DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region I
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October 7, 2003

Report Number: A-01-01-00547

John Meehan
President and CEO
Hartford Hospital
80 Seymour Street
Hartford, Connecticut 06102

Dear Mr. Meehan:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled, "Review of Graduate Medical Education Costs Claimed by the Hartford Hospital for Fiscal Year Ending September 30, 1999." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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To facilitate identification, please refer to Report Number A-01-01-00547 in all correspondence relating to this report.

Sincerely yours,

Michael J. Armstrong

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

James Kerr
Regional Administrator
Centers for Medicare and Medicaid Services
26 Federal Plaza, Room 3811
New York, New York 10278-0063

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF GRADUATE MEDICAL EDUCATION COSTS CLAIMED BY THE HARTFORD HOSPITAL FOR FISCAL YEAR ENDING SEPTEMBER 30, 1999

OCTOBER 2003
A-01-01-00547

Office of Inspector General

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Since its inception in 1965, the Medicare program has shared in the costs of educational activities incurred by participating providers. Medicare makes payments for direct graduate medical education (GME) and indirect graduate medical education (IME) costs. Both GME and IME payments are calculated annually for hospitals based on the number of full-time equivalent (FTE) residents and the proportion of Medicare days of care. Thus, the amount of Medicare funds received by each hospital is determined, in part, by the number of residents at each hospital and the proportion of time residents spend in training.

The Hartford Hospital (Hospital) is a teaching hospital affiliated with the University of Connecticut School of Medicine. More than 500 resident physicians participate in the 35 graduate medical education programs conducted at the Hospital. The Hospital claimed approximately $25.6 million for total GME and IME costs in Fiscal Year (FY) 1999.

OBJECTIVE

The objective of our audit was to determine the accuracy of resident FTE counts used by the Hospital for claiming GME and IME costs in its FY 1999 Medicare cost report.

SUMMARY OF FINDINGS

In its FY 1999 Medicare cost report, the Hospital submitted for reimbursement about $7.8 million in GME and $17.8 million in IME costs. To determine whether the Hospital had accurately computed resident FTEs, an integral part of the GME/IME computations, we reviewed Hospital documentation supporting the FTE counts. Our analysis showed that the Hospital had included 28.69 FTEs into its GME computations and 30.26 FTEs into its IME computations which were not eligible for Medicare reimbursement. Accordingly, we found that $1,530,441 in GME/IME costs did not meet Medicare criteria for reimbursement. The overstated costs included:

- $328,972 for residents who were participating in non-reimbursable residency training programs,
- $270,032 for residents exceeding their initial residency periods without appropriate GME weighting reductions,
- $394,644 resulting from various rotation posting errors,
- $266,878 through the lack of sufficient supporting rotation documentation,
- $125,488 for residents who spent time in non-reimbursable research activities,

- $68,652 for residents who rotated to nonprovider settings where an appropriate written agreement did not exist between the Hospital and the non-hospital provider, and

- $75,775 for residents who served rotations in non-reimbursable Hospital areas.

The computations of overpayments listed above involve the use of three year rolling averages of FTE counts for both IME and GME. The prior two year counts were obtained from the Medicare fiscal intermediary's (FI) 1997 and 1998 GME/IME audits at the Hospital. Our overpayment calculation of $1,530,441 includes $556,289 attributable to the FI's FTE adjustments in the prior two years. Such audits were incomplete during our audit and are used as estimates at this time.

RECOMMENDATIONS

We recommend that the Hospital:

- strengthen its procedures to ensure that resident FTE counts are computed in accordance with Medicare regulations, and

- work with Empire Medicare Services, the Medicare FI, in applying the calculated reductions of $681,540 in GME costs and $848,901 in IME costs to the Hospital's FY 1999 Medicare cost report.

The Hospital, in its August 29, 2002 response to our draft report (see APPENDIX) agreed with $860,875 of our audit findings and plans to develop and improve procedures regarding the (1) audit and monitoring of resident rotations, (2) credentialing of residents, (3) assurance of written agreements between off-site providers and the Hospital, and (4) approval process for research activities. However, the Hospital disagreed with us on specific audit findings regarding non-reimbursable residency programs, resident rotation documentation, non-reimbursable non-provider settings, and non-reimbursable research time. The Hospital also provided additional documentation to support its contentions. Where appropriate, we have adjusted our findings.

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INTRODUCTION

BACKGROUND

Hartford Hospital

The Hartford Hospital (Hospital) is a 600 bed acute care hospital located in Hartford, Connecticut. In 1999, more than 500 resident physicians performed residency rotations at the Hospital. These physicians were enrolled in residency programs sponsored by the Hospital or in affiliation with programs sponsored by the University of Connecticut School of Medicine (UCONN). The Hospital participates with four area hospitals in the UCONN sponsored residency programs in an organization called the Capital Area Healthcare Consortium (CAHC).

Graduate Medical Education and Indirect Medical Education Cost Reimbursement

Medical education costs are reimbursed separately for two distinct activities; Graduate Medical Education (GME) and Indirect Medical Education (IME). The Medicare reimbursement calculations for medical education costs claimed are different for GME and IME.

The formula for GME reimbursement includes the direct costs for salaries and fringe benefits for medical residents in an approved medical resident training program; expenses paid to teaching physicians for direct teaching activities; and overhead expenses related to the program. A provider is reimbursed using a fixed per resident amount which varies among providers. Medicare also makes a distinction between residents in primary care and non-primary care specialties. The per resident amount for primary and non-primary care specialties is updated annually for inflation, with the exceptions of FY 1994 and 1995 for non-primary care specialties. The Hospital claimed reimbursement of $7,762,874 for GME in FY 1999.

The IME reimbursement 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.[1] The IME formula is designed to reimburse the hospital for increased patient care costs and its calculation uses the resident to hospital bed ratio. The Hospital received reimbursement of $17,819,142 for IME in FY 1999.

