APR 21 2005

TO: Herb Kuhn
Director, Center for Medicare Management
Centers for Medicare & Medicaid Services

FROM: for Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Medicare Graduate Medical Education Payments to New York-Presbyterian Hospital (A-02-02-01011)

Attached is an advance copy of our final report on Medicare graduate medical education payments to New York-Presbyterian Hospital (the hospital) in New York, NY. We will issue this report to the hospital within 5 business days.

Medicare pays teaching hospitals for both direct graduate medical education (GME) costs and indirect graduate medical education (IME) costs. Hospitals claim reimbursement for these costs on their annual Medicare cost reports based on formulas that use fixed base costs and the number of full-time equivalent (FTE) residents. For payment purposes, the number of FTE residents is the average of the actual FTE count for the current year and the preceding two cost reporting periods. This is often described as the rolling average.

Our objective was to determine whether the hospital complied with Federal requirements in calculating the resident FTEs used to claim Medicare GME and IME payments for calendar year 1999. During that year, the hospital claimed payments of $31,072,569 for GME and $61,732,285 for IME.

The hospital did not fully comply with Federal requirements and therefore overstated its GME and IME FTEs on the 1999 Medicare cost report. These overstatements resulted in excess GME reimbursement of $1,253,269 in 1999. Because Medicare reimburses hospitals for GME and IME based on a 3-year rolling average, the overstated FTEs on the calendar year 1999 cost report also resulted in excess GME and IME reimbursement totaling $7,158,140 in 2000 and 2001. Thus, the hospital overstated its claim by a total of $8,411,409 for the 3 years.

We attribute the overstated FTE counts to weaknesses in the hospital's internal controls and oversight procedures. Controls did not ensure that FTEs claimed were sufficiently documented in rotation schedules; calculated using the appropriate initial residency period[1] weight factor; allowable as a new residency program; and properly reduced for

[1]The initial residency period is the minimum number of years required for board eligibility.

time spent in excludable IME units, research, and unapproved programs. Also, the hospital did not ensure that the correct per resident amount used to calculate GME was claimed for primary and specialty care residencies.

We recommend that the hospital:

- reimburse Medicare $8,411,409 for overclaimed GME and IME,
- make adjustments to reduce the FTE counts reported on its 1999 Medicare cost report by 119.45 FTEs for GME and 91.44 FTEs for IME,
- strengthen its procedures to ensure that future resident FTE counts and per resident amounts for residency specialties are calculated in accordance with Medicare requirements, and
- determine whether the errors identified in our review also occurred in prior and subsequent Medicare cost reports and coordinate with the Medicare fiscal intermediary to make any necessary financial adjustments.

In its response to our draft report, the hospital disagreed with our findings on the incorrect application of the initial residency period weight factor and excludable IME time for non-prospective-payment system units and research. The hospital believed that in some instances, its application of the initial residency period weight factor was consistent with Medicare laws and regulations. The hospital also maintained that the time residents spent performing research as part of an approved program anywhere in the hospital complex could be included in the FTE count.

The hospital did not address our recommendations to reimburse Medicare $8,411,409 and adjust its FTE counts. The hospital stated that it had implemented our recommendation on strengthening procedures but disagreed with our recommendation to identify errors in other periods.

Having reviewed all of the hospital's relevant comments, we believe that our audit determinations are correct and that no adjustment to our report is necessary.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Timothy J. Horgan, Regional Inspector General for Audit Services, Region II, at (212) 264-4620. Please refer to report number A-02-02-01011 in all correspondence.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services
Region II
Jacob K. Javits Federal Building
New York, New York 10278
(212) 264-4620

APR 25 2005

Report Number: A-02-02-01011

Ms. Phyllis Lantos
Chief Financial Officer
New York-Presbyterian Hospital
161 Fort Washington Avenue
14th Floor, Room 1410
New York, New York 10032

Dear Ms. Lantos:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Medicare Graduate Medical Education Payments to New York-Presbyterian Hospital." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

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

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5). Please refer to report number A-02-02-01011 in all correspondence.

Sincerely,

Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. James T. Kerr
Regional Administrator
Centers for Medicare & Medicaid Services, Region II
Department of Health and Human Services
26 Federal Plaza, Room 3811
New York, New York 10278

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE GRADUATE MEDICAL EDUCATION PAYMENTS TO NEW YORK-PRESBYTERIAN HOSPITAL

APRIL 2005
A-02-02-01011

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Medicare pays teaching hospitals for both direct graduate medical education (GME) costs and indirect graduate medical education (IME) costs. Hospitals claim reimbursement for these costs on their annual Medicare cost reports based on formulas that use fixed base costs and the number of full-time equivalent (FTE) residents. Specifically, GME payments are based on Medicare's share of a hospital-specific per resident amount multiplied by the number of FTE residents. The IME payments are based on the ratio of the hospital's FTE residents to the number of hospital beds. For payment purposes, the number of FTE residents is the average of the actual FTE count for the current year and the preceding two cost reporting periods. This is often described as the rolling average.

New York-Presbyterian Hospital (the hospital) is one of the largest nonprofit providers of health care and related services in the New York metropolitan area. More than 1,900 residents representing over 100 medical specialties provide medical care. On its calendar year 1999 Medicare cost report, the hospital claimed payments of $31,072,569 for 1,130.56 GME FTEs and $61,732,285 for 1,109.72 IME FTEs.

OBJECTIVE

Our objective was to determine whether the hospital complied with Federal requirements in calculating the resident FTEs used to claim Medicare GME and IME payments for calendar year 1999.

SUMMARY OF FINDINGS

The hospital did not fully comply with 42 CFR § 413.86, which establishes the procedures for hospitals to claim GME costs, and 42 CFR § 412.105, which governs payment for IME costs, and therefore overstated its GME and IME FTEs on the 1999 Medicare cost report. These overstatements resulted in excess GME reimbursement of $1,253,269 in 1999. Because hospitals are reimbursed for GME and IME based on a 3-year rolling average, the overstated FTEs on the calendar year 1999 cost report also resulted in excess reimbursement for both GME and IME totaling $7,158,140 in 2000 and 2001. Thus, the hospital overstated its claim by a total of $8,411,409 for the 3 years.

FTE Overstatements

Of the $1,253,269 overclaimed in 1999, $1,199,115 resulted from overstating the resident FTE count for GME by 119.45 FTEs and improperly calculating and reporting 9.28 FTEs for a new training program. The remaining $54,154 was caused by the misclassification of 37.45 GME specialty care FTEs as primary care residencies and 3.95 GME primary care FTEs as specialty care residencies. Because the per resident reimbursement for GME costs is higher for primary care residents than for residents in specialty care, these misclassifications overstated the hospital's claim.

In addition, the hospital overstated its IME FTE count by 91.44 FTEs. This overstatement had no effect on reimbursement for 1999 because the Medicare fiscal intermediary had adjusted the hospital's 1999 bed count. However, the overstatement affected the cost reports for the next 2 years.

We attribute the overstated FTE counts to weaknesses in the hospital's internal controls and oversight procedures. Controls did not ensure that FTEs claimed were sufficiently documented in rotation schedules; calculated using the appropriate initial residency period[1] weight factor; allowable as a new residency program; and properly reduced for time spent in excludable IME units, research, and unapproved programs. Also, the hospital did not ensure that the correct per resident amount used to calculate GME was claimed for primary and specialty care residencies.

Effect of the Rolling Average

Because reimbursement for graduate medical education is based on a 3-year rolling FTE average, the FTE overstatements on the 1999 cost report also resulted in excess reimbursement in 2000 and 2001. The hospital received improper payments of $1,154,242 for GME and $1,740,293 for IME in 2000 and $1,195,947 for GME and $3,067,658 for IME in 2001. The total adjustment for the 2 years following our audit period is $7,158,140.

RECOMMENDATIONS

We recommend that the hospital:

- reimburse Medicare $8,411,409 for overclaimed GME and IME,
- make adjustments to reduce the FTE counts reported on its 1999 Medicare cost report by 119.45 FTEs for GME and 91.44 FTEs for IME,
- strengthen its procedures to ensure that future resident FTE counts and per resident amounts for residency specialties are calculated in accordance with Medicare requirements, and
- determine whether the errors identified in our review also occurred in prior and subsequent Medicare cost reports and coordinate with the Medicare fiscal intermediary to make any necessary financial adjustments.

HOSPITAL'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

In its response to our draft report, the hospital disagreed with our findings on the incorrect application of the initial residency period weight factor and excludable IME time for units and research not subject to the prospective payment system (PPS). The hospital believed that in some instances, its application of the initial residency period weight factor was consistent with Medicare laws and regulations. The hospital also maintained that the time residents

[1]The initial residency period is the minimum number of years required for board eligibility.

spent performing research as part of an approved program anywhere in the hospital complex could be included in the FTE count.

The hospital did not address our recommendations to reimburse Medicare $8,411,409 and adjust its FTE counts. The hospital stated that it had implemented our recommendation on strengthening procedures but disagreed with our recommendation to identify errors in other periods.

