Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF GRADUATE MEDICAL EDUCATION REIMBURSEMENTS CLAIMED BY THE WASHINGTON HOSPITAL CENTER FOR FISCAL YEAR 2000

JANET REHNQUIST
INSPECTOR GENERAL

MAY 2002
A-03-01-00018

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OAS FINDINGS AND OPINIONS

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May 7, 2002

Our Reference: Common Identification Number A-03-01-00018

Gregory Ziegler, Director of Reimbursement
Washington Hospital Center
110 Irving Street, NW
Room EB8111
Washington, DC 20010-2975

Dear Mr. Ziegler:

This final audit report presents the results of an Office of Inspector General (OIG), Office of Audit Services audit of graduate medical education reimbursements claimed by the Washington Hospital Center (WHC) for Fiscal Year (FY) 2000. The objective of this review was to determine the accuracy of resident Full Time Equivalent (FTE) counts used by the WHC during FY 2000 to calculate direct graduate medical education (GME) and indirect medical education (IME) payments.

We determined that WHC overstated its calculations for GME and IME by 12.71 and 11.26 FTE's, respectively. These overstatements occurred because WHC claimed reimbursement for residents: (a) who participated in unapproved training; (b) who spent time in unallowable research activities; (c) who exceeded their initial residency period yet were counted as if they were within their initial residency period; (d) who rotated to non-hospital settings; and (e) whose time was not supported with adequate documentation. We also identified a cost reporting error involving a reversal of classifying the number of primary and non-primary residents. As a result of these errors, WHC over claimed GME and IME reimbursements by $768,246.

We are recommending that WHC: 1) adjust the FTE counts reported on its FY 2000 Medicare cost report by 12.71 for GME and 11.26 for IME, which will reduce WHC's FY 2000 claim for GME and IME by $768,246; 2) strengthen controls to ensure that future GME and IME FTE counts are calculated in accordance with Federal requirements; and 3) review prior year open Medicare cost reports and determine if the same criteria violations identified in our review occurred in prior years. If similar findings are identified, WHC should adjust cost reports prior to FY 2000 and notify the fiscal intermediary (FI), CareFirst of Maryland Inc., so the adjustments can be factored

into the audit settlement and where applicable carried forward to the FY 2000 Medicare cost report.

By letter dated March 5, 2002, WHC responded to a draft of this report. With a few exceptions, the WHC generally agreed with the findings and recommendations in our report. The WHC indicated that it has revised its procedures in an effort to further strengthen and improve controls over the verification of the FTE resident counts. In addition, the WHC stated that it will review records related to the prior 2 years, FY 98 and FY 99, to determine if the issues identified in our audit also affected the prior years. The WHC will forward all necessary adjustments resulting from their review of FY 98 and FY 99 together with the findings identified in our audit of FY 2000, to the FI to be incorporated in the cost report settlement process.

The WHC requested that we reconsider our position concerning four programs that we determined were not approved in accordance with Federal requirements. After giving careful consideration to the points raised by WHC on this issue, and affording WHC an opportunity to provide additional documentation to support their position, our finding remained as originally reported.

The WHC's comments are summarized after each finding and their written comments are appended to this report in their entirety. (See APPENDIX A).

INTRODUCTION

BACKGROUND

Washington Hospital Center

The WHC is a 907 bed teaching hospital located in Washington D.C. The WHC is owned by the MedStar Health, Inc., a $1.5 billion[1] multi-provider healthcare system with more than 30 healthcare facilities, 7 of which are hospitals. The WHC reported Medicare reimbursements totaling $201,988,368 for the period July 1, 1999 through June 30, 2000, FY 2000. Of the $201,988,368 reported, $27,182,110 was for medical education costs of interns, residents, and fellows (residents).

Graduate Medical Education Cost Reimbursement

Medical education costs are reimbursed separately by Medicare for two distinct activities; GME and IME. Medicare reimbursement is calculated differently for GME and IME.

The GME includes the direct costs of operating an approved medical resident training program such as the salaries and fringe benefits of the residents, expenses paid to teaching physicians for direct teaching activities and overhead expenses related to the program. The GME reimbursement is based on a formula. A provider is reimbursed

[1] Per the audited financial statements for Fiscal Year 2000.

using a fixed per resident amount which varies from provider to provider. Medicare also makes a distinction between residents in primary care and non-primary care specialties. The per resident amount for primary care specialties is higher than the per resident amount for non-primary care specialties because the primary care specialty amount is updated annually for inflation. The per resident amount for non-primary care specialties was frozen during FYs 1994 and 1995. The WHC claimed GME payments of $7,611,228 during FY 2000.

The IME covers increased patient care costs such as the costs associated with the additional tests that may be ordered by residents which would not be ordered by a more experienced physician. The IME is an *add-on* to a hospital's Diagnosis Related Group payment. In other words, the greater the number of Medicare patients, the higher the IME payments[2]. The IME formula is designed to reimburse a hospital for its increased patient care costs, and its calculation uses the resident to hospital bed ratio. The WHC reported IME reimbursements of $19,570,882 during FY 2000.