Full Time Equivalent Considerations

A primary factor in the calculation of both the GME and IME reimbursements is the total count of full time equivalent (FTE) residents. During FY 1999, the Hospital reported

[1] This is also true for direct GME, which uses as part of its formula the Medicare utilization for the particular hospital.

total FTE counts of 206.44 residents for GME and 222.25 residents for IME. During FY 1999, 97 Hospital employed residents and 468 CAHC 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 Hospital residents performed all of their duties at the Hospital, some Hospital residents rotated throughout the year to other area hospitals and some CAHC employed residents rotated exclusively to the Hospital 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.[2]

- All residents in their "initial residency period" (IRP) are eligible to be counted as 1.0 FTE. All residents who exceed their initial residency period are weighted only as 0.5 FTE. The IRP is the minimum length of time it takes the resident to be eligible for board certification.[3]

- 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.[4]

- 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 will be borne by the hospital.[5]

- Research must be performed as part of the approved residency program.[6]

Factors considered when counting IME FTEs are generally 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.[7]

- Residents must work in either; 1) the prospective payment system portion of the hospital, 2) the outpatient department of the hospital[8], or 3) a non-hospital setting,

[2] 42 CFR 413.86(b)
[3] 42 CFR 413.86(g)
[4] 42 CFR 413.86(h)(1)(i)
[5] 42 CFR 413.86(f)(4)
[6] 42 CFR 413.86 (f)
[7] Provider Reimbursement Manual 2405.3
[8] 42 CFR 412.105(f)(ii)

provided an appropriate written agreement exists between the hospital and the non-hospital provider.[9]

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our audit was to determine the accuracy of resident FTE counts used by the Hospital for claiming GME and IME costs in its FY 1999 Medicare cost report. Our audit was conducted in accordance with generally accepted government auditing standards. To test compliance with applicable criteria and to determine the correct amount of medical education payments to which the Hospital is entitled, we:

- Reviewed the results of past GME/IME audits with the Medicare FI,
- Obtained copies of the Hospital's FY 1999 Medicare cost report and supporting Intern and Resident Information System (IRIS) file,
- Identified all residents who were claimed on the Hospital's FY 1999 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,
- Reviewed the residency programs from which residents rotate at the Hospital and determined if these programs were approved in accordance with Federal regulations,
- Ascertained the length of the IRP per specialty and verified if FTEs were properly weighted,
- Identified all foreign medical school graduates and determined if these residents should be included in the FTE count,
- Obtained the rotation schedules for all claimed residents and verified whether individual FTE time was properly computed and that such time was claimed in accordance with Medicare regulations,
- Discussed the results of our audit with the Hospital, and
- Determined the net dollar effect of our audit adjustments to the GME and IME FTE counts by recalculating the Hospital's FY 1999 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

[9] 42 CFR 413.86(f)(3) and (f)(4)

conducted at the Hospital's Newington and Hartford, Connecticut offices from September 2001 through February 2002.

The Hospital's response to our draft report is appended to this report (see APPENDIX). For reasons of resident confidentiality, we have excluded the Hospital's appendices from our report.

FINDINGS AND RECOMMENDATIONS

The Hospital claimed $25,582,016 for medical education cost reimbursements on its FY 1999 Medicare cost report; $7,762,874 related to GME and $17,819,142 related to IME. We identified 28.692 GME FTEs and 30.259 IME FTEs which should not have been included in the computation of GME and IME Medicare reimbursement. Based on available cost report data, these errors effectively overstated the Hospital's FY 1999 Medicare cost report by $1,530,441 ($681,540 GME and $848,901 IME). The overstatement amount includes $556,289 ($345,942 GME and $210,347 IME) attributable to the FI's FTE adjustments for FY's 1997 and 1998. Findings from our review are summarized in the following chart and explained in detail on the following pages.

SUMMARY OF AUDIT RESULTS

FINDING	GME FTE	IME FTE	GME EFFECT	IME EFFECT	TOTAL EFFECT
Non-Reimbursable Residency Programs	5.178	7.342	$122,996	$205,976	$328,972
Completed Initial Residency Periods	11.368	N/A	$270,032	N/A	$270,032
Rotation Postings	7.410	7.793	$176,015	$218,629	$394,644
Rotation Documentation	3.543	6.513	$84,159	$182,719	$266,878
Non-Reimbursable Research Time	0.000	4.473	$0	$125,488	$125,488
Non-Reimbursable Non-Provider Setting	1.193	1.437	$28,338	$40,314	$68,652
Non-Reimbursable Hospital Areas	N/A	2.701	N/A	$75,775	$75,775
TOTALS	28.692	30.259	$681,540	$848,901	$1,530,441

NON-REIMBURSABLE RESIDENCY PROGRAMS

We found that the Hospital needs to strengthen its procedures to exclude from its GME/IME FTE counts those residents who were in residency programs not approved for Medicare reimbursement. Under 42 CFR §413.86(c), Medicare allows payments to hospitals "…for the costs of approved graduate medical education programs…." An approved graduate medical education program is defined under 42 CFR §415.152 as a program accredited by the American Medical Association's Accreditation Council for Graduate Medical Education (ACGME) or by approving bodies of the American Osteopathic Association, the American Dental Association, or the American Podiatric Medical Association. Moreover, 42 CFR §413.86(b) further defines an approved program as a training program which may count toward certification of the participant in a recognized specialty or subspecialty listed in the Directory of Graduate Medical Education Programs published by the American Medical Association or in the Annual Report and Reference Handbook published by the American Board of Medical Specialties.

We identified 37 residents, representing 5.178 FTEs GME and 7.342 FTEs IME, who were in programs not meeting the above criteria during FY 1999. The various programs are summarized below:

Surgical Pathology – (1.588 FTEs GME, 2.252 FTEs IME) The Hospital stated that its fellowship program in surgical pathology could qualify as a credentialing year toward board certification in analytical and clinical pathology. The Hospital supported the credentialing year requirement for two residents. However, the remaining residents showed evidence of completing their credentialing year prior to this year making such time non-reimbursable.

Vascular Surgery - (0.5 FTEs GME, 1 FTE IME) The Hospital sponsors a non-reimbursable second year of vascular surgery after completion of the one-year ACGME accredited program sponsored by UCONN.

Echocardiography – (1 FTE GME, 2 FTEs IME) The Hospital did not have an accredited program in echocardiography nor was there any recognized subspecialty certification in this area as defined in Medicare regulations.

Surgery Outcomes Research - (1.748 FTEs GME, 1.748 FTEs IME) The Hospital sponsors this one year program amid the UCONN-sponsored surgery program. It is not a requisite part of the surgery program and is not attended by all surgery residents.