Having reviewed all of the hospital's relevant comments, we believe that our audit determinations are correct and that no adjustment to our report is necessary.

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GLOSSARY OF ACRONYMS

ACGME	Accreditation Council of Graduate Medical Education
CMS	Centers for Medicare & Medicaid Services
ECFMG	Educational Committee for Foreign Medical Graduates
FTE	full-time equivalent
GME	direct graduate medical education
IME	indirect graduate medical education
IRIS	Interns and Residents Information System
MMA	Medicare Prescription Drug, Improvement, and Modernization Act
PPS	prospective payment system

INTRODUCTION

BACKGROUND

Medicare GME and IME

Since the inception of Medicare in 1965, the program has shared in the costs of educational activities incurred by participating providers. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, makes two different types of payments—GME and IME.

Pursuant to sections 1886(a)(4) and 1886(d)(1)(A) of the Social Security Act (the Act) and 42 CFR § 412.113, GME costs are excluded from the definition of hospital operating costs and, accordingly, are not included in the calculation of payment rates under the hospital inpatient PPS or in the calculation of the rate-of-increase limit for hospitals excluded from the PPS. Regulations (42 CFR § 413.85(b)) define approved educational activities as formally organized or planned programs of study usually engaged in by providers to enhance the quality of patient care in an institution. These activities include approved training programs for physicians, nurses, and certain allied health professionals. Pursuant to section 1886(h) of the Act and 42 CFR § 413.86, hospitals are paid for GME costs based on Medicare's share of a hospital-specific per resident amount multiplied by the number of FTE residents.

Medicare has made payments to hospitals pursuant to section 1886(d) of the Act on the basis of the PPS since 1983. Under the PPS, hospitals receive a predetermined payment for each Medicare discharge. Section 1886(d)(5)(B) of the Act specifically directs the Secretary to provide an additional payment under the inpatient PPS to hospitals for IME. This additional payment, which reflects the higher operating costs associated with medical education, is based in part on the applicable IME adjustment factor. The adjustment factor is calculated by using a hospital's ratio of residents to beds in the formula set forth in section 1886(d)(5)(B)(ii) and specified in 42 CFR § 412.105. The IME payment is usually viewed as an add-on to the basic PPS payment.

Both GME and IME payments are calculated annually for hospitals on the basis of formulas using fixed base costs and the number of FTE residents. The total number of FTE residents for payment purposes is the average of the actual FTE count for the current year and the preceding two cost reporting periods. This is often described as the rolling average. The GME calculation also uses the proportion of Medicare days of care to determine a hospital's payment. The amount of Medicare funds received by each hospital is determined, in large part, by the number of FTE residents and the proportion of training time that its interns and residents spend in the institution.

New York-Presbyterian Hospital

The hospital was formed in 1997 by the merger of New York Hospital and Presbyterian Hospital. Two major universities, Columbia and Cornell, operate its graduate medical education residency programs. The hospital is one of the largest nonprofit providers of health care and related services to individuals in the New York metropolitan area. The

hospital, with combined revenues of nearly $2 billion, operates a wide range of health care and related programs, including:

- acute care community hospitals, which have more than 2,000 inpatient beds and
- a network of continuum-of-care facilities, home health agencies, ambulatory sites, and specialty institutes.

The hospital has more than 1,900 residents representing more than 100 medical specialties. On its calendar year 1999 Medicare cost report, the hospital claimed payments of $31,072,569 for 1,130.56 GME FTEs and $61,732,285 for 1,109.72 IME FTEs.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the hospital complied with Federal requirements in calculating the resident FTEs used to claim Medicare GME and IME payments for calendar year 1999.

Scope and Methodology

To accomplish our audit objective, we:

- reviewed Medicare laws, regulations, and program guidelines related to the GME and IME programs;
- interviewed hospital staff to obtain an understanding of the hospital's procedures for operating the GME and IME programs;
- performed a 100-percent review of the 1,130.56 GME FTEs and 1,228.28[1] IME FTEs, representing 1,914 residents, claimed by the hospital on the calendar year 1999 Medicare cost report (the latest cost report available);
- reconciled the cost report data to CMS's Interns and Residents Information System (IRIS) data submitted to the fiscal intermediary;
- verified resident participation in approved teaching programs as defined by the Accreditation Council of Graduate Medical Education (ACGME), the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, and the American Dental Association;
- identified residents who graduated from a foreign medical school and confirmed that the residents were certified by the Educational Committee for Foreign Medical Graduates (ECFMG);

[1]The 1,228.28 IME FTEs include 1,109.72 IME FTEs claimed for reimbursement and 118.56 IME FTEs from excluded units.

- verified the application of the appropriate initial residency period weight factor;

- reviewed rotation schedules and other supporting documentation to determine whether the appropriate time was claimed;

- verified that the appropriate time was reported for residents working in areas and research unallowable for IME reimbursement;

- verified the classifications for primary care and other specialty residency programs;

- recalculated the final claimable FTE counts for GME and IME reimbursement;

- determined the net dollar effect of our audit adjustments to the GME and IME FTE counts by recalculating cost report Worksheet E-3, Part IV for GME (Appendix A) and Worksheet E, Part A for IME (Appendix B);

- determined the dollar effect of the 1999 adjusted GME and IME FTE counts on the calendar year 2000 and 2001 cost reports by recalculating cost report Worksheet E-3, Part IV for GME (Appendixes C and E, respectively) and Worksheet E, Part A for IME (Appendixes D and F, respectively); and

- discussed the results of our audit with hospital representatives.

We limited consideration of the hospital's internal control structure to those controls pertaining to the FTEs reported on the hospital's 1999 cost report because the objective of our review did not require a complete understanding or assessment of internal controls. We conducted our fieldwork at the New York-Presbyterian Hospital in New York, NY.

We performed the audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The hospital did not fully comply with 42 CFR § 413.86, which establishes the procedures for hospitals to claim GME costs, and 42 CFR § 412.105, which governs payment for IME costs, and therefore overstated its GME and IME FTEs on the 1999 Medicare cost report. These overstatements resulted in excess GME reimbursement of $1,253,269 in 1999.

Because Medicare reimburses hospitals for GME and IME based on a 3-year rolling average, the overstated FTEs on the calendar year 1999 cost report also resulted in excess GME and IME reimbursement totaling $7,158,140 in 2000 and 2001. Thus, the hospital overstated its claim by a total of $8,411,409 for the 3 years.

Of the $1,253,269 overclaimed in 1999, $1,199,115 resulted from overstating the resident FTE count for GME by 119.45 FTEs and improperly calculating and reporting 9.28 FTEs for a new training program. The remaining $54,154 was caused by the misclassification of 37.45 GME specialty care FTEs as primary care residencies and 3.95 GME primary care FTEs as specialty care residencies. Because the per resident reimbursement for GME costs is

higher for primary care residents than for specialty care residents, these misclassifications overstated the hospital's claim.

In addition, the hospital overstated its IME FTE count by 91.44 FTEs. Although the IME FTEs were overstated, there was no effect on the IME reimbursement for 1999. The reimbursement formula requires applying the lower of the current or prior-year FTE-to-bed count ratio. The prior-year ratio used by the hospital remained the lower ratio because the Medicare fiscal intermediary adjusted to the hospital's 1999 bed count. However, the overstatement affected the cost reports for the next 2 years.

A summary of our FTE adjustments is found below:

Error Categories	GME FTEs	IME FTEs
Overstated FTEs:		
Unallowable FTEs Reported	56.78	74.88
Incorrect Initial Residency Period Weight Factor	61.68	---
Excludable IME Time	---	14.82
Unapproved Programs	0.99	1.74
Overstated FTE Totals	**119.45**	**91.44**
Misclassified FTEs:		
New Program FTEs	9.28	---
Per Resident Amount – Primary	37.45	---
Per Resident Amount – Specialty	(3.95)	---

COMPLIANCE WITH MEDICARE REQUIREMENTS

Unallowable FTEs Reported

The hospital did not always sufficiently document or properly allocate the FTEs used to calculate the payment for GME and IME. This resulted in an overstatement of the FTE count by 56.78 GME and 74.88 IME FTEs.

Medicare payments for GME and IME are calculated based on the number of FTE residents and the portion of Medicare days of care. Pursuant to 42 CFR § 412.105(f)(1)(iii), the FTE status is based on the total time necessary to fill a residency slot. Pursuant to 42 CFR § 413.86(i), to include a resident in the FTE count for a particular cost reporting period, the hospital must furnish specific information, including, but not limited to, the resident's name and Social Security number, the type of residency program, the number of years completed in all types of residency programs, and the dates assigned to the hospital or other providers.

To document the time involved in resident training, the hospital uses rotation schedules, developed by the individual hospital departments, which list the residents by program level and location. The house staff office is responsible for manually inputting information from the rotation schedules into a database used to track resident time, and the finance department

is responsible for computing the IME and GME FTEs to be claimed on the cost report. The finance department also prepares a compilation spreadsheet based on the information provided by the house staff office.

