Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION COSTS AT SHANDS HOSPITAL AT UNIVERSITY OF FLORIDA

JANET REHNQUIST
INSPECTOR GENERAL

MAY 2002
A-04-01-01002

DEPARTMENT *OF* **HEALTH** & HUMAN **SERVICES**

Office of Inspector General
Office of Audit Services

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

MAY 10 2002

CIN: A-04-01-01002

Mr. Timothy Goldfarb, CEO
Shands Hospital at the University of Florida
1600 S.W. Archer Road, Room10226
Gainesville, Florida 32610

Dear Mr. Goldfarb:

This report provides you with the results of an Office of Inspector General, Office of Audit Services' review entitled, ***Review of Graduate Medical Education and Indirect Medical Education Costs at Shands Hospital at the University of Florida.*** The purpose of our review was to determine the accuracy of resident Full-Time Equivalents (FTEs) used by the Shands at the University of Florida (the Hospital) for claiming Direct Graduate Medical Education (GME) and Indirect Graduate Medical Education (IME) for the Fiscal Years (FY) 1999 and 2000 Medicare cost reports.

The review showed that the Hospital did not use accurate data when reporting FTEs for claiming GME and IME. The Hospital (1) did not support all FTEs claimed, (2) included time spent in unallowable *activities* and *areas,* and (3) inappropriately classified specialty residents as primary care residents. Hospital officials reported FTEs for IME inaccurately because they experienced difficulty using revised software for electronic cost reporting. Had Hospital officials used the correct FTE numbers, the reimbursement amount derived within the cost report would have been much less than what was calculated using a separate spreadsheet model. Correction of the cost reports would result in increasing the Hospital's 2-year claim for IME by $1,471,801 and reducing the 2-year claim for GME by $575,621. Hospital officials also reported that they have implemented procedures, where needed, to identify time spent in unallowable activities and areas.

INTRODUCTION

BACKGROUND

The Hospital is a 576-bed private, not-for-profit hospital located in the City of Gainesville, Florida. It is one of the most comprehensive in the Southeast, specializing in tertiary care and critically ill patients. The Hospital is also the primary teaching hospital for the University of Florida Colleges of Medicine and Dentistry. More than 500 resident physicians representing 110 medical specialties provide care to the patients at the Hospital.

Types of Education

Since the inception of Medicare in 1965, the program has shared in the costs of educational activities incurred by participating providers. Medicare now makes two different types of payments – GME and IME.

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

The IME payments are oriented towards services to Medicare patients. Medicare has made payments to hospitals under 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 indirect IME adjustment factor. The adjustment factor is calculated by using a hospital's ratio of residents-to-beds in the formula set forth at section 1886(d)(5)(B) and specified in regulations at 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 based on formulas, which are driven, by the number of FTEs and the proportion of Medicare days of care. Thus, the amount of Medicare funds received by each hospital is determined, in large part, by the number of FTE residents at each hospital and the proportion of training time residents spend in the institution.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of this audit was to determine the accuracy of resident FTEs used by the Hospital for claiming GME and IME on the FY 1999 and 2000 Medicare cost reports.

We conducted our audit during the period of November 2000 through May 2001 at the Hospital in Gainesville, Florida and at its Fiscal Intermediary's (FI) offices in Orlando and Jacksonville, Florida. The audit covered FYs 1999 and 2000. The audit was conducted in accordance with generally accepted government auditing standards.

We limited consideration of the internal control structure to those controls concerning the accumulation of FTEs reported on the Hospital's cost report because the objective of our review did not require a complete understanding or assessment of the internal control structure at the Hospital.

To determine the accuracy of the FTE residents reported on the cost reports, we first reconciled the FTEs reported on the FY 1999 and the FY 2000 cost reports to supporting documentation. After that, for each resident on the rotation schedules, we verified:

- participation in an approved teaching program;
- foreign medical graduate eligibility (if applicable);
- time spent in allowable areas and activities;
- the appropriate proportion of total time;
- the appropriate initial residency weighing factor;
- classifications for primary care and specialty residency programs; and
- the final FTE count.

We obtained the Hospital's comments on the draft report and revised our report to reflect additional information provided by the Hospital. The Hospital's comments are summarized in the body of the report and enclosed as an Appendix to this report.

