Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SOME HOSPITALS IN ALABAMA, GEORGIA, AND TENNESSEE CLAIMED RESIDENTS AS MORE THAN ONE FULL-TIME EQUIVALENT

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

James P. Edert
Regional Inspector General
for Audit Services

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Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

Some teaching hospitals in Alabama, Georgia, and Tennessee counted residents and interns as more than 1 full-time equivalent, resulting in excess Medicare reimbursement of approximately $84,000 over 2 years.

WHY WE DID THIS REVIEW

Prior Office of Inspector General reviews found that hospitals in two Medicare Administrative Contractor (MAC) jurisdictions counted residents and interns as more than one full-time equivalent (FTE) and, as a result, received excess Medicare graduate medical education (GME) reimbursement. (In this report, "resident" includes hospital interns.) Based on our findings, we initiated a nationwide series of reviews of hospitals' resident counts.

The objective of this review was to determine whether hospitals in MAC Jurisdiction 10 (consisting of three States – Alabama, Georgia, and Tennessee) claimed Medicare GME reimbursement for residents in accordance with Federal requirements.

BACKGROUND

Federal law authorizes two types of payments to teaching hospitals to support GME programs for physicians and other practitioners. Direct GME payments are Medicare's share of the direct costs of training residents, such as salaries and fringe benefits of residents and faculty and hospital overhead expenses. Indirect GME payments cover the additional operating costs that teaching hospitals incur in treating inpatients, such as the costs associated with using more intensive treatments, treating sicker patients, using a costlier staff mix, and ordering more tests.

A hospital claims reimbursement for both direct and indirect GME, in part, based on the number of FTE residents that the hospital trains and the portion of time those residents spend working at the hospital. No resident may be counted as more than one FTE.

CMS makes available the Intern and Resident Information System (IRIS), a software application that hospitals use to collect and report information on residents working in approved residency training programs at teaching hospitals. The primary purpose of the IRIS is to ensure that no resident is counted by the Medicare program as more than one FTE employee in the calculation of payments for the costs of direct and indirect GME.

Cahaba Government Benefit Administrators, LLC (Cahaba) is a MAC under contract with CMS to administer the Medicare Part A (hospital insurance) program for Jurisdiction 10. For fiscal years (FYs) 2009 and 2010, hospitals in MAC Jurisdiction 10 claimed GME reimbursement totaling approximately $189 million for direct GME and $444 million for indirect GME.

HOW WE CONDUCTED THIS REVIEW

We obtained and analyzed the IRIS data submitted by teaching hospitals in MAC Jurisdiction 10 to identify residents who were claimed by more than one hospital for the same period and whose total FTE count exceeded one. The FTE count for a resident exceeded 1 FTE when the total direct GME percentage and/or the total indirect GME percentage for overlapping rotational assignments, as reported in the IRIS, was greater than 100 percent. For each resident who was counted as more than one FTE during an overlapping period, we obtained and reviewed documentation from the hospitals to determine which hospital should have counted the resident.

WHAT WE FOUND

Hospitals in MAC Jurisdiction 10 did not always claim Medicare GME reimbursement for residents in accordance with Federal requirements. Specifically, 17 hospitals overstated direct and/or indirect FTE counts on cost reports covering FYs 2009 and 2010. As a result, 9 of the 17 hospitals received excess Medicare GME reimbursement totaling $84,355 for residents who were claimed by more than 1 hospital for the same period and counted in the IRIS as more than 1 FTE. For the remaining eight hospitals, the FTE overstatements did not impact the hospitals' Medicare GME reimbursement.

The overstated FTE counts and excess reimbursement occurred because there was no Federal requirement for Cahaba to review IRIS data that hospitals in MAC Jurisdiction 10 submitted to detect whether a resident had overlapping rotational assignments at more than one hospital. As a result, Cahaba did not have procedures to adequately ensure that no resident was counted as more than one FTE in the calculation of Medicare GME payments.