We reviewed all 1,130.56 GME FTEs and 1,228.28 IME FTEs reported by the hospital on its calendar year 1999 Medicare cost report and found that the hospital incorrectly claimed 56.78 GME and 74.88 IME FTEs that could not be verified by supporting rotation schedules or any other documentation.

The hospital was unable to support the FTEs claimed on its cost report because:

- The compilation prepared by the finance department for claiming IME reimbursement did not reconcile to the FTEs reported on the Medicare cost report.

- The FTEs were documented on rotation schedules that varied in format and detail from department to department. There was no standard rotation schedule form to assist in the consistent input of data by hospital staff. The variation among the types of rotation schedules made the task of inputting data onto the compilation susceptible to clerical error.

- The departments generally planned and prepared rotation schedules prior to the start of the academic year. During the academic year, residents often worked rotations that differed from the initial rotation schedules, but the departments did not routinely update the schedules to reflect the actual time that the residents worked or were present in the department. Therefore, variations from the planned rotation schedules were not always captured in the compilation by the finance department. For example, we identified instances when residents were terminated and the hospital claimed time for those residents beyond the termination date.

- Time worked by residents was not always accurately transferred from the rotation schedules to the compilation. In several instances, incorrect start and/or end of rotation periods were inputted. In addition, the hospital claimed entire rotation periods that were attributable to other hospitals or not specifically identified on the rotation schedules.

- Resident data were not accurately recorded in the compilation. Specifically, the hospital used a system-generated date for U.S. medical school graduations and foreign medical school student ECFMG certifications rather than using the actual dates. This resulted in claiming residents for periods prior to the actual start of their residency. The compilation did not prevent the claiming of residents for time worked prior to their graduation or ECFMG completion date.

Incorrect Application of Initial Residency Period Weight Factor

The hospital did not always apply the appropriate initial residency period weight factor in calculating the GME FTE count. This resulted in an overstatement of the FTE count by 61.68 GME FTEs.

The initial residency period weight factor is applied to the resident's time to arrive at the FTE count for GME reimbursement purposes. Pursuant to 42 CFR § 413.86(g)(1)(i), the initial residency period is the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the most recently published edition of the Graduate Medical Education Directory. Pursuant to 42 CFR § 413.86(g)(2), the initial residency period weight factor for a resident in an initial residency period is 1.0, and pursuant to 42 CFR § 413.86(g)(3), the initial residency period weight factor for a resident not in an initial residency period is 0.5.

Of the 1,914 residents represented in the FTEs claimed on the cost report, 282 residents (61.68 FTEs) had an incorrect initial residency period weight factor applied when the hospital calculated the GME FTE count. For the 282 residents, we identified 2 types of initial residency period errors:[2]

- There were 267 residents (totaling 65.04 FTEs) for whom the hospital incorrectly applied an initial residency period weight factor of 1.0, rather than a weight factor of 0.5.

- There were 15 residents (totaling minus 3.36 FTEs) for whom the hospital incorrectly applied an initial residency period weight factor of 0.5, rather than a weight factor of 1.0.

We found that the appropriate initial residency period weight factor was not always used because:

- In determining the number of years completed, the hospital did not always use accurate information regarding a resident's accredited residency, internship, or fellowship training begun or completed at other facilities. In this regard, we noted that verification supporting training at other hospitals was sometimes missing from resident files.

- The hospital incorrectly used the same program year (the year of training within a residency program) and years completed (the total number of years of training completed) for all residents. The hospital applied a formula that used the incorrect program years to compute GME FTEs claimed on the cost report. In many instances, the incorrect formula caused the residents to be assigned a weight factor of 1.0 after they had completed their initial residency period halfway through the cost reporting period.

- In several instances, the hospital misinterpreted the Medicare laws and regulations regarding the initial residency period weight factor. Specifically, the hospital used incorrect initial residency period factors as follows:

[2]For 47 of the 282 residents with incorrect initial residency weight factors, the hospital also claimed unsupported time. This unsupported time is included in our calculation of the 61.68 FTEs questioned for incorrect initial weight factors.

Clinical base year – Section 1886(h)(5)(F)(ii) of the Act states that the initial residency period applied should be that of the program in which the resident begins training. For residents who trained in a program that required a clinical base year of training in one specialty before switching to another specialty, the hospital interpreted the regulations to allow the initial residency period to be determined based on the program the resident entered into in the second year of graduate training rather than the first year.

Pediatric neurology – The hospital inappropriately applied regulations (42 CFR § 413.86) established in 2000 that retroactively allow for an initial residency period factor of the period of board eligibility for pediatrics plus 2 years rather than the 3-year initial residency period for pediatrics. However, the regulations specifically stipulate that the longer initial residency period factor does not apply retroactively in cases where residents completed their training before July 1, 2000.

Geriatrics – The hospital did not allow for the additional 2 years granted those residents completing fellowships in an approved geriatric program. Regulations (42 CFR § 413.86(g)(1)) state that to be counted toward determining FTE status, an initial residency period may not exceed 5 years except in the case of fellows in an approved geriatric program, whose initial residency period may last up to 2 additional years.

Pathology – Medicare regulations (42 CFR § 415.152) provide that ACGME may accredit approved residency programs. The ACGME accredits three tracks within the pathology residency program: anatomic (3 years), clinical (3 years), and anatomic/clinical (4 years). For its pathology residents, the hospital applied a universal 4-year initial residency period weight factor, regardless of whether the resident was receiving board certification in the 3-year or the 4-year program.

Foreign medical graduates receiving a waiver from their respective boards for training completed in other countries – The hospital did not always use a lower initial residency period, as required by Medicare regulations. Regulations (42 CFR § 413.86(g)(1)) state that effective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility.

Excludable IME Time for Non-PPS Units and Research

The hospital did not sufficiently reduce the IME FTE count for resident time spent in excludable units and research. This resulted in an overstatement of the FTE count by 14.82 IME FTEs.

To calculate the IME payment, the total allowable FTEs should be reduced for time spent in excluded units. Regulations (42 CFR § 412.105(f)(1)(ii)) state that to be counted for the purpose of determining the IME payment, a resident must be assigned to the portion of the hospital subject to the PPS and be involved in patient care activities. The Provider Reimbursement Manual, section 2405.3.F.2 further stipulates that time in which a resident was exclusively engaged in research is not included in the FTE count used for calculating the IME payment.

At the hospital, the time a resident spent in an excludable unit or in research was documented in the hospital rotation schedules. The hospital reported on its cost report 118.56 IME FTEs for time spent in excludable units (103.13 FTEs for time spent in psychiatric excludable areas and 15.43 in rehabilitation medicine excludable areas). The hospital did not report on its cost report any time spent in excludable research.

We determined that the hospital should have reported on the cost report 133.38 IME FTEs for time spent in excludable areas or research. The net overstatement of 14.82 FTEs occurred because the hospital:

- did not exclude resident time spent exclusively in research, without patient care activities (24.33 IME FTEs);

- did not exclude resident time spent training in the burn unit non-PPS area (5.30 IME FTEs); and

- overstated time spent by residents in the excludable psychiatric unit non-PPS area (resulting in an understatement of 14.81 IME FTEs).

Time Claimed for Residents in Unapproved Programs

The hospital claimed time for three residents who participated in unapproved programs. This resulted in an overstatement of the FTE count by 0.99 GME and 1.74 IME FTEs.

To be included in the calculation for Medicare graduate medical education reimbursement, Medicare regulations require that residents participate in approved medical residency programs. Regarding payment for GME costs, 42 CFR § 413.86(c) provides that beginning with cost reporting periods starting on or after July 1, 1985, hospitals, including hospital-based providers, are paid for the costs of approved graduate medical education programs. Regulations (42 CFR § 412.105(f)(1)(i)) provide that beginning on July 1, 1991, each resident must be enrolled in an approved teaching program to establish the count of FTE residents for IME.

We found that the hospital claimed time for 3 residents in unapproved programs that resulted in the hospital's overstating its claim by 0.99 GME FTEs and 1.74 IME FTEs, as follows:

- One resident reported as being in an approved pediatric program actually was trained in a pediatric emergency medicine program that was not accredited until July 1, 2000.

- Two residents reported as being in an approved anesthesiology program actually were trained in a pediatric anesthesiology program that was not accredited until June 7, 1999. The hospital claimed time for the entire first half of 1999.

The errors occurred because the hospital did not always accurately record the IRIS code and the name of the residency program in which the residents were training.

Incorrect New Program FTEs Reported

The hospital incorrectly reported FTEs attributable to a new residency program, family medicine. This resulted in the misclassification of 9.28 GME FTEs.