FINDINGS AND RECOMMENDATIONS

FINDINGS

For the period of our review, the Hospital did not use accurate data when calculating FTEs for claiming GME and IME. We found that the Hospital (1) did not support all FTEs claimed, (2) included time spent in unallowable *activities* and *areas,* and (3) inappropriately classified specialty residents as primary care residents. This would increase the Hospital's s 2-year claim for IME by $1,471,801 and reduce the 2-year claim for GME by $575,621 (see Appendix A).

FTEs Not Supported

In completing its FY 1999 cost report, the Hospital reported FTEs, which could not be verified to supporting schedules and documentation. The 42 CFR 105(f)(2)(i) states that to include a resident in the IME FTE count for a particular cost reporting period, a hospital must furnish

information including, but not limited to: name, social security number, type of residency, years in program, dates assigned to the hospital or other providers.

The hospital claimed 502 FTEs for IME in the FY 1999 cost report, while the rotation schedules supported 452 FTEs. Thus, 50 FTEs were not supported.

The Hospital uses rotation schedules to track residents for accounting purposes. These rotation schedules compiled by the Hospital are based on assignment sheets prepared by the various departments within the College of Medicine and the College of Dentistry. They list all the residents by location, residency, and percentage of time spent at each location. Our testing showed the rotation schedules to be accurate.

During our audit we could not determine the source of the numbers used by the Hospital in computing IME claimed for reimbursement on the FY 1999 cost report. In response to the draft report, the Hospital provided us with an explanation for the reported number. The response stated:

> *At the time that Shands was preparing its FYE 1999 Medicare cost report, HCFA was still issuing transmittal instructions to its cost report software vendors as to how IME should be calculated. Since that time, HCFA (CMS) has continued to issue revised transmittals to clarify how IME should be calculated within the cost report. As a result of these transmittals, the software vendors and the teaching hospital community were unclear as to how the cost report should be properly completed. Shands experienced difficulty using the software for the electronic cost reporting, such that the IME reimbursement amount derived within the cost report was much less than what was calculated using a separate spreadsheet model. Shands recognized that the electronic cost reporting process was, for some unidentified reason, producing an inaccurate IME reimbursement value.*

Thus, the FTEs reported were based on the number of FTEs needed to achieve the appropriate reimbursement amount.

Time In Unallowable Activities

The Hospital did not reduce the reported and supported FTEs for time spent in non-patient care activities or activities funded by other sources.

The computation of allowable FTEs is somewhat complex. The 42 CFR 412.105 (f)(ii) provides that time spent by residents in a non-hospital setting is not allowed for purposes of counting FTEs for IME unless the time is spent in patient care activities. Additionally, the Federal Register, Volume 66, Number 87 excludes time spent in research not specifically associated with the care and treatment of a particular patient of the hospital from inclusion in the computation of FTEs for IME. In computing allowable FTEs for GME, the time spent in research is allowed if required by the residency program.

Additionally, for time spent by residents in non-provider settings, 42 CFR 413.86(f) requires that a hospital have a written agreement with the entity for whom the work is to be done and incurs the cost of the resident and related supervision (all or substantially all of the costs for the training). The written agreement must specify that the hospital is bearing the costs and the amount of such costs.

For FY 1999 and FY 2000, the Hospital included in the cost report time spent by residents in unallowable activities including research, medical school, and non-provider settings. As a result, IME FTEs were overstated by 16.12 in 1999, 21.44 in 2000 while GME FTEs were overstated by 12.43 in 1999, and 17.49 in 2000.

The Hospital agreed with the finding, which resulted primarily from the confusion, related to the electronic cost report calculation. The hospital's rotation schedules can identify time spent in research, medical school and non-provider settings.

Time In Unallowable Areas

The Hospital did not reduce the reported FTEs for time spent in non-PPS areas of the hospital.

For purposes of counting FTEs for IME, 42 CFR 412.105 (f)(ii) provides that the resident must be assigned to the portion of the hospital subject to PPS or the outpatient area of the hospital.

For FY 1999 and FY 2000, the Hospital included, in the cost report, time spent by residents in the two non-PPS areas of the Hospital – the burn unit and the psychiatric unit. This resulted in IME FTEs being overstated by 4.39 in 1999 and 3.61 in 2000.