Full Time Equivalent Considerations

A primary factor in the calculation of both the GME and IME reimbursements is the total count of FTE residents. During FY 2000, WHC reported total weighted FTE counts of 212.41 residents for GME and 228.96 residents for IME. During FY 2000, 215 WHC employed residents and 259 non-WHC employed residents were included in whole or in part in the FTE counts. The hospital in which a resident works can include his/her time towards the FTE count. Some WHC residents performed all of their duties at WHC, some WHC residents rotated throughout the year to other hospitals and some non-WHC residents rotated to WHC throughout the year. In total, no resident can be counted for more than 1.0 FTE.

Federal regulations govern the FTE count for GME and IME. Factors to be considered when counting GME FTEs include:

- Residents must be in an approved program.[3]

- All residents in their "initial residency period" are eligible to be counted as 1.0 FTE. All residents who have exceeded their initial residency period are weighted only as 0.5 FTE. "Initial Residency Period" is the minimum length of time that it takes the resident to be eligible for board certification.[4]

- All residents who graduated from a foreign medical school must pass a Foreign Medical Graduate Examination in order to be counted in the GME reimbursement count.[5]

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[2] This is also true for direct GME, which uses as part of its formula the Medicare utilization for the particular hospital.
[3] 42 CFR 413.86(c)
[4] 42 CFR 413.86(g)
[5] 42 CFR 413.86(h)(1)(i)

- Residents' time in inpatient and outpatient settings is allowable. If a resident works in an outpatient setting which is not part of the hospital, the hospital can claim the time as if the resident worked in a part of the hospital provided an appropriate written agreement exists between the hospital and the non-hospital provider. The agreement should state that the costs of training the residents would be borne by the hospital.[6]

- Research must be performed as part of the approved residency program.[7]

Factors considered when counting IME FTEs are the same as the GME factors except:

- Time spent doing research can count for IME only if it relates to the direct care of a hospital patient.[8]

- Residents must work in either 1) the prospective payment system (PPS) portion of the hospital, 2) the outpatient department of the hospital[9] or 3) a non-hospital setting, provided an appropriate written agreement exists between the hospital and the non-hospital provider.[10]

Accreditation Council For Graduate Medical Education

The Accreditation Council for Graduate Medical Education (ACGME) is responsible for accreditation of allopathic graduate medical training programs within the United States. The ACGME Board of Directors consists of four representatives from each of its five membership organizations[11], as well as two representatives from the public, one representative from the Federal Government, one physician resident, and the Chair of the Residency Review Committee.

While the ACGME serves as the final authority for accreditation of allopathic residency programs, accreditation authority is delegated to each of its 27 component Resident Review Committees (RRC). The role of ACGME and its component RRCs is to accredit training programs and not to certify individuals in the various specialties and subspecialties.

During the period of our audit approximately 7,600 specialty and subspecialty graduate medical education programs throughout the United States were accredited by ACGME. A listing of all accredited allopathic programs is included in an annual American Medical Association (AMA) publication entitled "Graduate Medical Education Directory", also known as "The Green Book".

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[6] 42 CFR 413.86(f)(4)
[7] 42 CFR 413.86 (f)
[8] Provider Reimbursement Manual 2405.3
[9] 42 CFR 412.105(f)(ii)
[10] 42 CFR 413.86(f)(3) and (f)(4)
[11] The five membership organizations are: (1) the American Board of Medical Specialties, (2) the American Hospital Association, (3) the American Medical Association, (4) the Association of American Medical Colleges and (5) the Council of Medical Specialty Societies.

It should be noted that while the majority of medical training residencies are subject to ACGME approval, certain programs are not approved by ACGME but are subject to the approval of another recognized national organization. Most notably osteopathic residencies are subject to approval by the American Osteopathic Association (AOA), dental residencies are subject to approval by the American Dental Association (ADA), and Podiatry programs are subject to approval by Council of Podiatric Medical Education (CPME). Accreditation by ACGME, AOA, ADA, or CPME represents that a residency program is approved under Medicare reimbursement requirements.

OBJECTIVE, SCOPE, and METHODOLOGY

The objective of our review was to determine the accuracy of the FY 2000 resident FTE counts used by WHC for GME and IME. Our audit was conducted in accordance with generally accepted government auditing standards. To test compliance with the criteria referred to previously and to determine the correct amount of medical education payments that WHC is entitled to we:

- ✓ Identified all residents who were claimed on the WHC FY 2000 Medicare cost report for GME and IME and reconciled the FTE counts to Medicare cost report Worksheet E-3 Part IV for GME and Worksheet E, Part A for IME.

- ✓ Identified the specialty of each resident included on the Medicare cost report, and determined if the specialty was approved in accordance with Federal Regulations.

- ✓ Identified the length of the "initial residency period" per specialty and determined if FTEs were properly weighted for residents who exceeded the "initial residency periods".

- ✓ Identified all residents that graduated from a foreign medical school and determined if they should be included in the FTE count.

- ✓ Identified where the residents worked throughout the year to determine if an adjustment was required because the resident: 1) spent time in research which was not allowable for the purposes of calculating FTEs, 2) rotated to another hospital, 3) worked in a non-PPS area of the WHC (affects IME only), or 4) worked in a non-hospital setting without an appropriate written agreement between the WHC and the non-hospital provider.