Pursuant to 42 CFR § 413.86(g)(9), a new medical residency training program means a medical residency that received initial accreditation by the appropriate accrediting body or began training residents on or after January 1, 1995. In addition, 42 CFR § 413.86(g)(6)(ii) further distinguishes that if a hospital includes allopathic or osteopathic residents in its most recent cost reporting period ended on or before December 31, 1996, the hospital's unweighted FTE cap may be adjusted for new medical residency training programs established on or after January 1, 1996, and on or before August 5, 1997. The adjustment to the FTE resident limit for the new program is based on the product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program. New program FTEs are excluded from the required rolling average computation as a temporary adjustment and are included in full in the computation of GME reimbursement during the temporary period.

Regulations (42 CFR § 413.86(g)(6)(ii)(B)) further provide that a permanent adjustment to the base year limitation should be reported during the fourth year of the program based on the highest number of residents in any program year multiplied by the program's initial residency period.

The hospital classified 18.26 GME FTEs and 18.51 IME FTEs as new program FTEs for a family medicine program that was established on May 15, 1995, with a minimum accredited length of 3 years. There were no residents enrolled in the program during the 1995-96 academic year. The hospital began training residents in the new program during the 1996-97 academic year. Therefore, the program completed its initial program run on June 30, 1999.

We found that the hospital did not properly apply the regulations when calculating and reporting the FTEs associated with the new program. Specifically, the hospital erroneously claimed all the family medicine calendar year 1999 FTEs as a temporary adjustment attributable to new programs. Instead, the reported adjustment should have been computed using the highest number of residents in any program year during the third year of the program (1998-99 academic year) multiplied by the family medicine initial residency period (3 years). Because the program had completed its eligibility as a new program as of June 30, 1999, the hospital should have reported only the temporary adjustment FTEs for the new program for the first half of the year.

As a result of this incorrect application of the new program requirements, the hospital overstated the new program GME FTEs reported outside of the 3-year rolling average by 9.28 FTEs.

Per Resident Amount Reimbursement by Resident Specialty

On its Medicare cost report, the hospital did not always correctly classify the resident specialties, resulting in incorrect per resident amounts claimed for primary and other specialty care residents. This resulted in a misclassification of 41.40 GME FTEs (37.45 FTEs as primary and 3.95 as specialty care).

Regulations (42 CFR § 413.86(b)) define primary care residents as those enrolled in approved medical residency training programs in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice.

Reimbursement for GME costs is higher for primary care residents and obstetrics and gynecology residents than for residents in specialty care. The hospital reported residents on its compilation as training in primary care when, in fact, the resident files and rotation schedules showed those residents training in other specialty care programs. The hospital also sometimes treated primary care residencies as other specialties. The specialties included, among others, cardiology, hematology, gastroenterology, nephrology, and oncology.

The hospital misclassified 37.45 GME FTEs as primary care residencies for 98 residents and 3.95 GME FTEs as other specialty care residencies for 5 residents on its 1999 cost report. As a result of these misclassified residencies, the hospital's 1999 claim for GME reimbursement was overstated by $54,154.

MEDICARE OVERPAYMENT

To determine the effect of the FTE and specialty code overstatements, we recomputed the GME costs claimed on the 1999 Medicare cost report Worksheet E-3, Part IV (Appendix A) and the IME costs claimed on the 1999 Medicare cost report Worksheet E-3, Part A (Appendix B) using the revised FTEs and specialty codes discussed in this report. We found that the hospital overstated its claim for GME and IME reimbursement on the calendar year 1999 Medicare cost report by $1,253,269.

Because the total number of FTE residents for payment purposes is equal to the average of the actual FTE count for the current year and the preceding two cost reporting periods, the overstated 1999 FTE count also affected the 2 years following our audit period. Therefore, we also recomputed the GME and IME costs claimed on the 2000 and 2001 Medicare cost reports using the 1999 adjusted FTE counts (Appendixes C through F). We determined that the hospital received improper payments of $1,154,242 for GME and $1,740,293 for IME in calendar year 2000 and $1,195,947 for GME and $3,067,658 for IME in calendar year 2001.

Using the rolling average formula, we found that by overstating its 1999 FTE counts, the hospital overstated its GME reimbursement for the 3 calendar years 1999, 2000, and 2001 by $3,603,458 and its IME reimbursement by $4,807,951. In the aggregate, the hospital overstated its claim for GME and IME reimbursement by $8,411,409.

RECOMMENDATIONS

We recommend that the hospital:

- reimburse Medicare $8,411,409 for overclaimed GME and IME,
- make adjustments to reduce the FTE counts reported on its 1999 Medicare cost report by 119.45 FTEs for GME and 91.44 FTEs for IME,
- strengthen its procedures to ensure that future resident FTE counts and per resident amounts for residency specialties are calculated in accordance with Medicare requirements, and
- determine whether the errors identified in our review also occurred in prior and subsequent Medicare cost reports and coordinate with the Medicare fiscal intermediary to make any necessary financial adjustments.

HOSPITAL'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

In its response to our draft report, the hospital disagreed with our findings on (1) incorrect application of the initial residency period weight factor for clinical base years, (2) incorrect application of the initial residency period weight factor for its pathology residency programs, and (3) excludable IME time for non-PPS units and research. For the numerous other findings presented in the report, the hospital noted that the absence of comments in no way signified its agreement with our interpretation or conclusions in those sections.

The hospital did not address our recommendations to reimburse Medicare $8,411,409 and adjust its FTE counts. The hospital stated that it had implemented our recommendation on strengthening procedures but disagreed with our recommendation to identify errors in other periods.

We have summarized the hospital's relevant comments and provided our responses below. Appendix G contains the full text of the hospital's comments. We have reviewed all of the hospital's relevant comments and believe that our audit determinations are correct and that no adjustment to our report is necessary.

Incorrect Application of Initial Residency Period Weight Factor for Clinical Base Years

Hospital's Comments

The hospital stated that for residents who trained in a program requiring a clinical base year of training, Medicare regulations allowed the initial residency period to be based on the program that the residents entered in the second year of training. The hospital cited a conference report for the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 and a CMS proposed rule published on May 18, 2004, as support for its interpretation of the initial residency period regulations.

Office of Inspector General's Response

Section 1886(h)(5)(F)(ii) of the Act specifically requires that the initial residency period applied be that of the program in which the resident begins training. As to the conference report for the MMA cited by the hospital, the enacted legislation affected only geriatric residency programs for cost reporting periods beginning on or after October 1, 2003. Similarly, the CMS final rule published on August 11, 2004, changed the regulations regarding clinical base years only for geriatric residency programs.

Incorrect Application of Initial Residency Period Weight Factor for Pathology Residency Programs

Hospital's Comments

The hospital disagreed with our determination that it had incorrectly applied a universal 4-year initial residency period to all residents training in pathology residency programs. The hospital stated that during the audit period, the Cornell University campus offered only the 4-year combined anatomic/clinical pathology program. Therefore, according to the hospital, its application of the 4-year initial residency period to pathology residents training at the Cornell campus was accurate.

Office of Inspector General's Response

The two Cornell residents whose initial residency period weight factor we questioned had completed 3-year anatomic pathology residency programs at other institutions before entering fellowship programs at Cornell. Because they started their training in 3-year programs, the residents were clearly not eligible to be counted by the hospital in its 4-year program. Further, the hospital did not address the disallowances that we identified at the Columbia University campus.

Excludable IME Time for Non-PPS Units and Research

Hospital's Comments

According to the hospital, the time residents spent performing research as part of an approved program anywhere in the hospital complex could be included in FTE counts for both GME and IME. The hospital believed that research activity was part of a particular residency program when the research was required for completion of a specialty and that, therefore, the time met Medicare requirements for inclusion in GME and IME expenses.

Office of Inspector General's Response

The hospital's position that research time performed as part of an approved residency program is allowable for GME is correct, but it is not relevant to our finding on excludable IME time for non-PPS units and research.

For the calculation of IME payments, Medicare rules and regulations provide that the total allowable FTEs be reduced for time spent in excluded units. Specifically, 42 CFR

§ 412.105(f)(1)(ii) states that to be counted for the purpose of determining the IME payment, a resident must be assigned to the portion of the hospital subject to the PPS and be involved in patient care activities. The Provider Reimbursement Manual, section 2405.3.F.2 further stipulates that time in which a resident is engaged exclusively in research is not included in the FTE count used for calculating the IME payment.

Recommendations To Strengthen Procedures and Identify Errors in Other Periods

Hospital's Comments

In response to our recommendation that the hospital strengthen its procedures to ensure that future resident FTE counts and per resident amounts for residency specialties are calculated in accordance with Medicare requirements, the hospital described the steps that it had taken. Specifically, the hospital said that it had installed a new software system to help identify potential errors, implemented a new credentialing database to eliminate errors caused by manual entry, integrated the administrative staff responsible for data collection at the hospital, and created a standard rotation schedule procedure to accurately capture resident FTE counts and per resident amounts for residency specialties.

The hospital commented that in light of steps taken to correct deficiencies, a review of prior and subsequent cost reports would be unduly burdensome and unnecessary.