RECOMMENDATIONS

We recommend that Cahaba:

- recover $84,355 in excess Medicare GME reimbursement paid to nine hospitals in MAC Jurisdiction 10,
- adjust the direct and indirect FTE counts claimed on the Medicare cost reports covering FYs 2009 and 2010 for each of the hospitals that did not always claim Medicare GME reimbursement in accordance with Federal requirements,
- consider developing procedures to ensure that no resident is counted as more than one FTE in the calculation of Medicare GME payments, and
- consider identifying and recovering any additional overpayments made to hospitals in MAC Jurisdiction 10 for residents whose FTE count exceeded one on Medicare cost reports submitted after FY 2010.

CAHABA COMMENTS AND OUR RESPONSE

In written comments on our draft report, Cahaba did not concur with our recommendations. Regarding our first two recommendations, Cahaba stated that our related findings have an immaterial impact to the total reimbursable cost on each of the nine hospitals' cost reports and that Cahaba will not reopen and adjust the cost reports to collect excess GME reimbursement. Regarding our third and fourth recommendations, Cahaba stated that its statement of work with CMS does not require or provide funding for the review of IRIS data and its current procedures provide reasonable assurance that GME reimbursement is free from material errors.

After reviewing Cahaba's comments, we maintain that our findings and recommendations are valid. Federal regulations state that no individual may be counted as more than one FTE in the calculation of Medicare GME payments. The cost reports for the 17 hospitals included residents whose total FTE count exceeded one.

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INTRODUCTION

WHY WE DID THIS REVIEW

Prior Office of Inspector General (OIG) reviews found that hospitals in two Medicare Administrative Contractor (MAC) jurisdictions counted residents and interns[1] as more than one full-time equivalent (FTE) and, as a result, received excess Medicare graduate medical education (GME) reimbursement. Based on our findings, we initiated a nationwide series of reviews of hospitals' resident counts. Appendix A contains a list of related OIG reports.

OBJECTIVE

Our objective was to determine whether hospitals in MAC Jurisdiction 10 claimed Medicare GME reimbursement for residents in accordance with Federal requirements.

BACKGROUND

Medicare Payments for Graduate Medical Education

Since its inception in 1965, the Medicare program has shared in the costs of educational activities incurred by participating hospitals. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, makes two types of payments to teaching hospitals to support GME programs for physicians and other practitioners. Direct GME payments are Medicare's share of the direct costs of training residents, such as salaries and fringe benefits of residents and faculty and hospital overhead expenses. Indirect GME payments cover the additional operating costs that teaching hospitals incur in treating inpatients, such as the costs associated with using more intensive treatments, treating sicker patients, using a costlier staff mix, and ordering more tests.

A hospital claims reimbursement for both direct and indirect GME, in part, based on the number of FTE residents that the hospital trains and the portion of time those residents spend working at the hospital. FTE status is based on the total time necessary to fill a residency slot (42 CFR § 412.105(f)(1)(iii)(A)). If a resident is assigned to more than one hospital, the resident counts as a partial FTE based on the proportion of time worked in qualifying hospital areas[2] to the total time worked by the resident. A hospital cannot claim the time spent by residents training at another hospital.[3]

For payment purposes, the total number of FTE residents is the 3-year "rolling average" of the hospital's actual FTE count for the current year and the preceding two cost-reporting periods (42 CFR §§ 412.105(f) and 413.79(d)(3)). No individual may be counted as more than one FTE.[4]

[1] In this report, "resident" includes hospital interns.

[2] These areas are listed in 42 CFR § 412.105(f)(1)(ii).

[3] When referring to the time a resident spends at a hospital, the terms "working" and "training" are interchangeable.

[4] 42 CFR §§ 412.105(f)(1)(iii)(A) and 413.78(b).

Each time a hospital claims GME reimbursement for a resident it must provide CMS with information on the resident's program, year of residency, dates and locations of training (including training at other hospitals), and percentage of time working at those locations (42 CFR §§ 412.105(f) and 413.75(d)).