In response to the draft report, Shands has developed a rotation assignment to track time spent in non-PPS areas.

Misclassification of Specialty Residents

In its cost reports, the Hospital claimed specialty residents at a higher rate established for primary care residents.

The reimbursement for direct GME costs is higher for primary care residents and obstetrics and gynecology residents. The Hospital treated certain specialties on its rotation schedules as primary care residencies. These specialties were listed on the rotation schedules under general internal medicine and pediatrics, which are primary care residencies. The specialties included, among others, cardiology, hematology, nephrology, and oncology.

The 42 CFR 413.86(b) states that primary care residents are those enrolled in approved medical residency training programs in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. In addition, CMS

clarified which residencies are considered primary care in a letter addressed to the FI dated September 30, 1996.

The Hospital misclassified, as primary care residencies, 44.87 GME FTEs in FY 1999 and 45.81 GME FTEs in FY 2000.

In response to the draft report, the Hospital stated that their classification has been in accordance with historical direction provided by the Fiscal Intermediary. However, the Hospital agreed to take steps to ensure it assigns residents as primary and nonprimary care FTEs in accordance with the CMS clarification.

RECOMMENDATIONS

We recommend that the Hospital revise its claims for FY 1999 and FY 2000 by using the audit results. This would increase the Hospital's s 2-year claim for IME by $1,471,801 and reduce the 2-year claim for GME by $575,621. We will provide the results of our review to the FI, so it can use our adjustments in adjudicating the respective Medicare cost reports.

We also recommend the Hospital strengthen its procedures to ensure that future reported FTEs include only (1) residents who are included on the Hospital's rotation schedules or otherwise supported, and (2) time spent in allowable activities and areas. The Hospital has already implemented corrective actions.

In addition, we recommend the Hospital appropriately classify specialty residents in accordance with CMS's clarification of the regulations.

OTHER MATTERS

During our review of the FY 1999 data, we noted that the FTEs reported to CMS by the Hospital as part of the Intern and Resident Information System (IRIS) did not agree with the FTEs included on the Hospital's rotation schedules. The Hospital omitted 80 residents from their IRIS data in 1999.

The IRIS was developed by CMS to monitor resident activity affecting Medicare GME and IME payments. The purpose of the IRIS program is to capture information required by 42 CFR 413.86 and 42 CFR 412.105 about residents in approved programs that work at hospitals that participate in the Medicare program. This information is needed to determine Medicare payments. The IRIS records contain information on training rotations of residents, including chief residents and fellows. Among other things, each record includes information on the type of residency, year of residency, location of training, and percentage of time working at that location.

In addition to validating the data when they are received from the FIs, CMS edits the national database to assure that no resident is counted as more than one FTE, as required by regulations. Without accurate IRIS data, CMS cannot be assured the residents are not being claimed by more than one provider for a total exceeding one FTE.

We asked CMS to compare the 80 residents omitted from the Hospital's IRIS data to the national database and learned that 11 of the residents had FTEs also reported by other hospitals. We plan to shortly start a new audit to determine the extent of reporting problems and their financial implications.

INSTRUCTIONS FOR AUDITEE RESPONSE

Final determinations as to actions to be taken on all matters reported will be made by the CMS Action Official identified below. We request that you respond to the recommendation in this report within 30 days from the date of this report to the CMS action official, presenting any comments or additional information that you believe may have a bearing on final determination.

In accordance with the principles of the Freedom of Information Act, 5 United States Code 552, as amended by Public Law 1004-231, Office of Inspector General, Office of Audit Services reports are made available to the public to the extent information contained therein is not subject to exemptions in the Act (see CFR Part 5). As such, within 10 business days after the final report issued, it will be posted on the World Wide Web at http://oig.hhs.gov/.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures

CMS **Action Official:**
Mr. Dale Kendrick
Associate Regional Commissioner
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