Office of Inspector General's Response

On the basis of the overall significance of the weaknesses disclosed in this report and the dollars in question, we believe that it is appropriate for the hospital to determine whether the errors identified in our review also occurred in prior and subsequent Medicare cost reporting periods. The hospital also should coordinate with the Medicare fiscal intermediary to make any necessary financial adjustments.

APPENDIXES

CALENDAR YEAR 1999 GME REIMBURSEMENT, WORKSHEET E-3, PART IV

		Filed by Hospital	Revised per Audit	Notes
Computation of total direct GME amount				
1	Number of FTE residents for OB/GYN & primary care	0.00	0.00	
1.01	Number of FTE residents for all others	0.00	0.00	
2	Updated per resident amount for OB/GYN & primary care	0.00	0.00	
2.01	Updated per resident amount for all others	0.00	0.00	
3	Aggregate approved amount	0.00	0.00	
3.01	Unweighted resident FTE count for allopathic & osteopathic programs for cost report periods ended on or before December 31, 1996	1,182.50	1,182.50	(1)
3.02	Unweighted resident FTE count for allopathic & osteopathic programs that meet the criteria for an add-on to the cap for new programs pursuant to 42 CFR § 413.86 (g)(6)	18.51	18.25	
3.03	Unweighted resident FTE count for allopathic & osteopathic programs for affiliated programs pursuant to 42 CFR § 413.86 (g)(4)	0.00	0.00	
3.04	FTE adjustment cap	1,201.01	1,200.75	
3.05	Unweighted resident FTE count for allopathic & osteopathic programs for the current year	1,188.81	1,117.84	(2)
3.06	Lesser of line 3.04 or line 3.05	1,188.81	1,117.84	
3.07	Weighted FTE count for primary care physicians in an allopathic & osteopathic program for the current year	439.41	401.78	
3.08	Weighted FTE count for all other physicians in an allopathic & osteopathic program for the current year	637.19	567.10	
3.09	Sum of lines 3.07 and 3.08	1,076.60	968.88	
3.10	If line 3.05 is less than 3.04, enter the amount from line 3.09, otherwise multiply line 3.09 times the result of line 3.04 divided by line 3.05	1,076.60	968.88	
3.11	Weighted dental & podiatric resident FTE count for the current year	35.70	33.30	
3.12	Sum of lines 3.10 and 3.11	1,112.30	1,002.18	
3.13	Total weighted resident FTE count for the prior cost report year	1,114.98	1,114.98	(1)
3.14	Total weighted resident FTE count for the penultimate cost report year	1,132.13	1,132.13	(1)
3.15	Rolling average FTE count	1,119.80	1,083.10	
3.16	Weighted number of FTE residents in the initial years of the primary care program that meet the exception	18.26	8.98	
3.17	Weighted number of FTE residents in the initial years of another program that meet the exception	0.00	0.00	
3.18	Sum of lines 3.15 through 3.17	1138.06	1092.08	
3.19	Primary care physician per resident amount	85,571.00	85,570.61	
3.20	Other program per resident amount	81,028.19	81,027.83	
3.21	Primary care unadjusted approved amount	39,163,280	35,148,984	

3.22	Other unadjusted approved amount	54,523,059	48,649,109	
3.23	Sum of lines 3.21 and 3.22	93,686,339	83,798,093	
3.24	Divide line 3.23 by the sum of lines 3.07, 3.08, 3.11, 3.16, and 3.17	82,867	82,873	
3.25	Total approved amount for resident costs	94,307,618	90,503,918	
4	Program Part A inpatient days	204,127	204,127	(1)
5	Total inpatient days	626,249	626,249	(1)
6	Ratio of program inpatient days to total inpatient days	0.325952	0.325952	
6.01	Total GME payment for non-managed-care days	30,739,757	29,499,917	
6.02	Program managed care days occurring on or after January 1 of this cost reporting period	5,525	5,525	(1)
6.03	Total inpatient days from line 5 above	626,249	626,249	(1)
6.04	Appropriate percentage for inclusion of managed care days	40%	40%	(1)
6.05	Graduate medical education payment for managed care days on or after January 1 through the end of the cost reporting period	332,812	319,384	
6.06	Program managed care days occurring before January 1 of this cost reporting period	0.00	0.00	
6.07	Appropriate percentage using the criteria identified on line 6.04 above	20%	20%	(1)
6.08	Graduate medical education payment for managed care days prior to January 1 this cost reporting period	0.00	0.00	
23	Total program GME payment	0.00	0.00	
23.01	For cost reporting periods ending on or after January 1, 1998	31,072,569	29,819,300	
	GME Overclaimed by Hospital:		**1,253,269**	

Notes:

(1) This figure is unaudited.

(2) This figure is the revised IME allopathic/osteopathic current year FTEs (984.46 – line 3.08, Worksheet E, Part A) plus the revised excludable units (133.38).

CALENDAR YEAR 1999 IME REIMBURSEMENT, WORKSHEET E, PART A

		Filed by Hospital	Revised per Audit	Notes
1	Other than outlier payments occurring before October 1	130,455,847	130,455,847	(1)
1.01	Other than outlier payments occurring on or after October 1 and before January 1	43,963,143	43,963,143	(1)
1.02	Other than outlier payments occurring on or after January 1	0.00	0.00	
1.03	Payments prior to October 1	5,197,566	5,197,566	(1)
1.04	Payments on or after October 1 and prior to January 1	1,751,561	1,751,561	(1)
1.05	Payments on or after January 1	0.00	0.00	
1.06	Additional amount received or to be received	0.00	0.00	
2	Outlier payments	0.00	0.00	
2.01	Outlier payments on or after October 1, 1997, indirect medical education adjustment	32,886,892	32,886,892	(1)
3	Bed days available divided by No. of days in CR period	1,732	1,672	(2)
3.01	No. of interns & residents from Worksheet S-3, Part I	0.00	0.00	
3.02	Indirect medical education percentage	0.00	0.00	
3.03	Indirect medical education adjustment	0.00	0.00	
3.04	FTE count for allopathic & osteopathic programs for the most recent CR period ended on or before December 31, 1996	1,106.51	1,106.51	
3.05	FTE count for allopathic & osteopathic programs that meet the criteria for an add-on to the cap for new programs pursuant to § 1886 (d)(5)(B)(viii)	18.51	18.25	
3.06	Adjusted FTE count for allopathic & osteopathic programs for affiliated programs pursuant to § 1886 (d)(5)(B)(viii)	0.00	0.00	
3.07	Sum of lines 3.04 through 3.06	1,125.02	1,124.76	
3.08	FTE count for allopathic & osteopathic programs in the current year from your records	1,073.76	984.46	
3.09	For CR periods beginning before October 1, enter the percentage of discharges occurring prior to October 1	0.00	0.00	
3.10	For CR periods beginning before October 1, enter the percentage of discharges occurring on or after October 1	0.00	0.00	
3.11	FTE count for the period identified in line 3.09	0.00	0.00	
3.12	FTE count for the period identified in line 3.10	0.00	0.00	
3.13	FTE count for residents in dental & podiatric programs	35.96	33.83	
3.14	Current year allowable FTE	1,109.72	1,018.29	
3.15	Total allowable FTE count for the prior year	1,069.65	1,069.65	(1)
3.16	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	1,100.40	1,100.40	(1)
3.17	Sum of lines 3.14 through 3.16 divided by the number of those lines greater than zero	1,093.26	1,062.78	

3.18	Current year resident-to-bed ratio	0.631212	0.635634	
3.19	Prior year resident-to-bed ratio	0.626461	0.626461	(1)
3.20	For cost reporting periods beginning on or after October 1, 1997, enter the lesser of lines 3.18 or 3.19	0.626461	0.626461	
3.21	IME payments for discharges occurring prior to October 1	46,172,367	46,172,367	
3.22	IME payments for discharges occurring after September 30 but before January 1	15,559,918	15,559,918	
3.23	IME payments for discharges occurring on or after January 1	0.00	0.00	
3.24	Sum of lines 3.21 through 3.23	61,732,285	61,732,285	
	IME Overclaimed by Hospital:		**$0.00**	

Notes:

(1) This figure is unaudited.

(2) Bed count adjusted based on review by fiscal intermediary.