Intern and Resident Information System

CMS makes available the Intern and Resident Information System (IRIS), a software application that hospitals use to collect and report information on residents working in approved residency programs at teaching hospitals. Hospitals receiving direct and/or indirect GME payments must submit, with each annual Medicare cost report, IRIS data files that contain information on their residents, including, but not limited to, the dates of each resident's rotational assignment. The primary purpose of the IRIS is to ensure that no resident is counted by the Medicare program as more than one FTE employee in the calculation of payments for the costs of direct and indirect GME.[5]

Cahaba Government Benefit Administrators, LLC

Cahaba Government Benefit Administrators, LLC (Cahaba) is a MAC under contract with CMS to administer the Medicare Part A (hospital insurance) program. Cahaba administers the program for MAC Jurisdiction 10, which consists of three States—Alabama, Georgia, and Tennessee. For FY 2009, 51 hospitals in MAC Jurisdiction 10 collected and reported information to the IRIS on residents. In FY 2010, the figure was 50 hospitals.

For FYs 2009 and 2010, hospitals in MAC Jurisdiction 10 claimed GME reimbursement totaling approximately $189 million for direct GME and $444 million for indirect GME.

HOW WE CONDUCTED THIS REVIEW

We obtained and analyzed the IRIS data submitted by teaching hospitals in MAC Jurisdiction 10 to identify residents who were claimed by more than one hospital for the same period and whose total FTE count exceeded one. The FTE count for a resident exceeded 1 FTE when the total direct GME percentage and/or the total indirect GME percentage for overlapping rotational assignments, as reported in the IRIS, was greater than 100 percent. For each resident who was counted as more than one FTE during an overlapping period, we obtained and reviewed documentation from the hospitals to determine which hospital should have counted the resident.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B contains the details of our audit scope and methodology.

[5] 67 Fed. Reg. 48189 (July 23, 2002).

FINDING

RESIDENT FULL-TIME EQUIVALENT COUNT EXCEEDED ONE

If a resident is assigned to more than one hospital, the resident counts as a partial FTE based on the proportion of time worked in the hospital to the total time worked by the resident. A hospital cannot claim the time spent by a resident training at another hospital.[6] In addition, no individual may be counted as more than one FTE in the calculation of Medicare GME payments.[7]

For Medicare cost reports covering FYs 2009 and 2010, 17 hospitals[8] in MAC Jurisdiction 10 claimed GME reimbursement for a resident who was claimed by more than 1 hospital for the same period and whose total FTE count exceeded 1. Specifically, these 17 hospitals overstated FTE counts for direct GME reimbursement by a total of 2.50 FTEs for FY 2009 and 1.78 FTEs for FY 2010. In addition, the 17 hospitals overstated FTE counts for indirect GME reimbursement by a total of 2.06 FTEs for FY 2009 and 1.36 FTEs for FY 2010.

CONCLUSION

Nine of the seventeen hospitals with overstated FTEs in MAC Jurisdiction 10 received excess Medicare GME reimbursement totaling $84,355. Specifically, we determined that these hospitals overstated, on Medicare cost reports for 2009 through 2012,[9] FTE counts for FYs 2009 and 2010. We determined this by using CMS's 3-year rolling average formula. The nine hospitals overstated:

- direct GME reimbursement by $38,851 and
- indirect GME reimbursement by $45,504.

For the remaining eight hospitals, the overstated FTEs did not impact Medicare GME reimbursement because the hospitals were still over their FTE caps[10] after adjusting the claimable direct and/or indirect FTE counts.

The overstated FTE counts and excess reimbursement occurred because there was no Federal requirement for Cahaba to review IRIS data that hospitals in MAC Jurisdiction 10 submitted to detect whether a resident had overlapping rotational assignments at more than one hospital. As a

[6] 42 CFR § 412.105(f)(1)(iii)(A).

[7] 42 CFR §§ 412.105(f)(1)(iii)(A) and 413.78(b).

[8] For FYs 2009 and 2010, the 17 hospitals claimed GME reimbursement totaling approximately $118 million for direct GME and $315 million for indirect GME.

[9] The 2009 FTE overstatements affected GME costs claimed on FYs 2010 and 2011 Medicare cost reports. The FY 2010 FTE overstatements affected GME costs claimed on FYs 2011 and 2012 Medicare cost reports.

[10] Section 1886 of the Social Security Act established caps on the number of residents that a hospital may claim for Medicare direct and indirect GME reimbursement.

result, Cahaba did not have procedures to adequately ensure that no resident was counted as more than one FTE in the calculation of Medicare GME payments.