Internal Medicine and Pediatrics Pre-July 1 Start Dates - (0.342 FTEs GME, 0.342 FTEs IME) We identified first year internal medicine and pediatric residents whose time was being claimed by the Hospital prior to their contracted start date of residency training. In these cases, resident time was being claimed for several days prior to the July 1, 1999 start date stipulated on residents' contracts. According to program staff from

UCONN, the program's sponsor, these residents were not under contract until July 1, 1999. Prior to their contracted start dates, these residents were not in Medicare reimbursable programs.

As a result, we found that the Hospital had overstated its FY 1999 GME and IME claim for reimbursement by $122,996 and $205,976, respectively.

COMPLETED INITIAL RESIDENCY PERIODS

We found that the Hospital needs to improve its controls to provide the proper reduced FTE weighting to residents exceeding their IRP. As defined in 42 CFR §413.86, an IRP is the "…the minimum number of years required for board eligibility…." For purposes of GME reimbursement, residents in their IRP can be claimed at a full weighting factor of one. All residents who have exceeded their IRP are weighted at a reduced 0.5 factor. Reimbursement for IME is not affected by weighting factors.

Based on our review, we identified 61 residents, totaling 11.368 FTEs, who were beyond their IRP yet were erroneously claimed at full weight. The majority of these errors were discovered upon our review of residents' curriculum vitae or other personnel information, which identified a prior residency at another hospital. For example, we identified a resident who was enrolled in the addiction psychiatry program and was claimed at full GME weight during our audit period. However, upon examination of the resident's personnel file, we identified a prior initial residency in psychiatry at an out-of-state hospital. We also identified several residents who began their residency training in internal medicine, a three year IRP, but ultimately switched to another residency program of longer duration. The Hospital claimed the IRP of the longer program in error.

The Hospital's overstated FY 1999 GME resident count of 11.368 FTEs resulted in $270,032 overstated on its cost report.

ROTATION POSTINGS

We found that the Hospital needs to improve its controls to ensure the accurate recording of resident rotations to its IRIS file. Because residents also rotate to other area hospitals, proper safeguards must be in place to ensure no duplicate rotations are recorded and that no residents exceed 1.0 FTE per year. To this end, the CAHC hospitals have developed a shared database to record and track resident rotations. This system was first implemented for the FY 1999 reporting period. We found that this new system is an effective control in reporting accurate resident rotations. However, such a computer-based system is only as effective as the input made to the system. Our detailed reconciliation of resident rotation schedules to its IRIS files disclosed the following posting errors:

- *Database entry errors* – We identified 6.737 GME FTEs and 6.991 IME FTEs resulting from entry errors made in the compilation of the database shared by the CAHC. The most common error involved assignment of rotations to the wrong

hospital. Other database errors included duplicate entries and rotations claimed for residents subsequent to their termination date.

- *Discrepancies with Hospital monthly audit* – Each month, the Hospital reconciles its preset rotation schedules to actual rotations served by requiring program directors to certify resident attendance. In theory, this system is an effective control but we identified 0.673 GME FTEs and 0.802 IME FTEs from which program directors denoted changes from the original rotation schedule but no updating change was made to reduce the FTE count.

These posting errors resulted in an overstatement of 7.41 GME FTEs totaling $176,015 and 7.793 IME FTEs totaling $218,629.

ROTATION DOCUMENTATION

We found that the Hospital needs to strengthen its controls to ensure that residents' time claimed for GME/IME reimbursement was properly documented and in compliance with Medicare regulations. In accordance with 42 CFR §413.24, "…Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors…. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization…."

As evidence to support the FTEs claimed on its cost report, the Hospital provided us with rotation schedules which provided a basis for tracking resident activities throughout the year. Generally, these rotation schedules showed, for any given month, the hospital and department to which the resident rotated for that period. Nearly all programs had rotation schedules. These documents were critical to us in determining whether the time claimed was in accordance with Medicare regulations.[10]

We identified 19 residents enrolled in residency programs who had no rotation schedule to document their time in these programs. Many of these residents were in subspecialty fellowship programs. In lieu of rotation schedules, the Hospital provided program descriptions and resident summary sheets as documentary evidence. The Hospital also stated during our audit that, for many of these residents, all residency time was spent solely at the Hospital. For three residents, the Hospital initially could not locate rotation schedules but later presented us with a representation of a 1999-2000 rotation schedule signed by the program director in 2002. We believe that all such alternative documentation provided by the Hospital is not sufficient to prove Medicare compliance and support reimbursement.

[10] In fact, contrary to the Hospital's claim, rotation schedules identified residents in unallowable areas, in unallowable research time or at other providers. These findings are explained in detail in other captions of this report.

Accordingly, we identified 3.543 FTEs in GME totaling $84,159 and 6.513 FTEs in IME totaling $182,719 which should not be reimbursed by Medicare.

NON-REIMBURSABLE RESEARCH TIME

We found that the Hospital needs to take proper measures to exclude research time not eligible for Medicare reimbursement from its IME FTE computations. To be included in the IME count, the Medicare Provider Reimbursement Manual PRM1 2405.3(F)(2) states that IME reimbursement is not allowable if the resident "…is engaged exclusively in research." Further, the Federal Register, Volume 66, Number 87, page 22,695 states that "…Resident time spent 'exclusively' in research means that the research is not associated with the treatment or diagnosis of a particular patient of the hospital. Therefore, although the research component may be part of an approved program, the time that residents devote specifically to performing research that is not related to delivering patient care, whether it occurs in the hospital complex or in non-hospital settings, may not be counted for IME payment purposes…."

We identified 4.473 IME FTEs, totaling $125,488, related to monthly resident rotations spent in research. While the Hospital was able to provide a description of some of the residents' research projects, the residents' activities were not directly related to the treatment or diagnosis of a particular patient at the Hospital. Accordingly, we believe that these costs should not be reimbursed by Medicare.

