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-02-10-01007

Mr. Scott Kimbell
Director, Contract Administration-J13
National Government Services, Inc.
13550 Triton Park Boulevard
Louisville, KY 40223

Dear Mr. Kimbell:

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 National Government Services, Inc., and 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-02-10-01007 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 NATIONAL GOVERNMENT SERVICES, INC., AND HIGHMARK MEDICARE SERVICES, INC.

Daniel R. Levinson
Inspector General

April 2012
A-02-10-01007

# *Office of Inspector General*

http://oig.hhs.gov

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## 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.

National Government Services, Inc. (NGS) is a Medicare Administrative Contractor (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.

Highmark Medicare Services, Inc. (Highmark) is a 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.

### OBJECTIVE

The objective of our review was to determine whether hospitals in MAC Jurisdiction 13 claimed Medicare GME reimbursement for residents also claimed by hospitals in MAC Jurisdiction 12 in accordance with Federal requirements.

## SUMMARY OF FINDING

Hospitals in MAC Jurisdiction 13 did not always claim Medicare GME reimbursement for residents in accordance with Federal requirements. Specifically, 34 hospitals in MAC Jurisdiction 13 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 12. As a result, 24 of these 34 hospitals received excess Medicare GME reimbursement totaling $474,662 for residents who were also claimed by hospitals in MAC Jurisdiction 12 for the same period and counted in the IRIS as more than one FTE. For the remaining 10 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 NGS 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, NGS did not have procedures to ensure that residents working at hospitals in all other MAC jurisdictions were not counted as more than one FTE in the calculation of Medicare GME payments.

## RECOMMENDATIONS

We recommend that NGS:

- recover $474,662 in excess Medicare GME reimbursement paid to 24 hospitals in MAC Jurisdiction 13,

- 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 Highmark to identify and recover any additional overpayments made to hospitals in MAC Jurisdiction 13 for residents also claimed by hospitals in MAC Jurisdiction 12 and for whom the FTE count exceeded one on Medicare cost reports submitted after FY 2007.

## NATIONAL GOVERNMENT SERVICES, INC., COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, NGS did not concur with our recommendations. NGS stated that its statement of work for CMS does not require it to identify incorrect intern and resident FTE counts with other contractors and CMS does not provide funding for such work. In addition, NGS stated that it could not confirm the excess Medicare reimbursement identified because it does not have access to information provided to Highmark by hospitals in MAC Jurisdiction 12. Nevertheless, NGS indicated that it would pursue each recommendation if CMS were to modify its statement of work and provide funding for the effort required.

After reviewing NGS's comments, we maintain that our findings and recommendations are valid. NGS's comments appear 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.

**National Government Services, Inc.**

National Government Services, Inc. (NGS), is a Medicare Administrative Contractor (MAC)[3] 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.

For Medicare cost reports covering FYs 2006 and 2007, NGS reviewed IRIS data submitted by hospitals in MAC Jurisdiction 13 to identify any residents with overlapping rotational assignments at more than one hospital. Additionally, beginning with cost reports covering FY 2008, NGS compared IRIS data submitted by hospitals in MAC Jurisdictions 13, 14 (Massachusetts, New Hampshire, Vermont, Rhode Island and Maine) and 15 (Ohio and Kentucky) to identify residents with overlapping rotational assignments. However, as of October 1, 2010, NGS only reviews IRIS data to identify residents with overlapping rotations when a hospital's direct GME or indirect IME is selected for desk review or audit.

**Highmark Medicare Services, Inc.**

Highmark Medicare Services, Inc. (Highmark), is a 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 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.

[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.

## OBJECTIVE, SCOPE, AND METHODOLOGY

### Objective

The objective of our review was to determine whether hospitals in MAC Jurisdiction 13 claimed Medicare GME reimbursement for residents also claimed by hospitals in MAC Jurisdiction 12 in accordance with Federal requirements.

### 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-02-09-01021) to NGS on resident data reported in the IRIS by hospitals within its jurisdiction. In addition, we will be issuing a separate report (A-02-10-01006) to Highmark on hospitals in MAC Jurisdiction 12 that claimed Medicare GME reimbursement for residents also claimed by hospitals in MAC Jurisdiction 13.

We did not assess NGS'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 NGS officials to gain an understanding of NGS'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;[4]
- 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;

[4] 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.

- 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;[5] 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).[6]

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, 34[7] hospitals in MAC Jurisdiction 13 claimed GME reimbursement for residents who were also claimed by at least one hospital in MAC Jurisdiction 12 for the same period and whose total FTE count exceeded one. Specifically, these 34 hospitals overstated FTE counts for direct GME reimbursement by a total of 3.87 FTEs for FY 2006 and 2.51 FTEs for FY 2007. In addition, the 34 hospitals overstated FTE counts for indirect GME reimbursement by a total of 4.15 FTEs for FY 2006 and 2.57 FTEs for FY 2007.

Twenty-four of the thirty-four hospitals with overstated FTEs received excess Medicare GME reimbursement totaling $474,662. Specifically, we determined that these hospitals overstated, on Medicare cost reports for 2006 through 2009,[8] FTE counts for FYs 2006 and 2007. We determined this by using CMS's 3-year rolling average formula. The 24 hospitals overstated:

[5] According to NGS officials, 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.

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

[7] For FYs 2006 and 2007, the 34 hospitals claimed GME reimbursement totaling $641 million for direct GME and $1.1 billion for indirect GME.

[8] 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.

- direct GME reimbursement by $228,244, and

- indirect GME reimbursement by $246,418.

