ratio that could result in changes to the OIG overpayment amounts.
- Once HMS presents the audit adjustments for the duplicate residents to the hospitals, the hospitals may provide new evidence that could change the FTE counts.

Based on the above, HMS believes the final FTE count determinations will be different from the OIG's FTEs. Therefore, HMS does not concur with the OIG FTE counts. Although HMS does not concur with the OIG FTEs, HMS does agree that the 68 cost reports should be adjusted and settled for any duplicate residents.

- Of the 144 cost reports, there are 17 cost reports (that were not held open due to the SSI/DSH issue), 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 as recommended by the OIG. 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. As discussed with CMS, HMS does not concur to reopen any cost reports that are under our reopening thresholds.

Timing of settling the 68 cost reports:
As noted above of the 144 cost reports tested, 68 have not been final settled, these cost reports are not subject to reopening thresholds and will be settled with the resident adjustments determined by HMS 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. 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. As a result, HMS is waiting for CMS instruction and cannot commit to a time frame for settling these cost reports.

Resources to settle the 68 cost reports:
To proceed with this additional unplanned work (68 open settlements), HMS will need to obtain CMS approval to reduce the OY 4 audit plan. Without CMS approval to adjust workloads, HMS will not have the resources to review and incorporate the OIG findings into the settlement of the 68 cost reports.

III. **Third OIG recommendation:** Consider developing procedures to ensure that no resident working at hospitals in different MAC jurisdictions is counted as more than one FTE in the calculation of Medicare GME payments.

HMS response:
HMS does not concur with this finding, based on the following:
There is no specific requirement in the J12 SOW and CMS provides no funding for HMS to review for duplicate residents in other MAC jurisdictions. 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)." In addition, any sharing of data including protected health information between HMS and NGS would require CMS approval and a Joint Operating Agreement (JOA) between the organizations.

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).

IV. **Fourth OIG recommendation:** Consider working with NGS to identify and recover any additional overpayments made to hospitals in MAC Jurisdiction 12 for residents also claimed by hospitals in MAC Jurisdiction 13 and for whom the FTE count exceeded one on Medicare cost reports submitted after FY 2007.

HMS response:

HMS does not concur with this finding, based on the following:

There is no specific requirement in the J12 SOW and CMS provides no funding for HMS to review for duplicate residents in other MAC jurisdictions. 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)." In addition, any sharing of data including protected health information between HMS and NGS would require CMS approval and a Joint Operating Agreement (JOA) between the organizations.

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).

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

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

CIN: A-02/10-01306
Review of IRIS Resident Duplication for Medicare GME/IME Cost Reports
For the period January 1, 2006 through December 31, 2007

Summary of Findings and FTE detail

HIGHMARK

Prov #	# of Residents 1	FTE Audit Adjustment: GME 2006	IME 2006	GME 2007	IME 2007	GME EFFECT: 2006	2007	2008	2009
063300	1	0.0014	0.0027			$ -	$ -	$ -	$ -
010004	1	0.0640	0.0640			$ -	$ -	$ -	$ -
010011	2			0.0975	0.1123	$ -	$ 413	$ 417	$ -
310001	1	0.1044	0.1044			$ -	$ -	$ 360	$ -
310002	7	0.0015	0.0015	0.1071	0.1071	$ -	$ 522	$ 259	$ -
310014	3	0.0082	0.0082	0.2110	0.3127	$ -	$ -	$ -	$ -
310015	4	0.1014	0.1014			$ 23	$ 24	$ 34	$ -
310017	9	0.0015	0.0015	0.4602	0.4677	$ 10,048	$ 492	$ 190	$ 275
310021	1			0.0137	0.0137	$ -	$ -	$ 800	$ -
310038	1	0.5408	0.5408	0.3256	0.3256	$ 976	$ 333	$ 989	$ 319
310040	20	0.1014	0.1014	0.0877	0.0877	$ 1,562	$ 3,308	$ 3,505	$ 1,753
310051	17	0.1041	0.1041	0.0021	0.3621	$ -	$ 516	$ 533	$ 577
310054	3	0.0675	0.0675			$ 1,627	$ 1,674	$ 1,858	$ -
310058	1			0.5341	0.4793	$ -	$ 2,722	$ 2,701	$ 2,544
310063	1			0.0056	0.3006	$ -	$ 1,021	$ 1,106	$ -
310064	1			0.4438	0.4408	$ -	$ 5,263	$ 6,037	$ 6,592
310070	16	0.1707	0.1707	0.0408	0.0408	$ 1,499	$ 2,012	$ 2,587	$ 304
310073	4	0.0640	0.0640	0.0080	0.0403	$ -	$ 51	$ -	$ -
310074	4	0.0640	0.0640	0.1153	0.1544	$ 595	$ 1,604	$ 1,877	$ 1,147
310075	1	0.0640	0.0640			$ 511	$ 786	$ 823	$ -
310076	7	0.1452	0.1452	0.0707	0.0707	$ 1,663	$ 2,077	$ 2,507	$ 1,129
310086	1			0.1071	0.1071	$ -	$ -	$ -	$ -
310090	2	0.1315	0.1315	0.0027	0.3027	$ 2,231	$ 2,651	$ -	$ -
310093	1			0.0116	0.0116	$ -	$ -	$ -	$ -
310096	2	0.0356	0.0712	0.0411	0.3822	$ 811	$ 1,250	$ 1,301	$ 425
330027	2	0.0102	0.0102	0.0425	0.3840	$ 304	$ 575	$ 607	$ 583
330029	1			0.0027	0.3027	$ -	$ -	$ -	$ -
330046	2	0.0137	0.0137	0.0805	0.3791	$ -	$ 28	$ 22	$ 30
330071	2	0.0104	0.0104	0.0137	0.3137	$ 300	$ 425	$ 421	$ -
330110	1			0.0164	0.3164	$ -	$ 532	$ -	$ 572
330115	4			0.4521	0.3041	$ -	$ 3,903	$ 3,096	$ 4,138
330133	1			0.0648	0.3645	$ -	$ 3,147	$ 21	$ 21
330140	5	0.0137	0.0137	0.0102	0.0102	$ 8	$ 1,280	$ 1,327	$ 1,808
330164	2	0.0808	0.1616	0.0808	0.1071	$ -	$ -	$ -	$ -
330166	1	0.3408	0.3408			$ 1,051	$ 1,829	$ 579	$ -
330250	1	0.2301	0.2301			$ 260	$ -	$ -	$ -
Totals	127	2.9093	3.0456	4.6960	5.3909	$ 35,502	$ 35,591	$ 54,904	$ 22,294