NON-REIMBURSABLE NON-PROVIDER SETTINGS

We found that the Hospital needs to strengthen its controls to preclude inclusion of resident time in non-provider setting not reimbursable under Medicare. Effective January 1, 1999, 42 CFR §413.86(f)(4) requires that time spent in non-provider settings such as freestanding clinics, nursing homes, and physician offices in connection with approved programs may be included in FTE calculations provided resident's time is spent in patient care activities and an appropriate written agreement exists between the hospital and the non-hospital provider. The written agreement must 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. The hospital must incur all or substantially all of the costs for the training program in the nonprovider setting.

We identified 1.193 GME FTEs and 1.437 IME FTEs totaling $28,338 and $40,314, respectively, for non-hospital rotations. We found residency programs providing off-site monthly rotations to such organizations as the state medical examiner's office, the American Red Cross Blood Services-Connecticut Region, and a physician's office. The Hospital acknowledged that there were no written agreements in place in 1999 addressing compensation for the non-hospital rotations. The Hospital contends that the required written agreement did not have to be in place prior to the training being initiated. Therefore, the Hospital presented us with contracts prepared and signed during the time of our audit in 2002 but retroactive to 1999. Without existing written contractual

agreements with these organizations during the time the services were performed, we do not believe valid support exists to confirm that the Hospital incurred full program costs in accordance with Medicare regulations. Accordingly, such rotations should not have been included in the Hospital's GME/IME FTE counts for Medicare reimbursement.

NON-REIMBURSABLE HOSPITAL AREAS

The Hospital needs to improve its controls to exclude from Medicare reimbursement the IME computations for resident time spent in non-Prospective Payment System (PPS) areas of the hospital. For purposes of counting FTEs for IME, 42 CFR §412.105(f)(ii) states that residents must work in either 1) the prospective payment system (PPS) portion of the hospital 2) the outpatient department of the hospital, or 3) a non-hospital setting, provided an appropriate written agreement exists between the hospital and the non-hospital provider.

On its FY 1999 Medicare cost report, the Hospital identified certain psychiatry program residents rotating in its non-PPS unit inpatient psychiatric facility and excluded their time from its IME computations. However, we identified additional residents who also had inpatient psychiatric rotations in this program, the child and adolescent psychiatry program, and the internal medicine program. As a result, we identified an additional 2.701 FTEs, totaling $75,775, which should not have been claimed for IME reimbursement.

CONCLUSION

In its FY 1999 Medicare cost report, the Hospital submitted for reimbursement about $7.8 million in GME and $17.8 million in IME costs. Based on the results of our audit, we found that the Hospital had overstated the number of residents eligible for both GME and IME reimbursement. Such erroneous FTEs included residents in non-reimbursable programs, residents exceeding their initial residency periods without appropriate GME weighting reductions and various other recording errors. As a result, the Hospital overstated its claim for GME and IME by 28.692 and 30.259 FTE's, respectively.

The computations of overpayments listed above involve the use of three year rolling averages of FTE counts for both IME and GME. The prior two year counts were obtained from the FI's 1997 and 1998 GME/IME audits at the Hospital. Such audits were incomplete during our audit and are used as estimates at this time. Accordingly, we estimate that the Hospital was overpaid $1,530,441. This overpayment estimate includes $556,289 attributable to the FI's prior two year FTE adjustments.

RECOMMENDATIONS

We recommend that the Hospital:

- strengthen its procedures to ensure that resident FTE counts are computed in accordance with Medicare regulations, and

- work with Empire Medicare Services, the Medicare FI, in applying the calculated reductions of $681,540 in GME costs and $848,901 in IME costs to the Hospital's FY 1999 Medicare cost report. [11]

AUDITEE RESPONSE

The Hospital agreed with $860,875 of our audit findings and, in its response dated August 29, 2002 (see APPENDIX),[12] plans to develop and improve procedures regarding the (1) audit and monitoring of resident rotations, (2) credentialing of residents, (3) assurance of written agreements between off-site providers and the Hospital, and (4) approval process for research activities. However, the Hospital disagreed with us on specific audit findings addressing non-reimbursable residency programs, resident rotation documentation, non-reimbursable non-provider settings, and non-reimbursable research time. We address each of these issues below and provide our comments.

Non-Reimbursable Residency Programs

The Hospital provided us with a 1995 letter from the FI at that time in which this FI reconsidered the allowability of three previously disallowed residency programs. The Hospital also states that the HCFA regional office concurred with this issue. On the basis of its reliance upon this letter, the Hospital believes that all other programs we found non-reimbursable should be allowable.

The Hospital also states that certain programs should be considered approved because such training may count toward the certification of the participant in established specialties or subspecialties as specified under Medicare regulations. Further, the Hospital states that its surgical pathology fellowship may satisfy the "credentialing year" requirement to enter the American Board of Pathology's board certification examination. The Hospital provided documentation confirming that two residents had used the Hospital's fellowship as their credentialing year.

OIG Comments

Based on the documentation provided by the Hospital, we agree that resident training in the gastroenterology program would qualify toward certification in this subspecialty. In addition, we agree that pathology credentialing year time was satisfied by two residents in the surgical pathology fellowship. We have made the appropriate adjustments to our audit findings.

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[11] We recognize that the FY 1997 and 1998 Medicare cost reports were open at the time of our audit and the FY 1996 cost report may be reopened. Settlement of these cost reports with any resultant FTE adjustments by the FI play an important part in the computation of FY 1999 graduate medical education costs. Therefore, the reductions in GME/IME reimbursements recommended in this report may be subject to change.

[12] The Hospital's response included a narrative section along with 11 appendices. We are including the narrative section with this report but excluding the appendices as they contain confidential and personal identification information.

We disagree with the Hospital regarding the approval of its echocardiography program. This program does not meet the criteria set forth in 42 CFR §413.86(b) in that the program is not recognized in any of the specified publications. In regard to the remaining findings in this category, the Hospital introduced no new relevant information to cause us to adjust our findings.

Rotation Documentation

The Hospital states that our recommended disallowance based on its failure to produce documentation of the residents' rotation schedules within the Hospital exceeds the scope of Medicare rules and regulations, is unsupported by general Medicare record-keeping regulations, and results in the imposition of a standard which was not properly promulgated in accordance with the Federal administrative rule making requirements. The Hospital believes that imposing this retroactive requirement, which it states did not exist in FY 1999, is arbitrary and capricious. The Hospital states that had it been aware of this requirement, it would have retained such documentation for audit purposes. The Hospital further states that it provided us with applicable IRIS reports, which should, on its own, provide sufficient documentation to support the claimed costs. The Hospital provided us, as an attachment to its response, rotation schedules for internal medicine chief residents and another resident.