- ✓ Discussed the results of our audit with WHC.

- ✓ Determined the net dollar effect of our audit adjustments to the GME and IME FTE counts by recalculating the WHC FY 2000 Medicare cost report Worksheets E-3, Part IV for GME and Worksheet E, Part A for IME.

Our review of the internal control structure was limited to obtaining an understanding of the internal controls over reporting FTEs. This was accomplished through interviews

and testing pertaining exclusively to GME and IME FTE counts. Our audit fieldwork was conducted at the Washington Hospital Center from July 2001 through September 2001.

FINDINGS AND RECOMMENDATIONS

The WHC claimed $27,182,110 for medical education cost reimbursements on its FY 2000 Medicare cost report; $7,611,228 related to GME and $19,570,882 related to IME. Our audit showed that the WHC calculations of IME and GME payments were based on FTE counts which were too high. The WHC inappropriately included:

- 5.26 GME FTEs and 9.31 IME FTEs for residents who were participating in unapproved training.
- 5.0 GME FTEs for residents who spent time in unallowable research activities.
- 0.5 GME FTE for a resident that exceeded the initial residency yet was counted as if within the initial residency period.
- 0.84 GME FTE and 0.84 IME FTE for residents who rotated to non-hospital settings.
- 1.11 GME FTEs and 1.11 IME FTEs for residents whose time was not supported with adequate documentation.

We are recommending reducing the GME FTE count by 12.71 FTE's and the IME FTE count by 11.26 FTE's. In addition, the WHC erred in calculating GME reimbursements by reversing the classifications on the FY 2000 Medicare cost report of residents in primary specialties vs. residents in non-primary specialties. As a result of the FTE count and classification errors, the WHC over claimed GME and IME reimbursement on the FY 2000 Medicare cost report by $768,246. Our results are summarized on the chart on the following page.

SUMMARY OF AUDIT RESULTS					
FINDING	**GME FTE**	**IME FTE**	**GME EFFECT**	**IME EFFECT**	**TOTAL EFFECT**
Unapproved Residency Programs	**5.26**	**9.31**	**$89,483**	**$398,127**	**$487,610**
Unallowable Research	**5.00**	**0.00**	**$84,809**	**$0**	**$84,809**
Improper Weighting	**0.50**	**0.00**	**$8,468**	**$0**	**$8,468**
No written agreements with non-hospital providers	**0.84**	**0.84**	**$14,430**	**$35,643**	**$50,073**
Unsupported Time	**1.11**	**1.11**	**$21,188**	**$47,900**	**$69,088**
Cost Report Error	**N/A**	**N/A**	**$68,198**	**$0**	**$68,198**
TOTALS	**12.71**	**11.26**	**$286,576**	**$481,670**	**$768,246**

UNAPPROVED RESIDENCY PROGRAMS

In order to be included in the calculation for Medicare medical education reimbursement, Federal regulations require that residents be participating in approved medical residency programs. The hospital that employs the resident must be approved in the specialty that the resident has chosen to participate in for the hospital to claim the resident in its FTE count for Medicare reimbursement. A resident can be included in the FTE counts for more than one hospital if the resident rotated to more than one hospital. However, under no circumstance can a resident be counted for more than 1.0 FTE.

We found six unapproved residency programs at WHC in which residents were included in the WHC FY 2000 FTE counts. We also found three residency programs in which a sending hospital was not approved, however, WHC included the non-WHC residents in its FY 2000 FTE count.

As a result, WHC overstated its FY 2000 FTE counts by 5.26 residents for GME and 9.31 residents for IME resulting in overpayments of $487,610; $89,483 for GME and $398,127 for IME. The chart on the following page summarizes the residents programs that we determined were not approved, and the impact on the WHC FY 2000 Medicare cost report.

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UNAPPROVED PROGRAMS						
PROGRAM	HOSPITAL	FTE adjustments		Overpayment ($)		Total ($) Effect
		GME	IME	GME	IME	
Melanoma	WHC		1.0		42,915	42,915
Orthopedic Oncology	WHC		1.79		77,168	77,168
Pain Management	WHC	0.5	1.0	8,553	42,915	51,468
Radiology	AFIP[12]	0.06	0.12	1,067	4,753	5,820
Surgical Oncology	WHC	2.0	2.0	33,962	85,167	119,129
Trauma	WHC	0.5	1.0	8,468	42,915	51,383
Transplant	WHC	2.0	2.0	33,962	85,167	119,129
Pediatric Emergency Medicine	Bellevue[13]	0.04	0.08	711	3,247	3,958
Hematology-Oncology	NIH[14]	0.16	0.32	2,760	13,880	16,640
TOTALS		5.26	9.31	89,483	398,127	487,610

WHC Comments

The WHC agreed with our conclusions on the unapproved programs cited above except for the Surgical Oncology, Trauma, Transplant, and Hematology-Oncology programs. The WHC plans to identify the non-approved residency programs for FYs 1998 and 1999 and notify the FI of the status of these programs.