APPENDIX A

Shands at the University of Florida
Indirect Medical Education Costs
FYE 1999

Cost Report Line # (Wkst. E PT A)	Line Description	Shands as filed	Shands Revised
1.00	DRG Amount Prior to 10/01	13831727	13831727
1.01	DRG Amount After 10/01and Before 01/01		
1.02	DRG Amount After 01/01	42834102	42834102
1.03	HMO DRG Amount Prior to 10/01	56483	56483
1.04	HMO DRG Amount After 10/01 and Before 01/01		
1.05	HMO DRG Amount After 01/01	2716108	2716108
3.00	Calculated Beds	732.62	732.62
3.04	Base Year Medicine FTEs	362	329.61
3.06	FTE Count for Affiliated Programs		6
3.07	Adjusted Base Year Count	362	336.52
3.08	Current Year Medicine FTEs	440	372.79
3.13	Dental FTEs	62	56.91
3.14	Current Year Allowable FTEs	349.82	393.43
3.15	Total Allowable FTE Count for Prior Year	361.34	342
3.16	Total Allowable FTE Count for Pentultimate Prior Year		
3.17	Three Year Rolling Average	355.58	367.72
3.18	Current Year Resident to Bed Ratio	0.485354	0.501918
3.19	Prior Year Resident to Bed Ratio	0.488507	0.672937
3.21	IME Payments for DischargesPrior to 10101	4137984	4263793
3.22	IME Payments for Discharges After 10/01and Before 01/01		
3.23	IME Payments for Discharges After 01/01	12212854	12584165
3.24	Total IME Payments	16350838	16847958
	Difference Compared to As-filed OCR		497120

APPENDIX A

Shands at the University of Florida
Indirect Medical Education Costs
FYE 2000

Cost Report Line # (Wkst. E PT A)	Line Description	Shands as filed	Shands Revised
1.00	DRG Amount Prior to 10/01	13197908	13197908
1.01	DRG Amount After 10/01and Before 01/01	116287152	116287152
1.02	DRG Amount After 01/01	33684958	33684958
1.03	HMO DRG Amount Prior to 10/01	678359	678359
1.04	HMO DRG Amount After 10/01 and Before 01/01	678369	678369
I.05	HMO DRG Amount After 01/01	1356719	1356719
3.00	Calculated Beds	686.89	686.89
3.04	Base Year Medicine FTEs	370.81	329.61
3.06	FTE Count for Affiliated Programs	5.74	6.91
3.07	Adjusted Base Year Count		336.52
3.08	Current Year Medicine FTEs	384.02	375.92
3.13	Dental FTEs	50.53	64.75
3.14	Current Year Allowable FTEs	427.08	401.27
3.15	Total Allowable FTE Count for Prior Year	383.64	393.43
3.16	Total Allowable FTE Count for Pentultimate Prior Year	361.34	342
3.17	Three Year Rolling Average	390.69	378.9
3.18	Current Year Resident to Bed Ratio	0.568781	0.551617
3.19	Prior Year Resident to Bed Ratio	0.508350	0.537018
3.21	IME Payments for DischargesPrior to 10/01	3903241	4098079
3.22	IME Payments for Discharges After 10/01and Before 01/01	4798470	5079273
3.23	IME Payments for Discharges After 01/01	9997428	10496468
3.24	Total IME Payments	18699139	19673820
	Difference Compared to As-filed OCR		974681

APPENDIX A

Shands at the University of Florida
Direct Graduate Medical Education Costs
FYE 1999