CALENDAR YEAR 2000 GME REIMBURSEMENT, WORKSHEET E-3, PART IV

		Filed by Hospital	Revised 1999 FTEs	Notes
Computation of total direct GME amount				
1	Number of FTE residents for OB/GYN & primary care	0.00	0.00	
1.01	Number of FTE residents for all others	0.00	0.00	
2	Updated per resident amount for OB/GYN & primary care	0.00	0.00	
2.01	Updated per resident amount for all others	0.00	0.00	
3	Aggregate approved amount	0.00	0.00	
3.01	Unweighted resident FTE count for allopathic & osteopathic programs for cost report periods ended on or before December 31, 1996	1,182.50	1,182.50	(1)
3.02	Unweighted resident FTE count for allopathic & osteopathic programs that meet the criteria for an add-on to the cap for new programs pursuant to 42 CFR § 413.86 (g)(6)	18.51	18.25	
3.03	Unweighted resident FTE count for allopathic & osteopathic programs for affiliated programs pursuant to 42 CFR § 413.86 (g)(4)	0.00	0.00	
3.04	FTE adjustment cap	1,201.01	1,200.75	
3.05	Unweighted resident FTE count for allopathic & osteopathic programs for the current year	1,219.96	1,219.96	(1)
3.06	Lesser of line 3.04 or line 3.05	1,201.01	1,200.75	
3.07	Weighted FTE count for primary care physicians in an allopathic & osteopathic program for the current year	408.74	408.74	(1)
3.08	Weighted FTE count for all other physicians in an allopathic & osteopathic program for the current year	665.47	665.47	(1)
3.09	Sum of lines 3.07 and 3.08	1,074.21	1,074.21	
3.10	If line 3.05 is less than 3.04, enter the amount from line 3.09, otherwise multiply line 3.09 times the result of line 3.04 divided by line 3.05	1,057.52	1,057.30	
3.11	Weighted dental & podiatric resident FTE count for the current year	32.18	32.18	(1)
3.12	Sum of lines 3.10 and 3.11	1,089.70	1,089.48	
3.13	Total weighted resident FTE count for the prior cost report year	1,130.57	1,011.16	(2)
3.14	Total weighted resident FTE count for the penultimate cost report year	1,036.06	1,036.06	(1)
3.15	Rolling average FTE count	1,085.44	1,045.57	
3.16	Weighted number of FTE residents in the initial years of the primary care program that meet the exception	0.00	0.00	
3.17	Weighted number of FTE residents in the initial years of another program that meet the exception	0.00	0.00	
3.18	Sum of lines 3.15 through 3.17	1085.44	1,045.57	

3.19	Primary care physician per resident amount	88,729.00	88,729.00	
3.20	Other program per resident amount	84,018.00	84,018.00	
3.21	Primary care unadjusted approved amount	36,266,916	36,267,091	
3.22	Other unadjusted approved amount	58,615,248	58,615,158	
3.23	Sum of lines 3.21 and 3.22	94,882,164	94,882,249	
3.24	Divide line 3.23 by the sum of lines 3.07, 3.08, 3.11, 3.16, and 3.17	85,758	85,758	
3.25	Total approved amount for resident costs	93,085,164	89,665,995	
4	Program Part A inpatient days	206,512	206,512	(1)
5	Total inpatient days	641,805	641,805	(1)
6	Ratio of program inpatient days to total inpatient days	0.321768	0.321768	
6.01	Total GME payment for non-managed-care days	29,951,827	28,851,604	
6.02	Program managed care days occurring on or after January 1 of this cost reporting period	18,883	18,883	(1)
6.03	Total inpatient days from line 5 above	641,805	641,805	(1)
6.04	Appropriate percentage for inclusion of managed care days	60%	60%	
6.05	Graduate medical education payment for managed care days on or after January 1 through the end of the cost reporting period	1,470,693	1,416,674	
6.06	Program managed care days occurring before January 1 of this cost reporting period	0.00	0.00	
6.07	Appropriate percentage using the criteria identified on line 6.04 above	40%	40%	
6.08	Graduate medical education payment for managed care days prior to January 1 this cost reporting period	0.00	0.00	
23	Total program GME payment	0.00	0.00	
23.01	For cost reporting periods ending on or after January 1, 1998	31,422,520	30,268,278	
	GME Overclaimed by Hospital:		**1,154,242**	

Notes:

(1) This figure is unaudited.

(2) This figure is the revised GME FTE count for calendar year 1999 as found in Appendix A, lines 3.12 and 3.16 (1002.18 + 8.98).

CALENDAR YEAR 2000 IME REIMBURSEMENT, WORKSHEET E, PART A

		Filed by Hospital	Revised 1999 FTEs	Notes
1	Other than outlier payments occurring before October 1	140,097,900	140,097,900	(1)
1.01	Other than outlier payments occurring on or after October 1 and before January 1	46,699,300	46,699,300	(1)
1.02	Other than outlier payments occurring on or after January 1	0.00	0.00	
1.03	Payments prior to October 1	17,637,841	17,637,841	(1)
1.04	Payments on or after October 1 and prior to January 1	5,879,280	5,879,280	(1)
1.05	Payments on or after January 1	0.00	0.00	
1.06	Additional amount received or to be received	0.00	0.00	
2	Outlier payments	0.00	0.00	
2.01	Outlier payments on or after October 1, 1997, indirect medical education adjustment	30,702,656	30,702,656	(1)
3	Bed days available divided by No. of days in CR period	1,680	1,680	(1)
3.01	No. of interns & residents from Worksheet S-3, Part I	0.00	0.00	
3.02	Indirect medical education percentage	0.00	0.00	
3.03	Indirect medical education adjustment	0.00	0.00	
3.04	FTE count for allopathic & osteopathic programs for the most recent CR period ended on or before December 31, 1996	1,080.16	1,080.16	(1)
3.05	FTE count for allopathic & osteopathic programs that meet the criteria for an add-on to the cap for new programs pursuant to § 1886(d)(5)(B)(viii)	12.26	12.26	(1)
3.06	Adjusted FTE count for allopathic & osteopathic programs for affiliated programs pursuant to § 1886(d)(5)(B)(viii)	0.00	0.00	
3.07	Sum of lines 3.04 through 3.06	1,092.42	1,092.42	
3.08	FTE count for allopathic and osteopathic programs in the current year from your records	1,113.69	1,113.69	(1)
3.09	For CR periods beginning before October 1, enter the percentage of discharges occurring prior to October 1	0.00	0.00	
3.10	For CR periods beginning before October 1, enter the percentage of discharges occurring on or after October 1	0.00	0.00	
3.11	FTE count for the period identified in line 3.09	0.00	0.00	
3.12	FTE count for the period identified in line 3.10	0.00	0.00	
3.13	FTE count for residents in dental & podiatric programs	34.72	34.72	(1)
3.14	Current year allowable FTE	1,127.14	1,127.14	
3.15	Total allowable FTE count for the prior year	1,109.72	1,018.29	(2)
3.16	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	1,055.86	1,055.86	(1)
3.17	Sum of lines 3.14 through 3.16 divided by the number of those lines greater than zero	1,097.57	1,067.10	
3.18	Current year resident-to-bed ratio	0.653315	0.635177	
3.19	Prior year resident-to-bed ratio	0.672965	0.635634	(3)

3.20	For cost reporting periods beginning on or after October 1, 1997, enter the lesser of lines 3.18 or 3.19	0.653315	0.635177	
3.21	IME payments for discharges occurring prior to October 1	54,447,834	53,130,242	
3.22	IME payments for discharges occurring after September 30 but before January 1	17,468,654	17,045,953	
3.23	IME payments for discharges occurring on or after January 1	0.00	0.00	
3.24	Sum of lines 3.21 through 3.23	71,916,488	70,176,195	
	IME Overclaimed by Hospital		**1,740,293**	

Notes:

(1) This figure is unaudited.

(2) This figure is the revised 1999 IME count from Appendix B, line 3.14.

(3) This figure is the revised 1999 resident-to-bed ratio from Appendix B, line 3.18.

CALENDAR YEAR 2001 GME REIMBURSEMENT, WORKSHEET E-3, PART IV

		Filed by Hospital	Revised 1999 FTEs	Notes
Computation of total direct GME amount				
1	Number of FTE residents for OB/GYN & primary care	0.00	0.00	
1.01	Number of FTE residents for all others	0.00	0.00	
2	Updated per resident amount for OB/GYN & primary care	0.00	0.00	
2.01	Updated per resident amount for all others	0.00	0.00	
3	Aggregate approved amount	0.00	0.00	
3.01	Unweighted resident FTE count for allopathic & osteopathic programs for cost report periods ended on or before December 31, 1996	1,182.50	1,182.50	(1)
3.02	Unweighted resident FTE count for allopathic & osteopathic programs that meet the criteria for an add-on to the cap for new programs pursuant to 42 CFR § 413.86(g)(6)	12.26	12.26	(1)
3.03	Unweighted resident FTE count for allopathic & osteopathic programs for affiliated programs pursuant to 42 CFR § 413.86(g)(4)	0.00	0.00	
3.04	FTE adjustment cap	1,194.76	1,194.76	
3.05	Unweighted resident FTE count for allopathic & osteopathic programs for the current year	1,223.08	1,223.08	(1)
3.06	Lesser of line 3.04 or line 3.05	1,194.76	1,194.76	
3.07	Weighted FTE count for primary care physicians in an allopathic & osteopathic program for the current year	406.25	406.25	(1)
3.08	Weighted FTE count for all other physicians in an allopathic & osteopathic program for the current year	651.49	651.49	(1)
3.09	Sum of lines 3.07 and 3.08	1,057.74	1,057.74	
3.10	If line 3.05 is less than 3.04, enter the amount from line 3.09, otherwise multiply line 3.09 times the result of line 3.04 divided by line 3.05	1,033.25	1,033.25	
3.11	Weighted dental & podiatric resident FTE count for the current year	31.93	31.93	(1)
3.12	Sum of lines 3.10 and 3.11	1,065.18	1,065.18	
3.13	Total weighted resident FTE count for the prior cost report year	1,106.39	1,106.39	(1)
3.14	Total weighted resident FTE count for the penultimate cost report year	1,130.57	1,011.16	(2)
3.15	Rolling average FTE count	1,100.71	1,060.91	
3.16	Weighted number of FTE residents in the initial years of the primary care program that meet the exception	0.00	0.00	
3.17	Weighted number of FTE residents in the initial years of another program that meet the exception	0.00	0.00	
3.18	Sum of lines 3.15 through 3.17	1100.71	1060.91	
3.19	Primary care physician per resident amount	91,372.00	91,372.00	
3.20	Other program per resident amount	86,521.00	86,521.00	
3.21	Primary care unadjusted approved amount	37,119,875	37,119,875	
3.22	Other unadjusted approved amount	59,130,182	59,130,182	