The WHC stated that it interpreted Medicare regulations as permitting residents participating in fellowship programs to be included in the resident count if the programs were operated under the auspices of an ACGME accredited program. The Surgical Oncology program was operated under the auspices and direction of the accredited General Surgery and Hematology Oncology programs, while the Trauma and Transplant programs were operated as part of the General surgery program.

The WHC also noted that the fiscal intermediary accepted the WHC's contention regarding the trauma and transplant programs via an administrative resolution of the WHC FY 1992 Medicare cost report.

The WHC also stated that the NIH Hematology-Oncology residents that rotated to WHC should be considered allowable because the NIH has separately accredited programs in Hematology and Oncology. The WHC has an accredited combined Hematology Oncology program. Since NIH has accredited programs in both specialties, and the joint

[12] Armed Forces Institute of Pathology
[13] Bellevue Hospital Center
[14] National Institute of Health

program was being operated under the direction of both accredited programs, WHC does not believe that a separate accreditation was needed for the joint programs in Hematology/Oncology.

OIG Response to WHC comments

We do not agree with the WHC's contention that the residents participating in the WHC Surgical Oncology, Trauma and Transplant programs should be included in the FTE counts because they operated under the auspices of other ACGME approved programs. We reviewed the FI's documentation related to their audit and subsequent administrative resolution of issues related to WHC's FY 1992 Medicare cost report. We noted that the FI's decision was rendered in 1998 and that they accepted WHC's position that the Trauma and Transplant programs were operating under the auspices of the ACGME approved General Surgery program and, therefore, residents participating in these programs were includable in the FTE counts.

We also noted that the FI based its decision on the same limited documentation that led us to conclude that the residents were unallowable. We afforded WHC an opportunity to provide additional documentation to show that these programs were reviewed and determined to have met ACGME standards for approval. The WHC could not provide any additional documentation to show that these programs were determined to have met ACGME standards.

We do not agree with the WHC's contention that the NIH Hematology-Oncology residents should be allowable in the WHC FTE counts. The NIH was separately accredited for their Hematology and Oncology programs but was not accredited for their combined Hematology-Oncology program. The WHC argued that a third accreditation for the combined Hematology-Oncology program was not necessary. The NIH residents who were included in the WHC FTE counts were enrolled in the NIH combined Hematology-Oncology program. We discussed this issue with an official from ACGME and confirmed that an accreditation for the combined program was necessary and that a separate accreditation for the Hematology program and the Oncology program did not mean that the combined program was exempt. Since the NIH residents were enrolled in a program that was not approved, Federal regulations dictate that WHC cannot count the time these residents worked at WHC in their FTE counts.

We will advise the FI that the WHC plans to identify non-approved residency programs for FYs 1998 and 1999 so that results of the WHC review along with the results of our audit of FY 2000 can be used to settle the applicable Medicare cost reports.

UNALLOWABLE RESEARCH

Time that residents spend performing research can be included in both the GME and IME FTE counts provided that Federal criteria are followed. To be counted in the GME count, the research must be part of the approved program curriculum. To be counted in the IME count the research must be related directly to the care of a patient at the hospital. The

WHC's practice was to include all research in the GME FTE count, and to exclude all research from the IME FTE count.

We determined that five residents spent the entire FY 2000 in research. This research time was not part of their approved medical residency program, but was an "elective" research year. The WHC appropriately did not claim any of this time in its IME count; however, the WHC included 5.0 FTE in the FY 2000 GME FTE count. As a result the FY 2000 WHC GME FTE count was overstated by 5.0 FTE resulting in a total net effect on the Medicare cost report of $84,809.

WHC Comments

The WHC concurred with this finding. The WHC stated that beginning this FY, the GME office would reflect either mandatory or elective research on its report to the reimbursement department to clarify this information for reporting purposes. In addition, WHC will review its records from FY 98 and FY 99 to determine if research was inappropriately charged in those years and notify the FI of any adjustments that need to be made to the affected Medicare cost reports.

OIG Response to WHC Comments

We concur with WHC's plan of action.

IMPROPER WEIGHTING

Residents working in an approved medical residency program and performing in their "initial residency period" can be weighted as a full 1.0 FTE. The "initial residency period" is defined as the minimum number of years required for board eligibility, and is usually 3-5 years depending on the specialty. If a resident is not in an "initial residency period" then the FTE weighting factor is limited to 0.5.

We determined that one resident claimed as 1.0 FTE for WHC's FY 2000 GME count was not in the "initial residency period", and thus an improper weighting factor was applied. We found that a resident in internal medicine was listed in WHC's records as being in the 5th year during FY 2000. The "initial residency period" for internal medicine is 4 years. As a result, the FY 2000 WHC GME FTE count was overstated by 0.50 FTE resulting in a total net effect on the Medicare cost report of $8,468.

WHC Comments

The WHC concurred with this finding. The WHC believes that their existing controls are adequate in this area since the OIG found only one discrepancy out of 474 residents who rotated through WHC during FY 2000. The WHC does not feel a review of prior years records is warranted.

OIG response to WHC comments

We agree with WHC's plan of action.