OIG Comments

We reviewed the previously undisclosed rotation schedules provided by the Hospital for the four chief residents and one other resident. We adjusted our findings to allow for their time. Our adjustment did factor into account initial residency period errors and Hospital monthly audit discrepancies which we found with these residents' time.

We disagree with the Hospital that documentation requirements, including rotation schedules, were a retroactive requirement not in place in FY 1999. Prior FI audits of hospital medical education costs have traditionally included the testing of rotation schedules and other contemporary documentation to support the FTEs claimed on cost reports. In response to our initial request for documentation supporting the intern/resident FTE counts, the Hospital responded with a comprehensive collection of rotation schedules of residents rotating both among other hospitals and exclusively within the Hospital. In order to verify the validity of FTEs claimed by the Hospital, we relied upon these rotation schedules and other contemporary documentation contained in resident files supplied to us by the Hospital. We also accepted current testimonial evidence from Hospital staff to the extent that it corroborated or clarified the contemporary support. In a meeting with Hospital officials to discuss our draft report, we offered to review previously undisclosed resident evaluations for the audit period in an effort to verify the residents' time. The Hospital agreed but subsequently did not avail this information to us.

We disagree with the Hospital that its IRIS report provides sufficient documentation to support its claimed costs. Our audit results have shown that the Hospital's claim for medical education costs was materially inaccurate. Our testing of the validity of the resident FTEs documented in the IRIS report disclosed significant errors, of which many such errors were not disputed by the Hospital. The Hospital's implementation of a new automated resident tracking system is a positive step to IRIS report accuracy but such a database is only as accurate as the input from trained staff.

Non-Reimbursable Non-Provider Settings

The Hospital acknowledged that it did not enter into written agreements with outside entities for which it rotates residents during the subject year. The Hospital did prepare written agreements with these non-hospital settings dated subsequent to the audit. The Hospital states that our not accepting these agreements is unreasonable in that the applicable Medicare regulation does not specifically state that the written agreement must exist prior to the resident rotating to the non-hospital setting. The Hospital states that (1) the non-hospital settings did not file a Medicare cost report and thereby did not duplicate the same costs, (2) the Hospital assumed full responsibility for resident compensation, and (3) the residents were involved in patient care activities. Therefore, the Hospital states it incurred the full program costs for these residents. Nonetheless, the Hospital states that the fact that the Hospital did not incur any costs in connection with compensating the non-hospital site is not cause for the disallowance.

OIG Comments

We disagree with the Hospital. The contracts produced by the Hospital were prepared at the completion of our fieldwork in March 2002, approximately three years after our audit period. We reiterate that without existing written contractual agreements with these organizations during the time the services were performed, we do not believe valid support exists to confirm that the Hospital incurred full program costs in accordance with Medicare regulations.

Non-Reimbursable Research Time

The Hospital took exception to the identified research time of two residents. For one resident, the Hospital supplied additional information to support patient care activities during the time period in question. For the second resident, the Hospital states that this resident was not engaged in research during this period but was participating in the Hospital's surgical critical care program.

OIG Comments

Concerning the first resident, the Hospital supplied us with a 2002 letter from the program director stating that the resident was involved in bedside clinical research and was assigned in-hospital call every fourth day during the questioned month. We were unable to confirm this to contemporary documentation supplied by the Hospital and are

recommending disallowance of this research month. For the second resident, the Hospital supplied us with an appointment letter to the surgical critical care program dated in 1998. However, we obtained from the resident's file a House Staff Authorization form stating the resident was in research during the time period and a surgical house staff roster also showing the resident in research. Further, the Hospital's IRIS record showed the resident in the UCONN surgery program. The physician's profile filed with the State of Connecticut does not list any surgery critical care training. Without corroborating evidence, we are recommending disallowance of this resident's time.

A P P E N D I X

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August 29, 2002

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Re: Hartford Hospital Provider No. 07-0025/GME Audit FYE Sept. 30, 1999

Dear Greg:

On behalf of my client, Hartford Hospital (the "Hospital"), I would like to respond to your draft report entitled "Review of Graduate Medical Education Costs Claimed by Hartford Hospital for Fiscal Year Ending September 30, 1999 (the "Draft Report"). The following discussion will address those areas for which Hartford Hospital (the "Hospital") takes exception to your audit findings as outlined in the Draft Report.

I. Non-Reimbursable Residency Programs. The Draft Report states that the reimbursement claimed by the Hospital for 6.218 GME FTEs and 8.506 IME FTEs should be disallowed for Fiscal Year Ending September 30, 1999 ("FYE 1999"). The basis for the disallowance is the assertion that the subject residents were not in reimbursable residency programs. The Hospital disputes 5.876 GME FTEs and 8.164 IME FTEs of the proposed disallowance for the reasons described below.

a. *Intermediary Approved Subject Programs*. The Hospital relied upon the direction and guidance of Aetna Life Insurance Co., (the "Intermediary") in claiming reimbursement for its IME and GME costs associated with its Transplant, Trauma, and Surgical Critical Care Fellowships during the subject year. According to Mr. Charles Austin, the Hospital's Director of Medicare Reimbursement, the Hospital was in receipt of a letter from its Intermediary dated August 3, 1995 confirming that it was approving the Hospital's claim for

reimbursement for its Trauma, Transplant and Surgical Critical Care Fellowship programs. More specifically, the Intermediary stated:

> Upon reviewing your request, we contacted the accreditation council in Chicago for further guidance as to what the Transplant Fellow, EMS Trauma and Surgical Trauma residency program specialties would be accredited under. They informed us that the above mentioned specialties would be approved under the following residency programs:
>
> Transplant Fellow – Surgery
> EMS/Trauma – Emergency Medicine
> Surgical Trauma – Surgery Critical Care

See Attachment A.