Prov #	IME EFFECT: 2006	Total 2006	2007	Total 2007	2008	Total 2008	2009	Total 2009	Total Overpayments
063300	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
010004	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
010011	$ -	$ -	$ -	$ 413	$ -	$ 417	$ -	$ -	$ 827
310001	$ -	$ -	$ -	$ -	$ -	$ 360	$ -	$ -	$ 360
310002	$ -	$ -	$ -	$ 522	$ -	$ 259	$ -	$ -	$ 781
310014	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
310015	$ -	$ 23	$ -	$ 24	$ -	$ 24	$ -	$ -	$ 71
310017	$ -	$ 10,048	$ -	$ 492	$ -	$ 190	$ -	$ 275	$ 11,005
310021	$ -	$ -	$ -	$ -	$ 1,323	$ 2,123	$ -	$ -	$ 2,123
310038	$ -	$ 976	$ -	$ 933	$ -	$ 989	$ -	$ 319	$ 3,217
310040	$ -	$ 1,562	$ 6,965	$ 10,273	$ 7,834	$ 11,339	$ -	$ 1,753	$ 24,927
310051	$ -	$ -	$ -	$ 516	$ -	$ 533	$ -	$ 577	$ 1,626
310054	$ -	$ 1,627	$ -	$ 1,674	$ -	$ 1,858	$ -	$ -	$ 5,159
310058	$ -	$ -	$ -	$ 2,722	$ -	$ 2,701	$ -	$ 2,544	$ 7,967
310063	$ -	$ -	$ -	$ 1,021	$ 1,706	$ 2,812	$ -	$ -	$ 3,833
310064	$ -	$ -	$ -	$ 5,263	$ -	$ 6,037	$ -	$ 6,592	$ 17,892
310070	$ -	$ 1,499	$ 11,999	$ 14,011	$ 3,298	$ 5,885	$ -	$ 304	$ 21,619
310073	$ -	$ -	$ -	$ 51	$ -	$ -	$ -	$ -	$ 51
310074	$ 732	$ 1,327	$ 2,178	$ 4,842	$ 7,297	$ 9,174	$ 3,131	$ 4,278	$ 19,621
310075	$ -	$ 511	$ 1,027	$ 1,813	$ -	$ 823	$ -	$ -	$ 3,147
310076	$ -	$ 1,663	$ 6,648	$ 8,725	$ 6,830	$ 9,337	$ -	$ 1,128	$ 20,873
310086	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
310090	$ -	$ 2,231	$ -	$ 2,651	$ -	$ -	$ -	$ -	$ 4,882
310093	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
310096	$ 2,266	$ 3,077	$ 7,443	$ 8,693	$ 5,540	$ 6,841	$ 3,300	$ 3,725	$ 22,336
330027	$ -	$ 304	$ -	$ 878	$ -	$ 607	$ -	$ 583	$ 2,372
330029	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
330046	$ -	$ -	$ 1,953	$ 1,981	$ 8,560	$ 8,582	$ -	$ 30	$ 10,593
330071	$ -	$ 393	$ 2,441	$ 2,867	$ 1,176	$ 1,597	$ 1,144	$ 1,144	$ 6,001
330110	$ -	$ -	$ -	$ 532	$ 1,075	$ 1,075	$ 1,031	$ 1,603	$ 3,210
330115	$ -	$ -	$ -	$ 3,903	$ -	$ 3,696	$ -	$ 4,138	$ 11,794
330133	$ -	$ -	$ 4,940	$ 8,096	$ -	$ 21	$ -	$ 21	$ 8,138
330140	$ -	$ 8	$ -	$ 1,285	$ -	$ 1,327	$ -	$ 1,808	$ 4,428
330164	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
330166	$ -	$ 1,051	$ -	$ 1,029	$ -	$ 579	$ -	$ -	$ 2,659
330250	$ -	$ 260	$ -	$ -	$ -	$ -	$ -	$ -	$ 260
Totals	$ 2,998		$ 45,273		$ 46,173		$ 8,606		$ 221,772