NO WRITTEN AGREEMENTS WITH NON-HOSPITAL PROVIDERS

Residents who perform at non-hospital provider sites such as clinics or private physician offices can be included in the hospital's FTE count provided an appropriate written agreement exists between the hospital and the non-hospital provider. The written agreement must clearly state that the hospital is covering the costs of training the residents while they are performing at the non-hospital provider site. Costs include the salaries and fringe benefits of the resident as well as a payment to the non-hospital provider for the supervision of the resident.

At WHC internal medicine residents would typically perform a 4-week ambulatory rotation. During the 4-week rotations, some residents rotated to private practice/non-hospital providers once per week. The WHC was not able to provide a written agreement between WHC and the private practices/non-hospital providers. Therefore, the time spent at these providers by the resident physicians cannot be included in the FTE count.

In addition, three dermatology residents performed 3-month rotations at a private practice. Again, the WHC did not provide a written agreement and therefore the 3-month rotations for the three dermatology residents cannot be included in the FTE count.

As a result, the FY 2000 WHC FTE counts were overstated by 0.84 FTE's for GME and 0.84 FTE's for IME resulting in a total net effect on the Medicare cost report of $50,073; $14,430 for GME and $35,643 for IME.

WHC Comments

WHC concurred with this finding. The WHC stated that to strengthen existing controls, the GME office would ensure that any resident who rotates to an offsite location has a written agreement in place prior to that rotation. The written agreement will specify that the hospital is responsible for the residents' compensation while they are at the offsite location, and for compensation of supervisory teaching activities. The WHC also will review its records from FY 98 and FY 99 to determine if an appropriate written agreement was in place to support claiming FTEs for residents who rotated to non-provider settings.

OIG Response to WHC Comments

We concur with WHC's plan of action.

UNSUPPORTED TIME

As mentioned above, internal medicine residents typically performed a 4-week ambulatory rotation during the year. The WHC usually maintained a weekly schedule, which indicated where the resident rotated Monday through Friday during the 4-week ambulatory rotation.

The WHC could not provide the weekly schedules for several of the internal medicine residents to show where they worked during the 4-week ambulatory rotations. Therefore, we could not determine whether the residents worked in the hospital or at a non-hospital provider with a written agreement with WHC and thus could be counted on the FY 2000 Medicare cost report. As a result of this lack of documentation, the FY 2000 WHC FTE counts were overstated by 1.11 for GME and 1.11 for IME, resulting in a total net effect on the Medicare cost report of $69,088; $21,188 for GME and $47,900 for IME.

WHC Comments

The WHC agree that they could not provide evidence as to where the residents questioned above worked. The WHC attributed this to the departure of the WHC employee who maintained the schedules that listed where the resident worked. The WHC, as an alternative to providing the weekly schedules, asked the residents to recall the areas where they were assigned. The residents could not provide the exact location.

The WHC reviewed prior years (FY 98 and FY 99) and concluded that the appropriate documentation existed and therefore the issue was confined to FY 2000.

OIG Response to WHC Comments

As stated in our report, we could not determine whether residents worked in the hospital or at a non-hospital provider. Work performed at a non-hospital provider would require an appropriate written arrangement between WHC and the non-hospital provider in order to be includable in the FTE counts.

MEDICARE COST REPORT ERROR

For reimbursing of GME costs, Medicare makes a distinction between residents in primary care residencies and residents in non-primary care residencies. The average reimbursement per FTE is higher for primary care residents than for non-primary care residents because the average cost per resident for primary care specialties is updated annually by applying an inflation factor. The per resident amount for non-primary care specialties was frozen during FYs 1994 and 1995. The WHC erred in calculating their GME reimbursement on the FY 2000 Medicare cost report by reversing the classification of primary and non-primary residents. Because of this error, the higher primary care average cost per resident rate was applied to the non-primary care resident count and the lower average non-primary care rate was applied to the primary care residents. This error

resulted in an overstated GME reimbursement calculation of $68,198 on the WHC FY 2000 Medicare cost report.

This error was caused by a simple mistake. The WHC clearly identified the primary care and non primary care residents in its records. However, WHC accidentally reversed the two classifications in carrying the numbers to the FY 2000 Medicare cost report.

WHC Comments

WHC concurred with this finding. In addition, the WHC has reviewed FY 98 and FY 99 Medicare cost reports and determined that the classification of primary care residents and other residents was accurate. Therefore this issue is limited to FY 2000.

OIG Response to WHC Comments

No further comment.

CONCLUSIONS

The WHC overstated the number of residents eligible for both GME and IME reimbursement. As a result, WHC overstated its claim for GME and IME by 12.71 and 11.26 FTE's, respectively. As a result, WHC was overpaid $726,872 as follows.

- $487,610 for residents who were participating in unapproved training.
- $84,809 for residents who spent time in unallowable research activities.
- $8,468 for residents who exceeded their initial residency yet were counted as if they were within their initial residency period.
- $50,073 for residents who rotated to non-hospital settings where an appropriate written agreement did not exist between WHC and the non-hospital provider.
- $69,088 for residents in which time could not be supported with adequate documentation.
- $68,198 for a cost reporting error, as there was a reversal of classifying the number of primary and non-primary residents.