Based upon the Intermediary's letter, the Hospital believed that the GME and IME costs associated with its Transplant, Trauma and Surgical Critical Care Fellowships were approved by virtue of the Fellowships' respective relationships with existing ACGME approved residency programs. In reliance upon this instruction and guidance from the Intermediary, the Hospital perpetuated these programs. We understand that DHHS agrees with the Hospital that it was appropriate for the Hospital to rely upon the Intermediary's guidance with respect to whether or not these programs qualify for reimbursement.

In further reliance upon the Intermediary's guidance, the Hospital concluded that its other non-ACGME approved Fellowship programs would be similarly approved for reimbursement by virtue of their affiliation with other ACGME approved residency programs. It is the Hospital's position that its further reliance was reasonable given that "[t]he Intermediary has the responsibility of providing necessary guidance to providers in preparing their cost reports." Prov. Reimb. Man., Part I, § 2905.2. See Attachment B.

On behalf of the Hospital, I contacted Ms. Shannon P. Healy (formerly of the Intermediary and the author of the letter attached hereto as Attachment A) to confirm the Hospital's interpretation of the letter. Ms. Healy has confirmed that the Hospital's interpretation of the letter was correct and further informed me that the FYE 1995 audit performed by the Intermediary for the Hospital was randomly selected by the Health Care Financing Administration (the "HCFA" now CMS) from a pool of providers for a complete audit by the Regional Office. According to Ms. Healy, CMS rendered no findings with respect to either the Intermediary or the audit itself. The Hospital believes that this is a significant fact since the

Hospital claimed the same programs in its FYE 1999 cost report that it claimed in its FYE 1995 cost report. Accordingly, DHHS should not disallow costs for the subject programs because the Hospital reasonably relied upon the guidance and instructions of its Intermediary in perpetuating the subject programs.

Based upon the foregoing, it is the Hospital's position that the proposed audit adjustment for non-approved programs for the following residents should be reversed in that the subject programs were created and structured in reliance upon the Intermediary's guidance.

Program	**IME error**	**GME error**
IM-Cardiology-Echocardiography	2.00	1.00
Surgical Pathology	3.17	2.5
IM-Gastroenterology	0.249	0.125
Surgery	1.748	1.748
Vascular Surgery	1.00	0.500
Total	**8.167**	**5.873**

(b) *Counted Toward Certification*. Moreover, with respect to the proposed audit adjustment taken for the third year of the subject Gastroenterology Fellowship, and the proposed audit adjustments taken for IM-Cardiology-Echocardiography and Surgical Pathology, it is the Hospital's position that those audit adjustments should be reversed because the subject training either did count or may count in the future toward primary or specialty board certification for the subject residents.

More specifically, 42 CFR §413.86(b) provides, in relevant part, that an "approved medical residency program" means a program that meets one of the following criteria:

(1) Is approved by the national organizations listed in §415.152 of this chapter.

(2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications;

(a) The directory of Graduate Medical Education Programs published by the American Medical Association and available from American Medical Association....

(b) The Annual Report and Reference Handbook published by the American Board of Medical Specialties.

Based upon the above regulatory language, it is clear that there is no requirement for the Hospital to prove that the resident actually received certification in order to claim and receive program reimbursement. Instead, the Hospital must only demonstrate that the training program *may* count toward certification. If the Hospital were required to provide that each resident became certified, then it would illogically follow that the Hospital would not be entitled to claim reimbursement for residents who failed to become board certified. Accordingly, it is the Hospital's position that the audit adjustments for the Fellowship programs listed below should be reversed in that the training *may* count towards certification for the subject fellows.

As further support for the Hospital's position is the decision rendered by the Provider Reimbursement Review Board in Ellis Hospital (Schenectady, N.Y.) v. Blue Cross and Blue Shield Association/Empire Blue Cross and Blue Shield, PRRB Hearing, (Feb. 27, 1998), wherein the PRRB reversed the intermediary's decision to disallow Ellis Hospital's GME and IME costs for its non-ACGME accredited fellowship program in critical care. See Attachment C. In the Ellis Hospital case, the intermediary disallowed the cost of the FTEs for critical care fellows based on the fact that their program was not an ACGME approved fellowship. Ellis Hospital contended that ACGME accreditation is not the "sine qua non" of reimbursement and that, although the critical care training program was not accredited, it did count toward board certification in critical care medicine. The PRRB found that the provider properly included the critical care fellows in their cost report, and that even though no formal program had been established, it had residents performing critical care activities.

Specifically and in the instant case, the Hospital takes exception with respect to the disallowance for the third year of one of its Gastroenterology Fellows. Gastroenterology Fellow "aa 579" completed his third year of fellowship ending 6/30/99, seventeen months prior to the Hospital's Gastroenterology Fellowship was accredited by the ACGME as a three year fellowship program on 11/6/00. Although the subject fellow completed his third year of his fellowship prior to ACGME approval for the third year, the third year of his Fellowship did count toward board certification in Gastroenterology. See letter from the American Board of Internal Medicine with respect to aa 579 becoming board certified in Gastroenterology in 1999 attached hereto as Attachment D.

The Hospital also takes exception to the disallowance for the Surgical Pathology Fellowship since the training period at issue (aa 1851-1858 and aa 1929-1931) counted toward specialty certification and may count toward specialty certification in the cases of aa 1953-1961, aa 1816-1823, and aa 1871-1873. The Hospital believes that the letter from the American Board of Pathology confirming certification attached hereto as Attachment E confirms that its training would qualify towards certification.

According to The Amercian Board of Pathology, Inc.'s training requirements for primary board certification, a physician must complete a "Credentialing Year" in order to enter its examination system for Board Certification. More specifically, if board certification is in a Combined Anatomic Pathology and Clinical Pathology, the candidate must complete four full years of full-time approved training in an accredited APCP-4 program, followed by the Credentialing Year. If the board certification is in Anatomic Pathology, the candidate must complete 3 full years of full-time approved training in Anatomic Pathology in an accredited APCP-4 or AP-3 program followed by the Credentialing Year. If the board certification is in Clinical Pathology, the candidate must complete 3 years of full-time, approved training in Clinical Pathology in an accredited APCP-4 program followed by the Credentialing Year.