3.23	Sum of lines 3.21 and 3.22	96,250,057	96,250,057	
3.24	Divide line 3.23 by the sum of lines 3.07, 3.08, 3.11, 3.16, and 3.17	88,330	88,330	
3.25	Total approved amount for resident costs	97,225,714	93,709,652	
4	Program Part A inpatient days	194,700	194,700	(1)
5	Total inpatient days	643,661	643,661	(1)
6	Ratio of program inpatient days to total inpatient days	0.302488	0.302488	
6.01	Total GME payment for non-managed-care days	29,409,612	28,346,085	
6.02	Program managed care days occurring on or after January 1 of this cost reporting period	17,722	17,722	(1)
6.03	Total inpatient days from line 5 above	643,661	643,661	(1)
6.04	Appropriate percentage for inclusion of managed care days	80%	80%	
6.05	Graduate medical education payment for managed care days on or after January 1 through the end of the cost reporting period	1,904,859	1,772,439	
6.06	Program managed care days occurring before January 1 of this cost reporting period	0.00	0.00	
6.07	Appropriate percentage using the criteria identified on line 6.04 above	60%	60%	
6.08	Graduate medical education payment for managed care days prior to January 1 of this cost reporting period	0.00	0.00	
23	Total program GME payment	0.00	0.00	
23.01	For cost reporting periods ending on or after January 1, 1998	31,314,471	30,118,524	
	GME Overclaimed by Hospital:		**1,195,947**	

Notes:

(1) This figure is unaudited.

(2) This figure is the revised GME FTE count for calendar year 1999 as found in Appendix A, lines 3.12 and 3.16 (1002.18 + 8.98).

CALENDAR YEAR 2001 IME REIMBURSEMENT, WORKSHEET E, PART A

		Filed by Hospital	Revised 1999 FTEs	Notes
1	Other than outlier payments occurring before October 1	46,595,887	46,595,887	(1)
1.01	Other than outlier payments occurring on or after October 1 and before January 1	48,566,122	48,566,122	(1)
1.02	Other than outlier payments occurring on or after January 1	0.00	0.00	
1.03	Payments prior to October 1	6,332,312	6,332,312	(1)
1.04	Payments on or after October 1 and prior to January 1	6,586,939	6,586,939	(1)
1.05	Payments on or after January 1	0.00	0.00	
1.06	Additional amount received or to be received	0.00	0.00	
1.07	Payments for discharges on or after April 1, 2001, through September 30, 2001	97,253,181	97,253,181	(1)
1.08	Simulated payments from the PS&R on or after April 1, 2001, through September 30, 2001	11,362,158	11,362,158	(1)
2	Outlier payments	0.00	0.00	
2.01	Outlier payments on or after October 1, 1997, indirect medical education adjustment	97,253,181	97,253,181	(1)
3	Bed days available divided by No. of days in CR period	1,686	1,686	(1)
3.01	No. of interns & residents from Worksheet S-3, Part I	0.00	0.00	
3.02	Indirect medical education percentage	0.00	0.00	
3.03	Indirect medical education adjustment	0.00	0.00	
3.04	FTE count for allopathic & osteopathic programs for the most recent CR period ended on or before December 31, 1996	1,080.16	1,080.16	(1)
3.05	FTE count for allopathic & osteopathic programs that meet the criteria for an add-on to the cap for new programs pursuant to § 1886(d)(5)(B)(viii)	12.26	12.26	(1)
3.06	Adjusted FTE count for allopathic & osteopathic programs for affiliated programs pursuant to § 1886(d)(5)(B)(viii)	0.00	0.00	
3.07	Sum of lines 3.04 through 3.06	1,092.42	1,092.42	
3.08	FTE count for allopathic & osteopathic programs in the current year from your records	1,097.83	1,097.83	(1)
3.09	For CR periods beginning before October 1, enter the percentage of discharges occurring prior to October 1	0.00	0.00	
3.10	For CR periods beginning before October 1, enter the percentage of discharges occurring on or after October 1	0.00	0.00	
3.11	FTE count for the period identified in line 3.09	0.00	0.00	
3.12	FTE count for the period identified in line 3.10	0.00	0.00	
3.13	FTE count for residents in dental & podiatric programs	35.14	35.14	(1)
3.14	Current year allowable FTE	1,127.56	1,127.56	
3.15	Total allowable FTE count for the prior year	1,127.14	1,127.14	(1)
3.16	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	1,109.72	1,018.29	(2)

3.17	Sum of lines 3.14 through 3.16 divided by the number of those lines greater than zero	1,121.47	1,091.00	
3.18	Current year resident-to-bed ratio	0.664993	0.646923	
3.19	Prior year resident-to-bed ratio	0.676095	0.635177	(3)
3.20	For cost reporting periods beginning on or after October 1, 1997, enter the lesser of lines 3.18 or 3.19	0.664993	0.635177	
3.21	IME payments for discharges occurring prior to October 1	18,246,099	17,532,917	
3.22	IME payments for discharges occurring after September 30 but before January 1	19,754,677	18,982,552	
3.23	IME payments for discharges occurring on or after January 1	0.00	0.00	
3.24	Sum of lines 3.21 through 3.23	78,485,946	75,418,288	
	IME Overclaimed by Hospital		**3,067,658**	

Notes:

(1) This figure is unaudited.

(2) This figure is the revised 1999 IME count from Appendix B, line 3.14.

(3) This figure is the revised 2000 resident-to-bed ratio from Appendix D, line 3.18.

NewYork-Presbyterian
The University Hospitals of Columbia and Cornell

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June 11, 2004

Mr. Timothy J. Horgan
Office of Audit Services, Region II
Jacob K. Javits Federal Building
New York, NY 10278

Re: Medicare Graduate Medical Education Payments to New York-Presbyterian Hospital, Report No. A-02-02-01011

Dear Mr. Horgan:

We appreciate the opportunity to comment on the draft report presenting the results of the Office of Inspector General's ("OIG") review of the medical education payments claimed by New York-Presbyterian Hospital ("NYPH") for calendar year 1999. Our comments are numbered in a manner that corresponds with the sections of the draft report. Please note that we only comment on certain sections or subsections of the report. The absence of comments on the remaining sections in no way signifies NYPH's agreement with the OIG's interpretations or conclusions in those sections.

I. OVERVIEW

New York-Presbyterian Hospital is one the most comprehensive university hospitals in the country, with almost 2,400 beds and almost 2,200 residents. New York-Presbyterian Hospital was created in 1998 by the merger of the New York Hospital and the Columbia Presbyterian Hospital. Prior to the merger, both hospitals had systems in place to collect resident data and calculate full time equivalent ("FTE") counts and per resident amounts for residency specialties. The merger, however, resulted in the significant consolidation of staff, and a shifting of responsibilities among those responsible for tracking and calculating medical education payments. The challenges associated with the consolidation and combination of the staff of the two hospitals may have contributed to some of the errors identified by the OIG in calendar year 1999.

Since 1999, NYPH has continued to take steps to strengthen its procedures to ensure that resident FTE counts and per resident amounts for residency specialties are calculated in accordance with Medicare regulations. The administrative staff became more integrated, and many of the challenges of the prior consolidation have been addressed. In addition, NYPH has installed the same software program as used by the fiscal intermediary to help enhance the accuracy of its Medicare graduate medical education ("GME") and indirect medical education ("IME") counts, and specifically, the calculation of its medical education payments. Moreover,

NYPH has created and implemented a standard rotation schedule procedure for use on both campuses. These efforts have strengthened and improved NYPH's controls, and have ultimately reduced the prevalence of the types of errors identified in this report. NYPH will continue to monitor and improve its processes to ensure the accuracy of the GME and IME count submissions.

II. FINDINGS

B. Incorrect Application of Initial Residency Period Weight Factor

OIG found that the hospital did not always apply the appropriate initial residency period weight factor in calculating the GME FTE count, resulting in an overstatement of the FTE count by 61.68 GME FTEs. NYPH disagrees with this finding. As explained below, there were instances in which NYPH believes that its application of the appropriate initial residency period weight factor was consistent with Medicare laws and regulations, but the OIG has disagreed.