As a result, WHC overstated the FTE count reported on its FY 2000 cost report by 12.71 for GME and 11.26 for IME. Also, the WHC incorrectly classified primary and non-primary residents.

RECOMMENDATIONS

We recommend that WHC:

1) Adjust the FTE counts reported on its FY 2000 Medicare cost report based on our audit results by 12.71 for GME and 11.26 for IME. This adjustment would reduce WHC's FY 2000 claim for GME and IME by a total of $768,246.

2) Strengthen controls to ensure that future reported GME and IME FTE counts are calculated in accordance with Federal requirements.

3) Review prior year open Medicare cost reports and determine if the same criteria violations identified in our review occurred in prior years. Adjust cost reports prior to FY 2000, if necessary, and notify the FI so the adjustments can be factored into the audit settlement and where applicable carried forward to the FY 2000 Medicare cost report.

WHC Concluding Comments

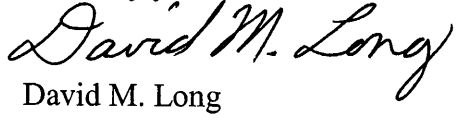
The WHC concluded their comments by stating that they believe that they have effective controls in place to ensure the accuracy of GME and IME FTE counts. The WHC will further strengthen controls based on the issues identified in our report. Finally, the WHC will notify the FI of the findings identified in our report so that they can be incorporated into the settlement of the WHC FY 2000 Medicare cost report.

OIG Response to WHC Concluding Comments

After giving careful consideration to the points raised by the WHC in their formal response to our draft report dated March 5, 2002, we did not adjust any of the findings in our report. We agree with the WHC's plan of action to strengthen their controls to ensure the accuracy of the GME and IME FTE counts. We will send a copy of this final report to the FI to be considered in their settlement of the WHC Medicare cost report.

To facilitate identification, please refer to the referenced common identification number in all correspondence related to this report.

Sincerely yours,



David M. Long
Regional Inspector General
for Audit Services

Washington Hospital Center

March 5, 2002

Mr. David M. Long
Office of Inspector General
Office of Audit Services
Department of Health and Human Services
150 S. Independence Mall West, Suite 316
Philadelphia, PA 19106-3499

Re: Washington Hospital Center Graduate Medical Education 6/30/00
Common Identification Number A-03-01-00018

Dear Mr. Long:

We appreciate this opportunity to comment on the draft report presenting the results of the Office of Inspector General ("OIG") review of the medical education payments claimed by the Washington Hospital Center ("WHC") for the fiscal year ending June 30, 2000 ("FY 2000"), as well as the opportunity we were previously afforded to comment on the OIG's proposed findings. We note that the OIG has revised those proposed findings and has apparently agreed with WHC's position that certain disputed residents were properly included in WHC's resident counts.

As the OIG is aware, WHC has detailed procedures in place to ensure the accuracy of the full-time equivalent ("FTE") resident counts reported on the Medicare cost report for purposes of graduate medical education ("GME") and indirect medical education ("IME") payments. Throughout the year, the Office of Graduate Medical Education ("GME Office") collects, confirms and maintains accurate rotation information for both employed and rotating residents and fellows. In addition, the GME Office compiles the total years of training for each resident and determines the initial residency periods. The GME Office maintains all affiliation agreements, and ensures that agreements are in place for our house staff that are rotating to other institutions per the accreditation requirements.

Upon receiving the IME and GME counts from the GME Office, the WHC Reimbursement Department performs the following verification procedures:

- Obtains yearly rotation schedules from the GME Office
- Verifies that the yearly departmental rotation schedules were properly completed (no blanks should occur in any of the months)
- Assures that all programs are approved by the Accreditation Council for Graduate Medical Education
- Verifies the accuracy of the affiliated rotations against the registration forms
- Verifies that the resident counts do not include residents who have been excluded from participation in the federal programs

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- Compares demographic and residency year against prior year's rotation schedules and resolves any inconsistencies
- Assures that demographic information and residency year on the registration forms agree with the submitted affiliated rotation schedules
- Assures that all in-house residents are included on WHC's payroll register
- Compares in-house rotation schedules against an in-house pictorial directory and resolves any discrepancies
- Verifies that all acronyms on the GME schedule appear on a legend
- Assures all foreign medical residents have an Educational Commission for Foreign Medical Graduates certificate and verifies that the expiration dates are within the qualification period
- Reviews all registration forms for completeness, i.e., social security number, residency level, hospital rotation form, medical school, date of graduation, explanation of any time gaps between graduation date and residency
- Obtains monthly schedules submitted by hospital departments to the GME Office identifying residents who rotated from outside the hospital; reconciles schedules to the registration forms completed by residents rotating from other hospitals to WHC and resolves any discrepancies
- Assures that rotations to a subprovider unit or related to research are excluded from the IME count

WHC devotes substantial personnel time to the performance of these procedures and verification of the FTE resident counts. In light of the size and complexity of WHC's residency training programs (which involve affiliations with many other institutions and the rotation of approximately 474 residents through the Hospital annually), we believe that these procedures worked reasonably well. Based on the OIG's audit and findings, we have revised our procedures in an effort to further strengthen and improve these controls.