Cost Report Line # (Wkst. E-3 PT IV)	Line Description	Shands as filed	Shands Revised
3.01	Unweighted Count for Allo/Osteo FTEs, Base Year	400.00	345.37
3.02	Unweighted Count for Allo/Osteo FTEs, New Program	0	0
3.03	Unweighted Count for AllolOsteo FTEs, Affiliated	0	6.91
3.04	Unweighted Count for Allo/Osteo FTEs, Total	400.00	352.28
3.05	CY Unweighted Count for AllolOsteo FTEs	440.00	393.08
3.06	Lesser of 3.04 or 3.05	400.00	352.28
3.07	Weighted Count of PC FTEs for CY	197.00	153.66
3.08	Weighted Count of Non-PC FTEs for CY	181.00	216.32
3.09	Sum of 3.07&3.08	378.00	369.98
3.10	If3.05<3.04, enter 3.09. Else, Multiply 3.09x(3.04/3.05)	343.64	331.58
3.11	Weighted Dental	50.00	55.91
3.12	Sum of 3.10&3.11	393.64	387.49
3.13	Weighted FTE Count from PY or PY Cap, if lesser	362.00	344.06
3.14	Weighted FTE Count from PPY or PPY Cap, if lesser	0	0
3.15	Three Year Rolling Average	377.82	365.77
3.19	PC APRA	75,420	75,420
3.20	Non-PC APRA	69,278	69,278
3.21	(3.07+3.16) x 3.19	14,857,740	11,589,185
3.22	(3.08+3.11+3.17) x 3.20	16,003,218	18,859,414
3.23	3.21 + 3.22	30,860,958	30,448,599
3.24	Weighted APRA	72,105	71,494
3.25	Gross DGME	27,242.711	26,150,652
4.00	Medicare A Days	67,840	67,840
5.00	Total Inpatient Days	207,958	207,958
6.00	Medicare Utilization	32.62%	32.62%
6.01	Medicare DGME	8,887,117	8,530,858
6.02	HMO after 01/01	2,394	1,197
6.03	Total Inpatient Days	207,958	207,958
6.04	HMO %	40%	40%
6.05	HMO DGME	125.447	60,209
6.06	HMO before 01/01		1,197
6.03	Total Inpatient Days		207,958
6.07	HMO %		20%
6.08	HMO DGME		30,104
	Total Managed Care	125,447	90,313
	Total Traditional Medicare	8,887,117	8,530,858
	Total Medicare	9,012,564	8,621,172
	Difference Compared *to* As-filed OCR		(391,392)

APPENDIX A

Shands at the University of Florida
Direct Graduate Medical Education Costs
FYE 2000

Cost Report Line # (Wkst. E-3 PT IV)	Line Description	Shands as filed	Shands Revised
3.01	Unweighted Count for Allo/Osteo FTEs, Base Year	370.81	345.37
3.02	Unweighted Count for Allo/Osteo FTEs, New Program		
3.03	Unweighted Count for Allo/Osteo FTEs, Affiliated		6.91
3.04	Unweighted Count for Allo/Osteo FTEs, Total	370.81	352.28
3.05	CY Unweighted Count for Allo/Osteo FTEs	400 65	396.07
3.06	Lesser of 3.04 or 3.05	370.81	352.28
3.07	Weighted Count of PC FTEs for CY	166 53	126.12
3.08	Weighted Count of Non-PC FTEs for CY	214.34	262.12
3.09	Sum of 3 07&3.08	380.87	388.23
3.10	If 3 05<3.04, enter 3 09 Else, Multiply 3 09x3 04/3.05	352.5	345.32
3.11	Weighted Dental	61.56	63.33
3.12	Sum of 3.10&3 11	414.06	408.65
3.13	Weighted FTE Count from PY or PY Cap, if lesser	378.45	387.32
3.14	Weighted FTE Count from PPY or PPY Cap, if lesser	362	344.06
3.15	Three Year Rolling Average	384.84	380.01
3.19	PC APRA	81125	81125
3.20	Non-PC APRA	76818	76818
3.21	(3.07+3.16) x 3.19	13509678	10231712
3.22	(3.08+3.11+3.17) x 3.20	21194048	25000216
3.23	3.21 + 3.22	34703726	35231928
3.24	Weighted APRA	78439	78021
3.25	Gross DGME	30186251	29648636
4.00	Medicare A Days	71483	71483
5.00	Total Inpatient Days	219586	219586
6.00	Medicare A Days	32 56	32.56
6.01	Medicare DGME	9827586	9852558
6.02	HMO after 01/01	3757	3757
6.03	Total Inpatient Days	219566	219566
6.04	HMO %	60	60
6.05	HMO DGME	309911	304391
6.06	HMO before 01/01	3758	3758
6.03	Total Inpatient Days	219566	219566
6.07	HMO %	40	40
6.08	HMO DGME	206662	202981
	Total Managed Care	516573	507373
	Total Traditional Medicare	9827586	9652558
	Total Medicare	10344159	10159930
	Difference Compared to As-filed OCR		(184229)

APPENDIX B

SHANDS
HealthCare

CIN: A-04-01-01002

Jeffrey F. Jones
Vice President, Finance

December 28, 2001

Mr. Charles J. Curtis
Regional Inspector General, for Audit
Services, Region IV
61 Forsyth Street, S. W., #3T41
Atlanta, Georgia 30303

Dear Mr. Curtis:

Attached is a formal response to your draft report issued August 29, 2001 and entitled *Review of Graduate Medical Education and Indirect Medical Education Costs at Shands Hospital of UF*. Prior to this response, we have provided your audit staff with the necessary detailed information reconciling all adjustments. Should there be any information that was not adequately detailed or supplied, please call me at your earliest convenience at 352-265-8304.