The American Board of Pathology, Inc., provides that the Credentialing Year can be satisfied as follows:

A. One full year of full-time, approved graduate medical education in a transitional year training program or in a clinical area of medicine such as internal medicine, surgery, obstetrics and gynecology, pediatrics, emergency medicine, or family practice;

B. One full year of full-time research in pathology or in another clinical discipline, provided that the research was done in the United States or Canada and has clearly defined clinical implications;

C. One year of training in one of the recognized subspecialty fields of pathology that includes clinical correlation and patient contact; or

D. The satisfactory completion of one full year of a combination of clinical training, clinical research, or subspecialty pathology training in addition to the required pathology training necessary to qualify for certification in anatomic pathology and clinical pathology, anatomic pathology, or clinical pathology. The pathology training program director is responsible for defining and

justifying this year to The American Board of Pathology. The Board recommends that for applicants meeting the Credentialing Year requirement by combinations of pathways A, B, and C, the periods of activity be at least four months in duration wherever possible.

Since the subject residents completed their Credentialing Year by satisfying subsection C and D above, their training should be reimbursed.

Finally, the Hospital takes exception with respect to the disallowance for its IM-Echocardiography resident in that the training period at issue may count toward specialty certification by the National Board of Echocardiography. See National Board of Echocardiography certification guidelines attached hereto as Attachment F. If DHHS requires, the Hospital can provide a letter from the National Board of Echocardiography confirming that the subject training would qualify a resident for certification.

Accordingly, it is the Hospital's position that the proposed audit adjustment for the following residents should be reversed:

Program	**IME error**	**GME error**
IM-Echocardiography	2.000	1.000
Gastroenterology	0.249	0.125
Surgical Pathology	2.586	2.086
Total	**4.835**	**3.211**

II. Rotation Schedule Documentation. DHHS proposes to disallow reimbursement for the training of residents in approved programs on the basis of the Hospital's failure to produce documentation of the residents' rotation schedules within the Hospital. The Hospital takes exception to this disallowance because the imposition by DHHS of such a standard exceeds the scope of the Medicare rules and regulations, is unsupported by the general Medicare record-keeping regulations (See 42 CFR §§ 413.20 and 413.24), and results in the imposition of a standard which was not properly promulgated in accordance with the Federal administrative rule making requirements (i.e., notice and public comment provisions). Had the Hospital been aware of this requirement by virtue of it being a properly promulgated regulatory requirement, it would have certainly retained such documentation for audit purposes.

In particular, it is the Hospital's position that DHHS is imposing a requirement now that did not exist during FYE 1999. To retroactively impose a standard that was not either applicable to the provider, or known to the provider, is arbitrary and capricious.

In University of Iowa Hospitals and Clinics v. Shalala., U.S. Court of Appeals for the Eighth Circuit, No. 97-1943, (June 8, 1999), the U.S. Court of Appeals found that it was improper for the Secretary to retroactively impose on a provider (during a re-audit) a standard that had been developed subsequent to the cost report year.

Specifically, in University of Iowa, the disputed subject matter related to a re-audit of the provider hospital's base year graduate medical education costs. During the re-audit, the intermediary lowered the hospital's "per resident amount" from $40,765 to $33,538, (resulting in a $10 million reduction in Medicare reimbursements for the hospital). Most of the reduction was the result of the imposition of a new requirement relating to determining office space usage for teaching physicians[1]. The new documentation standard had been informally published in a "Questions and Answers" booklet provided to intermediaries, but not providers. Consequently, because the hospital had not known of this requirement, it had not kept records relating to teaching physician office usage.

The U.S. Court of Appeals, in finding in favor of the provider, stated,

> Several inequities surround the Secretary's approach to the Hospital's teaching physician office costs. First, the Hospital had no notice of the space usage time study requirement until five years after the requirement could be satisfied. The Secretary and the intermediary had always accepted the Hospital's claim for the office space, and no statute, regulation, or administrative statement even hinted at the Secretary's new requirement. Second, the Secretary refused to permit the Hospital to provide a current time study to meet the November 1990 standard's requirement [subsequent] of a base year time study. Third, the standard's retroactive application had resulted in substantial underpayments to the Hospital (by its account, some $10 million dating back to the intermediary's re-audit). Fourth, the Secretary's approach perpetually "locks in" these underpayments because each subsequent year's reimbursement depends upon the inflation-adjusted "per resident amount" for the base year....Insofar as the Secretary's standard penalizes providers for not meeting a documentation requirement five years before the enactment of that requirement, we must reject the standard.... [W]hen Congress delegates legislative authority to an administrative agency, courts will presume that the delegation forbids the agency from creating

[1] "The Secretary's new standard required base year time studies to document the usage of the office space as being related to graduate medical education rather than direct patient care, research or other disallowed expenses." Id.

> retroactive prescriptions, and only express congressional authorization will overcome this presumption.

Id. See University of Iowa Hospitals and Clinics v. Shalala, U.S. Court of Appeals for the Eighth Circuit, No. 97-1943, (June 8, 1999) attached hereto as Attachment G.

Similarly and in the instant case, the Hospital had no notice that it was to keep rotation schedules for residents who were not rotating; the Hospital has offered to proffer attestations that the subject residents spent 100% of their time at the Hospital engaged in patient care activities, (you have stated that such attestations would not satisfy the documentation requirement); and the proposed disallowance will result in substantial underpayments to the Hospital now, and in the future. We therefore conclude that the proposed disallowance would constitute retroactive rule making.

In the alternative, the Hospital believes that DHHS' decision to disallow the Hospital's GME and IME costs because the Hospital could not produce written rotation schedules for the subject residents is nonsensical and capricious. Even assuming that a request for rotation schedules was appropriate for the purpose of confirming that particular hospitals with residents rotating between them were not claiming duplicate costs for the same residents, that is not the case here. Rather, in the instant case, only the Hospital is claiming costs for these residents on its cost report because the subject residents did not rotate at all. All of the residents at issue in this audit spent 100% of their time at the Hospital. Although the Hospital has related that fact to DHHS, you have stated that the Hospital must still produce rotation schedules. When asked why, you explained that it was to assure that the subject residents did not spend all of their time conducting research. To postulate that the residents were spending the entire twelve months conducting research is not only unfounded, but is entirely inconsistent with the structure and requirements of the subject training programs.