Prov #	GME and IME: Total 2006	Total 2007	Total 2008	Total 2009	Total
063300	$ -	$ -	$ -	$ -	$ -
010004	$ -	$ -	$ -	$ -	$ -
010011	$ -	$ 413	$ 417	$ -	$ 827
310001	$ -	$ -	$ 360	$ -	$ 360
310002	$ -	$ 522	$ 259	$ -	$ 781
310014	$ -	$ -	$ -	$ -	$ -
310015	$ 23	$ 24	$ 24	$ -	$ 71
310017	$ 10,048	$ 492	$ 190	$ 275	$ 11,005
310021	$ -	$ -	$ 2,123	$ -	$ 2,123
310038	$ 976	$ 933	$ 989	$ 319	$ 3,217
310040	$ 1,562	$ 10,273	$ 11,339	$ 1,753	$ 24,927
310051	$ -	$ 516	$ 533	$ 577	$ 1,626
310054	$ 1,627	$ 1,674	$ 1,858	$ -	$ 5,159
310058	$ -	$ 2,722	$ 2,701	$ 2,544	$ 7,967
310063	$ -	$ 1,021	$ 2,812	$ -	$ 3,833
310064	$ -	$ 5,263	$ 6,037	$ 6,592	$ 17,892
310070	$ 1,499	$ 14,011	$ 5,885	$ 304	$ 21,619
310073	$ -	$ 51	$ -	$ -	$ 51
310074	$ 1,327	$ 4,842	$ 9,174	$ 4,278	$ 19,621
310075	$ 511	$ 1,813	$ 823	$ -	$ 3,147
310076	$ 1,663	$ 8,725	$ 9,357	$ 1,128	$ 20,873
310086	$ -	$ -	$ -	$ -	$ -
310090	$ 2,231	$ 2,651	$ -	$ -	$ 4,882
310093	$ -	$ -	$ -	$ -	$ -
310096	$ 3,077	$ 8,693	$ 6,841	$ 3,725	$ 22,336
330027	$ 304	$ 878	$ 607	$ 583	$ 2,372
330029	$ -	$ -	$ -	$ -	$ -
330046	$ -	$ 1,981	$ 8,582	$ 30	$ 10,593
330071	$ 393	$ 2,867	$ 1,597	$ 1,144	$ 6,001
330110	$ -	$ 532	$ 1,075	$ 1,603	$ 3,210
330115	$ -	$ 3,960	$ 3,696	$ 4,138	$ 11,794
330133	$ -	$ 8,096	$ 21	$ 21	$ 8,138
330140	$ 8	$ 1,285	$ 1,327	$ 1,808	$ 4,428
330164	$ -	$ -	$ -	$ -	$ -
330166	$ 1,051	$ 1,029	$ 579	$ -	$ 2,659
330250	$ 260	$ -	$ -	$ -	$ 260
Totals	$ 26,560	$ 85,264	$ 79,126	$ 30,822	$ 221,773

# of MAC J12 Hospitals w/FTE Adjustments: 36

Total Direct GME Adjustment: $ 120,421

Total Indirect GME Adjustment: $ 101,101

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	Amount Collectible	# of Cost Reports
Cost report settled, OIG adjustments do not meet materiality thresholds, no reopening will be performed	$31,021	17
Cost reports with no overpayment identified by the OIG	$0	59
Cost report not finalized, OIG adjustments will be implemented	$190,751	68
Total OIG Recommendation	$ 221,772	144
Total Actually to be Collected	$190,751	

	2006	2007	2008	2009	Total
No overpayment	20	10	10	19	59
Under RO Threshold	15	24	25	17	81
Over RO Threshold	1	2	1	0	4
Totals	36	36	36	36	144