In our prior conference with your audit staff, it was agreed that we would have the opportunity to meet with the your staff and discuss any remaining issues prior to the issuance of the final report. We look forward to this additional conference.

Sincerely,

Jeffrey Jones
Vice President of Finance,
Shands HealthCare

cc: Tim Goldfarb
Bill Robinson
Dennis Fuller
Mary Ann Moreno
Manuel Guerrero, CPA

PO Box 100226, Gainesville, FL 32610-0326 · 352.265.8304 · 352.265.7966 fax · jonesjf@shands.ufl.edu

APPENDIX B

Shands Hospital at the University of Florida's Response to OIG Draft Report, A-04-01-01002, "Review of Graduate Medical Education and Indirect Medical Education Costs at Shands Hospital at UF"

The findings stated in the OIG Draft Report, A-04-01-01002, titled, "Review of Graduate Medical Education and Indirect Medical Education Costs at Shands Hospital at UF" (hereafter " the draft" or "the draft report") understate the full-time equivalent (FTE) residents that should be reported in the Medicare cost reports and misapplied instructions to calculate reimbursement for both years reviewed. Shands has reviewed the draft report, analyzed its processes after the release of the draft report, and worked with OIG audit staff to reconcile all purported FTE count discrepancies.. This will formalize the verbal response provided to the OIG audit staff, provide additional documentation to support allowable FTEs, and identify the correct interpretation of the cost report instructions.

It is the contention of the draft report that Shands Hospital at the University of Florida:

I. Could not support all the resident FTEs claimed;
II. Included time spent by residents in unallowable activities, such as research and teaching;
III. Included time spent in unallowable areas, and;
IV. Inappropriately classified specialty residents as primary care residents.

Shands respectfully submits that after thorough review of the issues, the OIG will agree that the primary contentions in the draft report are in error.

I. Support of FTEs Claimed

While the draft report correctly sets forth the basic foundations in the law related to IME and GME reimbursement, it failed to consider the changes introduced in the Balanced Budget Act of 1997 (BBA). The BBA introduced a number of changes to Medicare reimbursement for both Graduate Medical Education (GME) and Indirect Medical Education (IME).

A. IME Reimbursement

As part of the changes set forth in the BBA related to IME, limitations were introduced that affected how the resident-to-bed ratio should be calculated

for Medicare inpatient services *on or after October 1, 1997*. In order to calculate resident FTEs appropriately, teaching hospitals are required to follow a specific methodology:

1. A teaching hospital must determine its current year allowable number of resident FTEs. The determination of allowable FTEs for a fiscal period begins by identifying the lesser of (i) the current year FTE count of allopathic and osteopathic residents, or (ii) the base year FTE count of allopathic and osteopathic residents. The current year FTE count of any dental or podiatry residents is then added to this value yielding the current year allowable FTE amount.
2. After the current year allowable FTE amount is determined, a teaching hospital must then use that value plus the allowable FTE count from the most recent two years to arrive at a three-year average FTE amount.
3. It is this averaged value that is used in the determination of the current year resident to bed ratio. This current year resident to bed ratio is then compared to the prior year ratio, which is the prior year allowable FTEs divided by prior year available beds.
4. Medicare then instructs teaching hospitals that the lesser of these ratios determines a teaching hospital's IME adjustment factor and reimbursement. (hereafter these 4 steps are referred to as the "lesser of" method)

In reviewing the work papers and analyses that support the draft report, Shands staff has determined that the OIG did not correctly apply the new methodology to calculate the allowable resident FTEs and the resident-to-bed ratio. The OIG staff utilized cost report instructions that are applicable to hospital fiscal years *that straddled October 1, 1997*, the implementation date for BBA changes and this error yielded an inappropriately low current year allowable amount in step 1 described above. The OIG staff utilized this understated FTE count to arrive at the current and prior year resident-to-bed ratios by erroneously carrying forward the understated value through the remaining steps of the prescribed "lesser of" method. Therefore the basis of the OIG calculation understated the values throughout the analysis.