Below are our responses to each of the OIG findings. We have also identified the changes we will make to the current controls and have stated how we will address the OIG findings for the cost report periods which have not been settled (FYs 1998 and 1999).

NON-APPROVED PROGRAMS

Based on its findings, the OIG concluded that WHC had overstated its Medicare GME and IME payments by a total of $768,246; of this amount, $487,610 (63.5%) related to what the OIG considered non-approved residency programs. Specifically, the OIG reduced WHC's GME FTE resident count by 5.26 FTEs (reimbursement impact of $89,483) and its IME FTE resident count by 9.31 FTEs (reimbursement impact of $398,127) for non-approved programs.

WHC has a procedure requiring that the GME and IME counts be reviewed to ensure that all programs for which FTE residents are reported qualify as "approved programs" for Medicare purposes. Many of the residents in non- approved programs identified by the OIG were included as the result of a difference in interpretation of the regulations or, in some cases, a mistake (for example, WHC had mistakenly included in the IME counts two programs that were clearly identified by WHC as non-approved).

The following chart summarizes the FTE residents identified by the OIG as participating in non-approved programs and the circumstances relating to their inclusion in the residents' counts.

	GME	IME
WHC Intended to Exclude FTEs	-	2.79
Interpretation of Regulations	4.66	5.32
Other Error	0.60	1.20
Total	5.26	9.31

WHC Intended To Exclude Residents From IME Count

WHC did not intend to include the residents participating in the non- approved programs for Melanoma (1 FTE) and Orthopedic Oncology (1.79 FTE) in the IME FTE resident count. This is evidenced by several documents filed with the intermediary which, when reviewed, demonstrate clearly that WHC intended to exclude these residents.

On the summary worksheet submitted to the Medicare intermediary, WHC reduced the IME and GME FTE resident counts to exclude the residents participating in the Melanoma and Orthopedic Oncology programs. WHC also deleted residents in these programs from the Intern and Resident Information Survey (IRIS) diskette, from the IME resident count on Worksheet S-3 of the as-filed Medicare cost report, and from the GME resident count on Worksheet E, Part IV of the Medicare cost report. However, when completing Worksheet E, Part A of the cost report, WHC mistakenly included the IME resident count figure before the exclusion of the Melanoma and Orthopedic Oncology residents. This error was easily made because the resident count figures before and after the exclusion of Melanoma and Orthopedic Oncology were in close proximity on the spreadsheet used by WHC. It is apparent, however, that this was an unintentional mistake, as evidenced by WHC's exclusion of these residents from the GME resident count and from the IME resident count elsewhere on the cost report.

Difference In Interpretation of Regulations

The OIG's findings indicate that residents participating in the fellowship programs for Surgical Oncology, Trauma and Transplant should be excluded from the GME and IME resident counts because these programs were considered non- approved. Residents excluded in these programs were 5 IME residents (reimbursement impact of $213,249) and 4.5 GME residents (reimbursement impact of $76,392).

WHC interpreted Medicare regulations (42 C.F.R. § 413.86) as permitting residents participating in fellowship programs to be included in the resident counts if the programs were operated under the auspices of an ACGME-accredited program. The Surgical Oncology program was operated under the auspices and direction of the accredited General Surgery and Hematology Oncology programs, while the Trauma and Transplant programs were operated as part of the General Surgery program. In an administrative resolution for WHC's fiscal year 1992, the Medicare

fiscal intermediary accepted this interpretation of the regulations and explicitly approved the inclusion of residents in the Trauma and Transplant programs in WHC's GME and IME resident counts. Based on this, WHC had no reason to exclude these residents from its resident counts and, to the contrary, believed that it was proper to include them in the counts.*/

In addition, the OIG claimed that the NIH Hematology-Oncology residents that rotated to WHC were in a non- approved program (.16 FTE for GME and .32 FTE for IME). NIH has separately accredited programs in Hematology and Oncology WHC has an accredited combined Hematology/Oncology program. Since NIH had accredited programs in both specialties, and the joint program was being operated under the direction of both accredited programs, WHC does not believe that a separate accreditation is needed for the joint program in Hematology Oncology. The OIG disagrees with this interpretation of Medicare requirements and has claimed that these residents are not allowable. We ask that the OIG reconsider its position on this matter.

Other Errors

The remaining non-approved programs identified by the OIG were Pain Management, Radiology and Pediatric Emergency Medicine. For purposes of the IME resident count, Pain Management was 1.0 FTE, Radiology was .12 FTE, and Pediatric Emergency Medicine was .08 FTE. For the GME resident count, each of these FTE amounts was weighted by .5.

Only one resident participated in the Pain Management program. WHC's failure to exclude this resident was simply a mistake which is likely attributable to the small size of the program. The Pediatric Emergency Medicine program was approved in September of 1999, just one month after the resident's rotation to WHC; while the resident participating in that program should have been excluded from the resident counts, in light of this timing, this mistake is understandable. WHC also concurs that the Radiology resident (.12 FTE) should have been excluded; again, this was an error involving a very small residency program at WHC.

