DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

July 25, 2006

Report Number: A-05-04-00071

Ms. Christine Bronson
Medicaid Director
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55155-3815

Dear Ms. Bronson:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Medicaid Support for Graduate Medical Education in Minnesota During Fiscal Year 2000." 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 will make final determination 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-05-04-00071 in all correspondence.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
For Audit Services

Enclosures

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID SUPPORT FOR GRADUATE MEDICAL EDUCATION IN MINNESOTA DURING FISCAL YEAR 2000

Daniel R. Levinson
Inspector General

JULY 2006
A-05-04-00071

Office of Inspector General

http://oig.hhs.gov

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

Office of Audit Services

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

Office of Evaluation and Inspections

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

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

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

The Office of Management and Budget requested that we review Medicaid payments to hospitals for medical education because of concerns regarding the growth of the payments and questions about whether Medicaid funds were involved in intergovernmental transfers.

Under the Social Security Act, Medicare is required to fund the graduate medical education program. Under Medicaid, States may elect to participate in this program, subject to approval by the Centers for Medicare & Medicaid Services (CMS). The Medicaid program offers more flexibility than Medicare in that States have latitude in determining how to best use available funds.

Similar to Medicare, Minnesota currently pays hospitals for Medicaid graduate medical education under two categories: (1) direct medical education (DME) and (2) indirect medical education (IME). Payments for DME are intended to help cover costs incurred by a hospital for medical residents and teaching faculty, including salaries, fringe benefits, and allocations of overhead. A hospital reports the total costs it incurs for DME under separate items on its Medicare cost report. Payments for IME are unlike payments for DME in that no corresponding cost items are reported by the hospital on its Medicare cost report. The costs are therefore not precisely defined or quantified.

Our review covered fiscal year 2000, when Medicaid provided $26 million in graduate medical education funding for DME at 27 teaching hospitals in Minnesota.

OBJECTIVES

Our objectives were to analyze Minnesota's Medicaid graduate medical education payment formula and the methods used by Minnesota to establish the amount of funds that individual hospitals will receive and to determine whether (1) Minnesota followed the approved State plan in administering the Medicaid graduate medical education program and (2) intergovernmental transfers included any funds for graduate medical education.

SUMMARY OF FINDINGS

Payment Methodology

Our analysis of Minnesota's graduate medical education payment formula and the methods used to determine the amount of funds that hospitals receive showed that the payments were generally not based on the hospitals' current needs. Although DME payments of $11 million were based on costs reported on the hospitals' fiscal year 1995 Medicare cost reports, additional one-time payments of $15 million were based on formula calculations from non-cost data.

Except as cited below, payments were made in accordance with State plan provisions.

Noncompliance with State Plan

Although the funds were earmarked for medical education, the State used $150,000 ($77,220 Federal share) for administrative expenses. In accordance with the State plan, the State should have distributed these funds to eligible teaching hospitals.

Other State Plan Issues

Contrary to Federal regulations, the State plan does not include a detailed description of the payment methodology used for the distribution of Medicaid DME funds claimed for Federal matching.

Intergovernmental Transfers

Graduate medical education funds were not used for any intergovernmental transfers between publicly owned hospitals and the State.

Although Federal regulations specify that public funds may be considered as the State's share if the funds are transferred from other public agencies to the State or local agency and are under its administrative control, our prior audits of other types of Medicaid payments identified patterns of abuse. This was not the case for publicly owned hospitals that received graduate medical education funds from Minnesota.

While there were no intergovernmental transfers involved with graduate medical education funding, six hospitals had reassigned funds, totaling $15 million, back to the State. The State used the reassigned funds to support numerous healthcare-related training sites. Although the reassignments were specifically required by the State plan covering fiscal year 2000, we noted that this payment structure was changed effective with fiscal year 2006. Through coordination with CMS, Minnesota amended its State plan to no longer allow for the reassignment of funds.

RECOMMENDATIONS

We recommend that Minnesota:

- report a $77,220 financial adjustment to CMS for the Federal share of graduate medical education funds used for other purposes and

- coordinate with CMS to include the appropriate language in the State plan to explain how the distributions of Medicaid graduation medical education funds were computed and paid to eligible hospitals and training sites.