RECOMMENDATIONS

We recommend that Cahaba:

- recover $84,355 in excess Medicare GME reimbursement paid to nine hospitals in MAC Jurisdiction 10,

- adjust the direct and indirect FTE counts claimed on the Medicare cost reports covering FYs 2009 and 2010 for each of the hospitals that did not always claim Medicare GME reimbursement in accordance with Federal requirements,

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

- consider identifying and recovering any additional overpayments made to hospitals in MAC Jurisdiction 10 for residents whose FTE count exceeded one on Medicare cost reports submitted after FY 2010.

CAHABA COMMENTS

In written comments on our draft report, Cahaba did not concur with our recommendations. Regarding our first two recommendations, Cahaba stated that our related findings have an immaterial impact to the total reimbursable cost on each of the nine hospitals' cost reports and that Cahaba will not reopen and adjust the cost reports to collect excess GME reimbursement. Regarding our third and fourth recommendations, Cahaba stated that its statement of work with CMS does not require or provide funding for the review of IRIS data and its current procedures provide reasonable assurance that GME reimbursement is free from material errors.

Cahaba's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing Cahaba's comments, we maintain that our findings and recommendations are valid. As stated in our conclusion, we acknowledge that there was no requirement for Cahaba to review IRIS data to detect whether a resident in its jurisdiction had an overlapping rotational assignment at more than one hospital. Nevertheless, we identified FTE overstatements that are inconsistent with Federal regulations (42 CFR §§ 412.105(f)(1)(iii)(A) and 413.78(b)) on Medicare GME payments.

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We have provided Cahaba with the overlapping resident data for the hospitals in Jurisdiction 10, along with rotation schedules and other supporting documentation for the FTE overstatements in its jurisdiction. We believe that Cahaba has sufficient information and documentation needed to make the adjustments and appropriate recoveries for all the hospitals that overstated FTE counts.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Review of Resident Data Reported in the Intern and Resident Information System for Medicare Cost Reports Submitted to Highmark Medicare Services, Inc.	A-02-09-01019	01/03/2012
Review of Resident Data Reported in the Intern and Resident Information System for Medicare Cost Reports Submitted to National Government Services, Inc.	A-02-09-01021	10/13/2010
Review of Resident Data Reported in the Intern and Resident Information System for Medicare Cost Reports Submitted to Highmark Medicare Services, Inc., and National Government Services, Inc.	A-02-10-01006	04/02/2012
Review of Resident Data Reported in the Intern and Resident Information System for Medicare Cost Reports Submitted to National Government Services, Inc., and Highmark Medicare Services, Inc.	A-02-10-01007	04/02/2012

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed IRIS data that hospitals in MAC Jurisdiction 10 submitted to support resident training costs claimed on annual Medicare cost reports covering FYs 2009 and 2010. We did not assess Cahaba's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our audit, which did not require an understanding of all internal controls over the Medicare program.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- held discussions with Cahaba officials to gain an understanding of Cahaba's procedures for reviewing IRIS data submitted by hospitals in MAC Jurisdiction 10;
- obtained FYs 2009 and 2010 IRIS data from Cahaba for all hospitals in MAC Jurisdiction 10;
- analyzed the IRIS data to identify residents claimed by more than one hospital for the same rotational assignment (e.g., weekly rotation schedule) and for whom the total FTE count exceeded one;
- obtained and reviewed rotation schedules and other documentation from each hospital in MAC Jurisdiction 10 for each resident for whom the total FTE count exceeded one to determine which hospital should have claimed Medicare GME reimbursement for the resident during an overlapping period;
- adjusted the claimable direct and/or indirect FTE counts for hospitals that should not have claimed GME reimbursement for residents during an overlapping period or provided conflicting documentation that did not resolve the overlapping rotation dates;[11]
- determined the net dollar effect of the adjustments to the direct and indirect FTE counts by recalculating each hospital's Medicare cost report(s);[12] and

[11] We contacted hospitals to determine which hospital was responsible for a resident's overlapping rotation date that exceeded one FTE. If the hospitals could not agree on which hospital should have claimed the resident, we questioned the overlapping FTE count for each hospital using procedures that other MAC contractors have in place.