At the time that Shands was preparing its FYE 1999 Medicare cost report, HCFA was still issuing transmittal instructions to its cost report software vendors as to how IME should be calculated. Since that time, HCFA (CMS) has continued to issue revised transmittals to clarify how IME should be calculated within the cost report. As a result of these transmittals, the

software vendors and the teaching hospital community were unclear as to how the cost report should be properly completed. Shands experienced difficulty using the software for the electronic cost reporting, such that the IME reimbursement amount derived within the cost report was much less than what was calculated using a separate spreadsheet model. Shands recognized that the electronic cost reporting process was, for some unidentified reason, producing an inaccurate IME reimbursement value. A representative of the software vendor has confirmed at that time there was "great confusion" regarding use of the cost report software as it related to the "lesser of" method used to calculate IME reimbursement.

Given these confusing circumstances, Shands modified the FTE count and entered 440 into the electronic cost report to achieve the appropriate IME reimbursement value as calculated by separate spreadsheet model. In the absence of the confusion and erroneous results, produced by the software, the FTE values corresponding to the resident rotation schedules utilized in the separately prepared calculations would have also been utilized in the cost report. In any event, each method achieved the same end result, i.e. Shands stated the appropriate reimbursement value due.

B. GME reimbursement

The BBA of 1997 also introduced a number of changes that affected the reimbursement for GME. First, BBA required that if the current year unweighted allopathic and osteopathic FTE resident count exceeded the unweighted count from the base year, then the current year weighted FTE count would need to be adjusted by a factor of the base year unweighted FTE count divided by the current unweighted FTE count. These adjusted current year weighted primary and non-primary care resident FTE amounts are then multiplied by their applicable Per Resident Amounts (PRA), are summed together and then divided by the total adjusted weighted current year FTE count to arrive at a weighted PRA. This weighted PRA is then multiplied by the three-year average of weighted FTEs.

The importance of the current year unweighted FTE count is that if it exceeds the base year unweighted FTE count, then the otherwise current year weighted FTE count must be reduced. Upon the issuance of the draft report, Shands conducted a comprehensive review of its GME FTE counts.This review indicated that the proper adjusted weighted FTE count, inclusive of dental residents for FYE 1999 reflected in the rotation schedules provided to the OIG auditors should be 387.49 as compared to the originally

reported amount of 393.64. This yields a variance of 6.15 FTEs or 1.56%. Similarly, for FYE 2000, as reflected in schedules provided to the OIG auditors the proper adjusted weighted FTE count should be 408.65 as compared to the originally reported amount of 414.06. This yields a variance of 5.41 FTE or 1.3%. These values are within the traditional level of variance experienced during an audit by the Fiscal Intermediary.

A detailed explanation of the differences in the FTE counts was provided to the OIG audit staff to reconcile the purported discrepancies stated in the draft report. Shands also reviewed the appropriate methodology for evaluating the rotation schedules with the OIG audit staff.

Office of Audit Services Note – This paragraph is not applicable because the issue referred to by the auditee is no longer included in this report.

II. Time in Unallowable Activities

In the draft report, the OIG asserted that Shands did not reduce the number of FTE residents for time spent in unallowable activities and that this omission resulted in an incorrect cost report filing. The report asserts that time identified within Shands rotation schedules for off-site patient care services, ~~vacation, sick time~~, research and ~~teaching~~ should not be allowed as time included for GME and IME purposes. Shands respectfully disagrees. Both federal regulation and GME guidelines support the hospital's position as stated more specifically below.

A. Nonprovider Settings

Resident time spent working in nonprovider settings is allowable, subject to meeting the criteria delineated in 42 CFR 413.86(f). The criteria include the situation when the hospital is bearing substantially all the of resident's salary, fringe benefit costs, and teaching supervision costs. Shands does, in fact, bear substantially all of the residents' salary, fringe benefit costs, and teaching supervision costs in most instances where residents work in nonprovider settings. In response to the draft report, Shands has provided the OIG with contracts that evidence such bearing of costs and demonstrate that this criterion is met. In those cases where the criteria were not met or contracts did not exist, Shands has excluded those applicable FTEs.

Office of Audit Services Note – This paragraph is not applicable because the issue referred to by the auditee is no longer included in this report.