STATE'S COMMENTS

In written comments to a draft of this report, Minnesota concurred with our recommendations. Minnesota also pointed out what it believed were inaccurate statements included in the Background section of the draft report. We have attached the State's comments in their entirety as an appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We revised the report to eliminate the inaccuracies mentioned by the State.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

The Office of Management and Budget requested that we review Medicaid payments to hospitals for medical education because of concerns regarding the growth of the payments and questions about whether Medicaid funds were involved in intergovernmental transfers.

Medicaid Program

Medicaid was established in 1965 under Title XIX of the Social Security Act as a jointly funded Federal-State program to provide medical assistance to qualified low-income persons. Each State administers its Medicaid program in accordance with a State plan approved by the Centers for Medicare & Medicaid Services (CMS), which is responsible for the program at the Federal level. In Minnesota, the Minnesota Department of Human Services (the State agency) administers the program.

With Federal approvals, State agencies decide whether to cover optional services and how much to pay providers for a particular service. The Federal government pays its share of Medicaid expenditures according to a defined formula, which yields the Federal medical assistance percentage. During fiscal year 2000, the Federal medical assistance percentage for Minnesota was 51.48 percent; the State provided the remaining 48.52 percent.

Graduate Medical Education

Medicare is one of the traditional funding sources for graduate medical education. Medicare funding is authorized under sections 1886(h) of the Social Security Act and covers two categories: (1) direct medical education (DME) and (2) indirect medical education (IME). Payments for DME are intended to help cover a hospital's costs for medical residents and teaching faculty, including their salaries, fringe benefits, and allocations of overhead. A hospital reports the total costs it incurs for DME under separate items on its Medicare cost report. Payments for IME[1] are unlike payments for DME in that no corresponding cost items are reported by the hospital on its Medicare cost report. In contrast to Medicare, Medicaid does not mandate funding of graduate medical education. Nevertheless, almost all States have opted to provide such funding.

Minnesota funds Medicaid graduate medical education under both DME and IME. Part of Minnesota's DME program is based on the Medicare formulas used to establish the diagnosis related group (DRG) rates, meaning that funds are distributed based on formulas that consider the number of residents and other characteristics of each hospital's teaching program. For this part, the DME funds were paid to hospitals through DRGs.

Also under graduate medical education funding, the State made additional Medicaid payments to the six teaching hospitals with the highest number of medical assistance admissions under a program designed to support medical training sites throughout the State.

[1] Indirect Medical Education should not be confused with indirect costs, i.e., allocations of overhead paid under Direct Medical Education.

Intergovernmental Transfers

In certain circumstances, Medicaid allows the use of public funds (funds from county-, city-, or State-owned facilities) as the State's share of financial participation. Pursuant to 42 CFR § 433.51, public funds may serve as the State's share for drawing Federal funds if the public funds are appropriated directly to the State or local Medicaid agency or are transferred from other public agencies to the State or local agency and are under its administrative control. Our prior audits of other types of Medicaid payments found that some States abused this provision. For example, some States required county providers to return Medicaid payments to the State through the use of intergovernmental transfers. The States then used the funds for non-Medicaid purposes.

OBJECTIVES, SCOPE AND METHODOLOGY

Objectives

Our objectives were to analyze Minnesota's Medicaid graduate medical education payment formula and the methods used by Minnesota to establish the amount of funds that individual hospitals will receive and to determine whether:

- Minnesota followed the approved State plan in administering the Medicaid graduate medical education program and

- intergovernmental transfers included any funds for graduate medical education.

Scope

Our review of Minnesota's payment formulas and methods for distribution of graduate medical education funding to 27 teaching hospitals covered fiscal year 2000. These hospitals received a total of $26 million in DME payments from the program.

We visited six institutions to verify payments and determine whether payment controls were adequate. We verified receipt of funds.

We also determined whether intergovernmental transfers were used for program funding.