For the remaining 10 hospitals, the overstated FTEs did not have a dollar effect on Medicare GME reimbursement because the FTE adjustments for 5 hospitals was equal to 0 when rounded to the nearest hundredth, 4 hospitals were still over their FTE caps[9] after adjusting the claimable direct and/or indirect FTE counts, and the remaining 1 hospital was new to the GME program and had not yet claimed GME reimbursement at the time of our review.

The overstated FTE counts and excess reimbursement occurred because there was no Federal requirement for NGS 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, NGS did not have procedures to ensure that residents working at hospitals in MAC jurisdictions not administered by NGS were not counted as more than one FTE in the calculation of Medicare GME payments.

## RECOMMENDATIONS

We recommend that NGS:

- recover $474,662 in excess Medicare GME reimbursement paid to 24 hospitals in MAC Jurisdiction 13,

- 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 Highmark to identify and recover any additional overpayments made to hospitals in MAC Jurisdiction 13 for residents also claimed by hospitals in MAC Jurisdiction 12 and for whom the FTE count exceeded one on Medicare cost reports submitted after FY 2007.

## NATIONAL GOVERNMENT SERVICES, INC., COMMENTS

In written comments on our draft report, NGS did not concur with our recommendations. NGS stated that its statement of work for CMS does not require it to identify incorrect intern and resident FTE counts with other contractors and CMS does not provide funding for such work. In addition, NGS stated that it could not confirm the excess Medicare reimbursement identified

[9] 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.

because it does not have access to information provided to Highmark by hospitals in MAC Jurisdiction 12. Nevertheless, NGS indicated that it would pursue each recommendation if CMS were to modify its statement of work and provide funding for the effort required.

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

## OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing NGS's comments, we maintain that our findings and recommendations are valid. While NGS's statement of work for CMS does not require it 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, NGS is responsible for ensuring that the payments it makes to hospitals are in accordance with Federal regulations (Social Security Act §§ 1874(A) and 1886). The excess Medicare reimbursement amounts we identified are based upon FTE overstatements that are inconsistent with Federal regulations. 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 one FTE in the calculation of Medicare GME payments, cost reports for hospitals in MAC jurisdiction 13 included residents whose total FTE count exceeded one. Accordingly, we continue to recommend that NGS recover $474,662 and adjust the direct and indirect FTE counts for each of the hospitals in MAC jurisdiction 13 that claimed Medicare GME reimbursement for residents whose total FTE count exceeded one. Finally, we provided NGS with the information necessary to confirm the excess reimbursement we identified.

# APPENDIX

## APPENDIX: NATIONAL GOVERNMENT SERVICES, INC., COMMENTS

Medicare

National Government Services, Inc.
P.O. Box 4900
Syracuse, NY 13221-4900

www.NGSMedicare.com
*A CMS Contracted Agent*

February 20, 2012

Report Number: A-02-10-01007

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

Dear Mr. Edert:

National Government Services (NGS) is in receipt of your draft report (A-02-10-01007) dated January 24, 2012, entitled Review of Resident Data Reported in the Intern and Resident Information System for Medicare Cost Reports Submitted to National Government Services, Inc., and Highmark Medicare Services, Inc. NGS has noted the OIG recommendations below and respectfully offers a response to each as requested.

First OIG Recommendation:
Recover $474,662 in excess Medicare GME reimbursement paid to 24 hospitals in MAC Jurisdiction 13.

NGS Response:
NGS does not concur with this recommendation. As delineated in the OIG report, the excess Medicare GME reimbursement amount of $474,662 was determined by comparing hospital information provided to NGS for J13 and Highmark for J12. NGS does not have access to the hospital information provided to Highmark in J12. As such, NGS is not able to confirm this recovery amount nor is NGS able to determine the appropriate recovery by provider. Since it is not currently a CMS requirement that NGS collaborate with other contractors in determining incorrect identification of intern and resident FTE counts, NGS is not in a position to determine the proper recovery amount by provider. The J13 MAC SOW does not require NGS to complete this work nor has CMS provided funding to do so.

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.

NGS Response:
NGS does not concur with this recommendation. The J13 MAC SOW section C.5.11.3.3 subsection entitled, "Interns and Residents Information System", states, "The contractor shall implement and notify providers that the residents in approved graduate medical education (GME) programs of all Interns and Residents Information System (IRIS) updates in accordance with CMS instructions provided in periodic change requests (CR's)." There is no requirement in the J13 MAC SOW nor has CMS provided funding for the effort recommended by the OIG.

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.

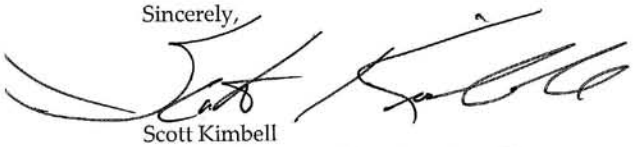
NGS Response:
NGS does not concur with the recommendation. The J13 MAC SOW does not include this requirement nor has CMS provided funding for this effort.

Fourth OIG Recommendation:
Consider working with Highmark to identify and recover any additional overpayments made to hospitals in MAC Jurisdiction 13 for residents also claimed by hospitals in MAC Jurisdiction 12 and for whom the FTE count exceeded one on the Medicare cost report submitted after FY2007.

NGS Recommendation:
NGS does not concur with this recommendation. The J13 MAC SOW does not include this requirement nor has CMS provided funding for this effort.

Although our response does not support the directives recommended by the OIG, NGS is prepared to accept and pursue each of these recommendations if CMS were to modify the J13 MAC SOW and provide funding for the effort required. NGS has processes in place for examining Intern and Resident overlaps within J13, and we are prepared to expand our processes to a cross-jurisdictional application if funding is made available.

Sincerely,



Scott Kimbell
Director, Contract Administration- J13