[12] For 2009 and 2010 cost reports, we used Worksheet E-3, Part IV, to recalculate direct GME reimbursement and Worksheet E, Part A, for indirect GME reimbursement. For 2011 and 2012 cost reports, we used Worksheet E-4 to recalculate direct GME reimbursement and Worksheet E, Part A, for indirect GME reimbursement. (We analyzed different worksheets because CMS changed the worksheets during our audit period.)

- discussed the results of our review with Cahaba officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objectives.

APPENDIX C: CAHABA COMMENTS

May 30, 2014

US Department of Health and Human Services
Office of the Inspector General
Office of Audit Services, Region II
Attention: James P. Edert, Regional Inspector General for Audit Services
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

RE: Some Hospitals in Alabama, Georgia, and Tennessee Claimed Residents as More Than One Full-Time Equivalent **(Report Number A-02-13-01012)**

Dear Mr. Edert:

We appreciate the opportunity to respond to the above mentioned draft report. Cahaba has reviewed the report and its response to each recommendation is as follows:

1. Recover $84,355 in excess Medicare GME reimbursement paid to nine hospitals in MAC Jurisdiction 10: Cahaba does not concur;

2. Adjust the direct and indirect FTE counts claimed on the Medicare cost reports covering FYs 2009 and 2010 for each of the hospitals that did not always claim Medicare GME reimbursement in accordance with Federal requirements: Cahaba does not concur;

3. Consider developing procedures to ensure that no resident is counted as more than one FTE in the calculation of Medicare GME payments: Cahaba does not concur; and

4. Consider identifying and recovering any additional overpayments made to hospitals in MAC Jurisdiction 10 for residents whose FTE count exceeded one on Medicare cost reports submitted after FY2010: Cahaba does not concur.

Reason(s) for nonconcurrence with recommendation #1 and #2:
Each of the individual nine hospital cost reports where the OIG found excess GME reimbursement has an immaterial impact to the total reimbursable cost on each cost report; therefore a reopening of each individual cost report or additional scoping of current work is not necessary.

In addition, due to the immateriality of the adjustments found by the OIG to the direct and indirect FTE counts on the 2009 and 2010 cost reports, we will not incorporate the specific FTE overstatements noted by the OIG, but proceed with our current procedures.

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A CMS Medicare Administrative Contractor

Reason(s) for nonconcurrence with recommendation #3 and #4:
Cahaba GBA is contracted by CMS to fulfill the directives outlined in the J10 Statement of Work (SOW). The J10 SOW requires the contractor to perform an analysis of the provider's cost report to determine the reasonableness of the data contained therein. As part of this analysis, risk is assessed and audit resources are allocated accordingly. Our audit plan considers empirical knowledge, past performance of the provider, and the relative risk associated with the settlement amount calculated from the cost report.

There is no specific requirement in the J10 SOW to audit IRIS data. However, where we find that there is a need to scope GME/IME reimbursement for additional review, we do review hospital rotation schedules, the IRIS data source documentation, to determine if adjustments to the FTE counts are warranted.

Budgetary constraints do not allow for Cahaba to perform a 100% review of each hospital's GME/IME reimbursement. We maintain that our process provides reasonable assurance that the GME/IME reimbursement is free from material error. The OIG's review documented the following:

GME/IME Reimbursement of Total Provider Population Reviewed

	Reimbursement FYs 2009 and 2010	Reimbursement Overstatement	Reimbursement Percentage Error
GME	$189,000,000	$38,851	0.02%
IME	$444,000,000	$45,504	0.01%

GME/IME Reimbursement of 17 Providers with Errors Noted

	Reimbursement FYs 2009 and 2010	Reimbursement Overstatement	Reimbursement Percentage Error
GME	$118,000,000	$38,851	0.03%
IME	$315,000,000	$45,504	0.01%

The review conducted by the OIG supports that our current procedures provide reasonable assurance that no material overpayment of medical education reimbursement exists. Further, the J10 SOW does not require or provide funding for the review of IRIS data or 100% of all FTE counts claimed.

If you should have any questions regarding this report, please contact me at (205) 220-1385 (dgreene@cahabagba.com) or Lisa Bramer at (205)220-1957 (lbramer@cahabagba.com).

Sincerely,

/S. Daniele Greene/

S. Daniele Greene
Internal Audit
Cahaba Government Benefit Administrators®, LLC