Our review of internal controls was limited to the State agency's procedures for administering the Medicaid graduate medical education program and the institutions' procedures for verifying receipt of funds and their payment and accounting for funds. We performed fieldwork in June 2004 at the State agency, selected institutions, and the Medicare fiscal intermediary.

Methodology

To understand payment formulas and the methods used for distribution of graduate medical education funding, we reviewed the State plan amendments and discussed distributions with State officials.

We determined whether graduate medical education funds were distributed in accordance with the approved State plan by obtaining from the State agency supporting documentation for payments to the 27 hospitals, institutions and training sites. We resolved discrepancies through discussions with State agency personnel.

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

FINDINGS AND RECOMMENDATIONS

Our analysis of Minnesota's graduate medical education payment formula and the methods used to determine the amount of funds that hospitals receive showed that the payments were generally not based on the hospitals' current needs. Of the $26 million in payments for DME, $11 million was included in diagnosis related group (DRG) rates based on Medicaid cost data taken from the 1995 Medicare cost reports. The remaining $15 million in DME payments were made as one-time payments for medical education to the six teaching hospitals with the highest number of medical assistance admissions.

We found that:

- the State retained as an administrative fee, $150,000 ($77,220 Federal share) of the funds earmarked for supporting Medical training sites.

- the CMS-approved State plan does not contain sufficient information describing the payment mechanism for Medicaid graduate medical education.

- although intergovernmental transfers did not include Medicaid graduate medical education funds, six hospitals had reassigned $15 million back to the State for other Medicaid activities.

PAYMENT METHODOLOGY

Minnesota's Medicaid payment methodology for graduate medical education included a component in the hospitals' DRG rates and one-time DME payments to six teaching hospitals. The DME component was based on formulas not included in the State plan, while the one-time DME payments were provided to the top six teaching hospitals with an approved medical education program.

The DME payments included in the DRG rates were calculated from data taken from each hospital's 1995 Medicare cost report. The hospital's routine costs for 7 cost centers, 17 ancillary service cost-to-charge ratios, and the number of patient days were utilized to compute the average cost per admission. This average cost per admission was standardized for case mix and the average DRG weight factors.

Additional one-time payments were distributed to the top six hospitals based on hospital admissions using non-cost data from the hospital's 1996 Medicare cost report. These payments were calculated based on a formula using the total number of eligible FTEs in each medical program and the statewide average cost per FTE.

Detailed descriptions of the payment methodologies were not provided in the State plan.

NONCOMPLIANCE WITH STATE PLAN

Regarding the additional one-time payments to the top six hospitals, the State plan amendment 4.19-A at section 15.09 required that "the Department of Health must transfer 100 percent of this payment to eligible providers, according to State law." Contrary to this requirement, the Minnesota Department of Health retained $150,000 ($77,220 Federal Share) of these funds for administrative expenses. We noted that these costs were claimed by the State agency as medical service costs, not as administrative expenses.

OTHER STATE PLAN ISSUES

The State plan does not contain adequate description of the payment methodology for Medicaid DME included in hospitals' DRG rates or the additional one-time payments to teaching hospitals. A major portion of the methodology related to the distribution of the additional one-time payments was in the State law but not included in the State plan.

According to 42 CFR 430.10, the State plan must contain all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program. We believe that CMS approved the State plan amendment (TN:00-04) without the necessary information to determine whether these payment methodologies for graduation medical education were appropriate for FFP.

In fiscal year 2000, the State paid $11 million in DME to hospitals through DRG payments and made additional one-time payments totaling $15 million.

INTERGOVERNMENTAL TRANSFERS

The Office of Management and Budget requested that we determine whether publicly owned hospitals that received Medicaid graduate medical education funds had later transferred any part of those funds back to the State.

Medicaid regulations (42 CFR § 433.51) specify that public funds (funds from county-, city-, or State-owned facilities) may serve as the State's share for drawing Federal funds if the public funds are transferred from other public agencies to the State or local agency and are under its administrative control. Our prior audit work, targeting other types of Medicaid payments, identified instances in which States required publicly owned hospitals to transfer the State-funded portion of certain Medicaid payments back to the State agency. States then used the funds for other purposes.