1. Clinical Base Year

With regard to clinical base year, NYPH interprets the regulation to allow the initial residency period to be determined as of the time the resident enters his residency program, rather than the clinical base year program. NYPH notes that the Medicare statute defines "initial residency period" or "IRP" as the period of time defined by the ACGME for board eligibility. Under the statute, the period of board eligibility "means, for a resident, the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training."[1] The statute further provides that the IRP "shall be determined, with respect to a resident, as of the time the resident enters the residency program."[2] This means that only when the resident enters the residency program for which he is training will the IRP be determined. The use of the language "as of the time the resident enters the residency program" makes clear when the calculation is determined for a specific resident and any training prior to the period that the resident enters a program, *i.e., a "clinical base year,"* is not used as the basis for determining the length of an IRP.

NYPH's view has now been unequivocally articulated in the congressional report for the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "Modernization Act"). The Conference Report, which provides additional clarification for all initial residency periods states:

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1 42 U.S.C. § 1395ww(h)(5)(G)(i). This provision was incorporated by section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272 (effective for cost reporting periods beginning after June, 1985).

2 42 U.S.C. § 1395ww(h)(5)(F).

> The conferees also clarify that under section 1886(h)(5)(F), the initial residency period for which the ACGME [the American Council for Graduate Medical Education] requires a preliminary or general clinical year of training is to be determined in the resident's second year of training.

This would mean that regardless of whether a resident completes a clinical base year of training in a "Preliminary" slot or in a "Transitional Year" program, the determination of the training program for calculating initial residency period is to be made during the resident's second year (when he or she enters the specific program for which the clinical base year was a requirement). NYPH's application of the appropriate initial residency period weight factor in calculating the GME FTE count was consistent with this interpretation.[3]

3. Pathology

ACGME accredits three tracks within the pathology residency program: Anatomic, Clinical, and Anatomic/Clinical. Residents in either the Anatomic or the Clinical program require three years of training to be board eligible. Residents in an Anatomic/Clinical program, on the other hand, require four years of training to become board eligible. In 1999, the Cornell campus' Anatomic/Clinical program was neither two separate programs, nor a combination of programs, but rather was one integrated program leading to board eligibility in both major aspects of pathology.

The OIG found that NYPH applied a universal 4-year initial residency period weight factor, regardless of whether the resident was receiving board certification in a 3-year or the 4-year program. For a number of residents, however, the OIG incorrectly determined that the resident's program at issue was Anatomic Pathology, when in fact it was an Anatomic/Clinical Pathology Program -- NYPH notes that in 1999, the Cornell campus did not administer separate Anatomic Pathology or Clinical Pathology programs. The only pathology residency program available at the Cornell campus was the integrated Anatomic/Clinical program, which has an initial residency period of four. Accordingly, NYPH's application of a 4-year initial residency program to pathology residents training at the Cornell campus was accurate.

C. Excludable IME Time for Non-PPS Units and Research

Based on its findings, the OIG concluded that NYPH did not sufficiently reduce the IME FTE count for resident time spent in excludable units and research, resulting in an overstatement of the FTE count of 14.82 IME FTEs. The OIG asserts that NYPH did not report any excludable research time and that the certain resident time should not be counted because time spent "exclusively in research" is not included in the IME FTE count.

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[3] NYPH also notes that on May 18, 2004, CMS published a proposed rule that discusses the calculation of the initial residency period for residency programs that require a clinical base year. In this rule, CMS set forth proposed changes to its policy on calculating initial residency periods that are consistent with NYPH's interpretation. See 69 Fed. Reg. 28196 (May 18, 2004).

Under Medicare regulations, for purposes of determining the total number of FTE residents for the direct GME payment amount, "residents in an approved program working in all areas of the hospital complex may be counted."[4] Time residents spend performing research as part of an approved program anywhere in the hospital complex, therefore, may be included in this count.

In addition, Medicare regulations regarding counting residents for IME purposes provide that the resident time is counted if the resident is enrolled in an "approved teaching program"[5] and certain other requirements regarding location of the services are met. Many—if not most—approved programs require some type of research activity to meet completion requirements. When research is required for completion of a specialty or subspecialty, the research activity is part of a particular residency department's program. Therefore, when a resident has performed research as part of NYPH's approved programs, this time meets Medicare requirements for inclusion in direct GME and IME expenses. It is not correct to view such residents as being engaged "exclusively in research."

NYPH asserts that time spent (including elective time) by residents in research activities was part of the requirements for completion of an ACGME-approved program in the applicable specialty. Therefore, the resident time may be counted for calculating total FTE residents for purposes of calculating GME expenses. Further, according to Medicare policies, the research time may be counted for purposes of calculating IME expenses as well.

III. RECOMMENDATIONS

C. Strengthening of Procedures

In the draft report, OIG recommends that NYPH strengthen its procedures to ensure that future resident FTE counts and per resident amounts for residency specialties are calculated in accordance with Medicare requirements. In fact, since 1999, NYPH has already taken several steps to strengthen its procedures, and to reduce potential errors associated with its medical education payment.

NYPH purchased and implemented a KPMG software system. This software product is the same software used by NYPH's fiscal intermediary. The software checks the data runs generated by Columbia and Cornell and can run greater than fifty reports to identify potential errors. The software utilizes built-in checks for identifying potential errors in such areas as weighting, IRPs and double-counting. In addition, the software follows the calendar year, not the academic year schedule and bases its calculations on years completed and not program year ("PGY"). The software alerts the user that certain data needs to be checked for consistency. After generating a report, NYPH researches each of the potential errors identified by the software. NYPH goes back to the individual residency programs and re-reviews the rotation schedules and other supporting documentation. NYPH then reconciles this information with the

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[4] 42 C.F.R. § 413.86(f)(1) (1999).

[5] 42 C.F.R. § 412.105(f)(1)(i) (1999).

electronic data. After NYPH inputs the corrected information in the system, the software takes the "clean" data runs and generates the Medicare cost report. NYPH used the KPMG software for the first time in generating the 2000 cost report. NYPH believes that the KPMG software has eliminated many of the types of errors identified in the OIG audit.

In 2000, NYPH also began using a new credentialing database ("Maxsys"). Maxsys captures residents' graduation date, residents' prior training, and foreign graduates' start date. This information is then imported directly into the KPMG software. The electronic importation of this data eliminates the possibility for human error associated with manual entry of the information. Accordingly, the use of Maxsys has increased the accuracy of the data used to generate NYPH's cost reports.

Further, NYPH has integrated the administrative staff responsible for data collection at the hospital, and has made improvements in their data collection processes. Prior to July 2001, NYPH used a simple resident application form and general career statement, which were both filled out by the resident prior to entering the residency, to obtain the information that was input into its resident database. From 2001-2003, NYPH used a customized curriculum vitae ("CV") form that is extensive in length and depth of information to capture resident data accurately. The use of the new CV form allowed NYPH to make changes and corrections to residents' data prior to the submission of the 2000 and 2001 cost reports. In 2003, the customized CV form was replaced by a standardized application form designed to capture complete educational and training history, which all resident applicants are required to complete prior to appointment.

In addition, NYPH created a standard rotation schedule procedure that was used at the Columbia campus beginning in spring 2002, and at the Cornell campus in spring 2003. The standardized schedule procedure requests each program to include the institution, campus, program name, accreditation program, resident name, approval by program director/coordinator, and a key to the codes that describe the resident's activities during the period. The program directors/coordinators were trained on the new rotation schedule procedures, and were given sample standard schedules. Program directors/coordinators are asked to submit reconciled schedules to the GME office twice annually, at the mid-point and end of the cost report year. The use of a standard rotation schedule procedure allows NYPH to capture all of the information necessary to accurately calculate resident FTE counts and per resident amounts for residency specialties. This, in turn, has lead to a reduction in the types of errors noted in this report.

D. Assessment of Prior and Subsequent Medicare Cost Reports

In the draft report, OIG recommends that NYPH determine whether the errors identified in the review also occurred in prior and subsequent Medicare cost reports and coordinate with the fiscal intermediary to make any necessary final adjustments. As noted above, NYPH has taken significant steps to integrate its administrative staff, and strengthen its processes. These efforts have improved NYPH's controls, and have ultimately reduced the prevalence of the types of errors identified in this report. In light of the steps taken by NYPH, a review of prior and subsequent cost reports is unduly burdensome and unnecessary.

* * *

Thank you for the opportunity to comment on the draft report. Please contact Cheryl Parham at (212) 746-1171 if you have any questions or need any additional information.

Sincerely,

Phyllis Lantos /B.P.

Phyllis Lantos
Chief Financial Officer
New York-Presbyterian Hospital

ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy J. Horgan, Regional Inspector General for Audit Services, Region II. Other principal Office of Audit Services staff who contributed include:

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