In response to the OIG findings, WHC plans to identify the non-approved residency programs for FYs 1998 and 1999 and notify the intermediary of the status of these programs.

UNALLOWABLE RESEARCH

The OIG, during the audit of the resident counts, reviewed all of WHC's personnel files and identified five residents who participated in elective research. Time spent in research activities is included in the GME resident count only if the research is performed as part of the approved program. The reimbursement impact of excluding this resident time from the GME resident count is $84,809.

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*/ If WHC had been aware that these programs were considered non-approved programs, it could have billed Medicare Part B for the patient care services rendered by the fellows (who were licensed physicians). Because it believed, however, that it was permissible to include these fellows in its resident counts, WHC has forgone the opportunity to bill and receive payment for the fellows' services.

The GME Office reports research as part of the resident count to the Reimbursement Department. Beginning this year, the GME Office will reflect either mandatory or elective research on its report to the Reimbursement Department to clarify this information for reporting purposes.

In response to this OIG finding, WHC will identify all residents participating in elective research in FYs 1998 and 1999, determine the amount of time which should be excluded from the resident count, and notify the intermediary of this information.

IMPROPER WEIGHTING

WHC has a number of procedures in place to ensure that the resident's program year and initial residency period are correctly identified and that residents are properly weighted in the GME count. For in-house residents, WHC verifies all program years and initial residency periods assigned against prior years' counts, application forms and the in-house pictorial directory. All residents rotating from outside facilities are required upon arrival to complete a registration form for the GME Office. To ensure the accuracy of the program year and initial residency period for these residents, WHC verifies that the information on the rotation schedule agrees with the registration form. If the resident rotated to WHC in the prior year, WHC will verify that the resident's program year increased by one. All discrepancies are resolved with the Medical Education Department.

The OIG found that, out of 474 residents who rotated through WHC during FY 2000, only one was improperly weighted because he/she had exceeded the initial residency period. WHC considers this finding to be immaterial and believes the controls presently in place to be effective. As a result, WHC does not plan to review FYs 1998 and 1999 for the proper assignment of the initial residency period.

NO WRITTEN AGREEMENTS WITH NON-HOSPITAL PROVIDERS

WHC has Internal Medicine and Dermatology residents rotating to offsite locations. In Internal Medicine, ambulatory rotations are one of many disciplines in which the residents rotate. The ambulatory rotations differ from the other Internal Medicine rotations because they occur in half-day increments. The rotations for ambulatory residents are documented on a block rotation schedule. The block schedules identify the department or facility where the resident is assigned. WHC had excluded most of the rotations to offsite locations when calculating the ambulatory rotation for Internal Medicine. The OIG, however, identified a few offsite rotations for Internal Medicine that were not excluded by WHC. Furthermore, for Dermatology, WHC inadvertently failed to exclude residents who rotated to physician private offices where no written agreement was in place. A total of .84 FTEs were disallowed by the OIG due to the absence of a written agreement for offsite rotations.

To strengthen existing controls, the GME OFFICE will ensure that any resident who rotates to an offsite location has a written agreement in place prior to that rotation. The written agreement will specify that the hospital is responsible for the residents' compensation while they are at the offsite location, and for compensation of supervisory teaching activities.

As a result of this OIG finding, WHC will review the Internal Medicine ambulatory rotation schedules for FYs 1998 and 1999 and ensure that rotations to non-provider settings are excluded from the resident count. WHC will also review the Dermatology rotation schedules to ensure that rotations to physician private offices were excluded.

UNSUPPORTED TIME

During FY 2000, the person maintaining the ambulatory rotation schedules left WHC employment. As a result, WHC was unable to obtain some of the block rotations. The block rotations identified the exact location of the residents for half-day increments. In lieu of providing the block rotations, the ambulatory department called the residents to determine where they rotated during FY 2000. The residents were able to identify the areas where they were assigned but were unable to identify the exact location of their rotation. Since WHC did not have a block rotation schedule to identify the exact location of the residents, the OIG excluded these residents (representing a total of 1.11 FTEs) from the counts.

WHC has reviewed its records for FYs 1998 and 1999 and found that all the ambulatory rotation schedules exist. The problem of missing ambulatory block rotation schedules is confined to FY 2000.

COST REPORT ERROR

WHC agrees that it mistakenly reversed the primary care and other intern and resident counts when transferring the counts from the rotation schedules to the Medicare cost report. As the OIG acknowledges, this error was simply a mistake. WHC has reviewed the cost reports for FYs 1998 and 1999 and has confirmed that primary care and other residents were properly stated.

In conclusion, we believe that we have effective controls in place for ensuring the accuracy of WHC's GME and IME resident counts, and we will make the changes above to further strengthen those controls. WHC will provide the OIG findings to the intermediary for FY 2000, so that they can be incorporated when settling the FY 2000 cost report.

If you have any questions or need any additional information, please feel free to call me at (202) 877-3275.

Sincerely,

Gregory H. Ziegler
Director of Reimbursement

cc: Sean B. Gallagher