While there were no intergovernmental transfers involving graduate medical education funds during fiscal year 2000, six hospitals had reassigned the additional one-time payments, totaling $15 million, back to the State. The State used the reassigned funds to support numerous healthcare-related training sites. Although the reassignments were specifically required by the State plan covering fiscal year 2000, we noted that this payment structure was changed effective with fiscal year 2006. Through coordination with CMS, Minnesota amended its State plan to no longer allow for the reassignment of funds.

RECOMMENDATIONS

We recommend that Minnesota:

- report a $77,220 financial adjustment to CMS for the Federal share of graduate medical education funds used for other purposes and

- coordinate with CMS to include the appropriate language in the State plan to explain how the distribution of Medicaid graduation medical education funds were computed and paid to eligible hospitals and training sites.

STATE'S COMMENTS

In written comments to a draft of this report, Minnesota concurred with our recommendations. Minnesota also pointed out what it believed were inaccurate statements included in the Background section of the draft report. We have attached the State's comments in their entirety as an appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We revised the report to eliminate the inaccuracies mentioned by the State.

APPENDIX

Minnesota Department of **Human Services**

June 15, 2006

Mr. Paul Swanson
Regional Inspector General for Audit Services
Department of Health and Human Services, Region V
Office of Audit Services
233 North Michigan Avenue
Chicago, Illinois 60601

Re: Report Number A-05-04-00071

Dear Mr. Swanson:

Thank you for the opportunity to provide formal comment regarding your draft audit report entitled "Review of Medicaid Support for Graduate Medical Education in Minnesota During Fiscal Year 2000."

Regarding the findings, I have two comments related to accuracy. First, on page 1, the report states: "Although Minnesota currently funds Medicaid graduate medical education under both DME and IME, it only covered DME during fiscal year 2000. Part of Minnesota's DME program is based on the Medicare design, meaning that funds are distributed based on formulas that consider the number of residents and other characteristics of each hospital's teaching program."

In general, Minnesota's methodology for payment of inpatient hospital services is the use of diagnostic related groups (DRGs) that are specific to each Minnesota hospital. Those DRGs are developed using costs from the Medicare cost report and the hospital's Medicaid claim history. It is incorrect to say that Minnnesota distributes DME funds using the Medicare formula. The only relationship to Medicare is that to the extent DME costs are unallowable for purposes of the Medicare GME payment, they would also be excluded from cost used to calculate each hospital's Medicaid DRGs. Also, Minnesota's DRG payments included both IME and DME in fiscal year 2000, as it did in previous and later years.

Second, on page 3, the report provides that our payment methodology "included an add-on component in the hospital's DRG rates and one-time DME payments to six teaching hospitals." The statement is incorrect to the extent that this statement implies that there is an identifiable component of the DRG that is earmarked for medical education. As noted above, Minnesota's DRGs are specific to each participating hospital, meaning the DRGs are developed based on Medicare allowable cost and Medicaid utilization. Because Medicare's DRG system involves peer grouping, in order to reimburse a specific hospital for its medical education costs, Medicare must use an add-on that is specific to each hospital. In Minnesota, there is no need for an add-on to the DRG because the hospital's specific medical education costs are built into the hospital-specific DRG.

We agree with the recommendation on page 5 that we report a $77,220 financial adjustment for the federal share of medical education funds related to funds retained by the Department of Health for administrative costs.

On pages 4 and 5, the report finds that the state plan does not contain adequate description of the payment methodology, and recommends that we coordinate with CMS to include language in the state plan explaining how the funds were computed and paid to eligible hospitals and training sites. That particular part of the state plan has been reviewed, revised and approved by CMS several times since FY 2000. The current, approved language contains all information necessary under the relevant regulations.

Again, thank you for the opportunity for review and comment. Please feel free to call me if you have questions about this letter.

Sincerely,

Christine Bronson

Christine Bronson
Medicaid Director

Cc: Lynn Barker, Senior Auditor, Office of Audit Services