C. Research

Shands agrees with the OIG that research time that is directly related to patient care should be included for IME FTE count purposes. Shands also agrees that time spent in accordance with residency requirements should be included for GME FTE count purposes if required by the residency program. GME guidelines consistently support this inclusion as part of the GME FTE count. The Shands cost reporting process has always excluded funded research time for FTE purposes. As discussed previously (Section t.a., Support Claimed, IME Reimbursement), the confusion related to the preparation of the FYE 1999 electronic cost report led to discrepancies between the electronic cost report calculation and that calculated by a separate spreadsheet model. It may, therefore, be difficult to specifically identify the exclusion in the FYE 1999 electronically filed cost report. However, the exclusion is easily identified in Shands' separate spreadsheet calculations, in the FYE 2000 cost report, and in all supporting rotation schedules.

Office of Audit Services Note – This paragraph is not applicable because the issue referred to by the auditee is no longer included in this report.

III. Time in Unallowable Areas

In the draft report, the OIG asserted that Shands did not reduce the number of FTE residents for time spent in unallowable areas. The OIG staff asserted that Shands failed to remove resident FTEs who were assigned to non-PPS areas of the hospital, e.g. the rehabilitation distinct **part** unit and the psychiatric distinct **part** unit.

It has been a part of Shands' cost reporting procedure to make a reduction to account for FTEs in both the rehabilitation distinct **part** unit and the psychiatric distinct part unit and factor this into the as-filed cost report. This reduction was based on a prior year effort analysis of the time spent in these areas. However, in response to the OIG's stated concerns, Shands developed a specific rotation assignment for accurate backing of these areas and will implement it in January 2002.

IV. Misclassification of Residents

The draft report asserted that Shands claimed specialty residents on the cost report at the higher rate of reimbursement for primary care residents. The draft report claims that Shands misclassified, as primary care residents, 44.87 GME FTEs in FY 1999 and 45.51 GME FTEs in FYE 2000. Shands classification of residents is consistent with the historical direction provided by the Fiscal Intermediary. Although inconsistency in the definitions for primary and specialty care residents exists, Shands concurs with the clarified CMS definitions provided by the OIG. Shands will take steps to ensure it assigns residents as primary and nonprimary care FTEs in accordance with the clarified CMS definitions,

V. IRIS Reconciliation

Shands concurs with the OIG that the IRIS software has problems that affect reporting resident FTE data to the Fiscal Intermediary. However, Shands did not omit data in its reporting process; rather some FTEs were nor: generated in the report because certain data elements are unavailable in the software. For example, if a resident who graduated from a medical or dental school that has not been assigned a number within rhe IRIS database at the time a prim-out of IRIS data is generated, this resident will not appear in the report, Past audits conducted by the Fiscal Intermediary have brought these

problems to light and have resulted in the Intermediary working with CMS to assign numbers for these non-IRIS identified graduate medical and dental programs. The situation was especially problematic in FYE 1999 because Shands added a large number of dental residents whose dental schools were not assigned an IRIS identification number. As a result, at the time when the IRIS report was generated for the OIG's review, these residents did not appear on the IRIS report. This contributed to the discrepancy identified in the report that Shands subsequently reviewed with OIG audit staff. The draft report noted that eleven residents reported in Shands' IRIS data were also reported by other hospitals. A review of the partial FTE amounts claimed by Shands and the other hospitals summed to one FTE or less for all eleven residents. Thus no excess FTEs were claimed against the Medicare program. Shands respectfully suggests that CMS review its IRIS processes to see if improvements can be made.

Conclusion

As a result of Shands' review and analyses following receipt of the draft report, Shands concludes that its FYE 1999 and FYE 2000 cost report reimbursement for IME and GME was understated by approximately $105,728 and $790,452, respectively.

Office of Audit Services Note – This paragraph is not applicable because the issue referred to by the auditee is no longer included in this report.

Should there be any information that was not adequately detailed or supplied, please contact Jeff Jones, Vice President of Finance, at 352-265-8304. In Shands' prior conference with the OIG auditors, it was agreed that Shands would have the opportunity to meet with the OIG staff and discuss any remaining issues prior to the issuance of the final report. Shands looks forward to scheduling this additional conference.