Since the subject residents did not rotate, but performed all of their services within the Hospital, one has to wonder if the purpose of the audit is to appropriately determine duplicate costs between hospitals *or* to find disallowances for appropriate training conducted in approved programs. Notwithstanding, the Hospital can offer attestations as to the fact that these residents spent all of their time in direct patient care activities in the Hospital for the subject time period. If DHHS would like to audit all of our medical records for that time period and track the entries in patient records by these residents, we are confident that it would find that the residents were performing direct patient care services as claimed on our cost report for FYE 1999.

Notwithstanding, the Hospital did provide DHHS with the applicable IRIS reports, which should, on its own, provide sufficient documentation to support the claimed costs. In United Hospitals Medical Center v. Blue Cross and Blue Shield

Association/Blue Cross and Blue Shield of New Jersey, PRRB Hearing, (Mar. 02, 2000), the intermediary disallowed 2.56 FTEs due to residents not being reported on the Interns and Residents Information System (IRIS) report. In this particular case, the residents at issue rotated through the provider for one month, but did not appear on the provider's IRIS report. The intermediary in United pointed out, "that as part of its normal auditing procedures, it uses the IRIS." The intermediary further contended that "if the remainder of the Provider's Interns/residents were verified to a source document (i.e., rotation schedule and/or IRIS listing) then the documentation for these two residents should have been available." The PRRB ruled in favor of the intermediary's disallowance by finding that the "two residents did not appear on the Provider's IRIS listing not [sic] did their names appear on any of the Provider's rotation schedules." Based upon the facts of this case and the PRRB's holding, it is clear that either the IRIS listing or a rotation schedule would have been sufficient.

In the instant case, the Hospital did provide the IRIS report to the Intermediary even though the subject residents were not rotating between hospitals. It is our position that since it is clear that the PRRB would accept the IRIS report alone as sufficient documentation and the purpose of the IRIS report is to track residents' time, then it is inappropriate for the DHHS to impose additional standards. See United Hospitals Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Hearing, (Mar. 02, 2000) attached hereto as Attachment H.

Based upon the foregoing, the proposed audit adjustment for the following residents should be reversed:

Program	**IME error**	**GME error**
Anesthesiology	1.000	0.500
Emergency Med-EMS	1.414	0.707
Emergency Med	0.178	0.089
IM Cardiology	4.095	2.173
Surgery	0.252	0.252
Surgery-Critical Care	0.252	0.126
IM-Chief Resident	2.070	1.943
Total	**9.261**	**5.790**

Please refer to the rotation schedules for some of the subject residents attached hereto as Attachment I.

III. Non Reimbursable/Non Provider Setting. DHHS proposes to disallow 1.193 GME FTEs and 1.437 IME FTEs on the basis that the Hospital failed to have a written agreement in place with the "non-provider settings". For cost reporting periods

beginning after January 1, 1999, the applicable regulations provide that the hospital must satisfy the following conditions:

(a) the resident spends his or her time in patient care activities;

(b) the written agreement between the hospital and the non hospital site indicates that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the non hospital site and the hospital is providing reasonable compensation to the non hospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the non-hospital site for supervisory activities; and

(c) the hospital must incur all or substantially all of the costs for the training program in the non-hospital setting.

42 CFR §413.86(f)(3)

With respect to the requirement for a written agreement, the Hospital has acknowledged that it did not enter into such written agreements during the subject year. It did, however, proffer to DHHS written agreements entered into by the Hospital and the non hospital settings dated subsequent to the audit. DHHS has rejected such documentation as evidence that the Hospital incurred the full program costs at issue. The Hospital views this response by DHHS to be unreasonable in that the applicable regulation does not specifically state that the written agreement must exist prior to the resident rotating to the non hospital setting.

The Hospital believes that the primary purpose of the requirement for a written agreement is to assure that the hospitals do not claim costs which are not actually incurred and/or to assure that not more than one provider is claiming the same costs on their Medicare cost report. With respect to the subject residents who rotated to non hospital settings: (i) none of the non hospital settings filed cost reports with Medicare and thus, could not and did not claim the costs at issue; (ii) the Hospital assumed full responsibility for the compensation of the subject residents and can produce payroll documentation to support its claim; and (iii) there is no dispute that the subject residents were involved in patient care activities. The Hospital believes that these facts coupled with the fact that the Hospital offered written agreements signed post audit, should provide adequate documentation to confirm that the Hospital incurred the full program costs.

Furthermore, the fact that the Hospital did not incur any costs in connection with compensating the non-hospital site for activities during the period following January 1, 1999, is not cause for the disallowance. We provide the following legislative history as support:

> Comment: In regard to our proposed technical change to the nonhospital payment policy as specified in § 413.86(f)(4)(iii), one commenter asked us to define the difference, if any, in our use of "nonprovider" entity and "nonhospital" entity. In addition, the commenter asked whether a skilled nursing facility or a unit excluded from the prospective payment system is considered to be a nonhospital setting.
>
> Also, similar to the public comments addressed in the July 31, 1998 final rule, several commenters asked us to clarify whether hospitals would still be eligible to receive payments in situations where the teaching faculty volunteers their services and neither the hospital not the nonhospital entity incurs costs for supervisory teaching physicians. The commenters asked us to continue to support the following statement that we included in the July 31, 1998 final rule (63 FR 40996) allowing hospitals to remain eligible for payment in such situations where supervisory physicians in the nonhospital setting are volunteering their time: "for the purposes of satisfying the requirement of a written agreement, the written agreement between a hospital and a nonhospital site may specify that there is no payment to the clinic for supervisory activities because the clinic does not have these costs."
>
> Response: For purposes of our nonhospital payment policy for GME in § 413.86(f)(4), we use the terms "nonhospital" and "nonprovider" interchangeably. A free-standing SNF (that is, a SNF that is not part of a hospital) is a nonhospital site. An excluded unit of a hospital is not a nonhospital site because an excluded unit is still part of a hospital. We will continue a volunteer supervisory physician policy consistent with the policy stated in the July 31, 1998 final rule, as requested by the commenter. Hospitals may receive payment for the costs of training residents in the nonhospital site even thought the hospital might not be incurring any costs for supervisory physician activities.

64 Fed. Reg. 41490 (July 30, 1999). Accordingly, the fact that the Hospital did not pay the non-hospital provider for its supervisory physicians should not result in an audit adjustment to the Hospital.

Based upon the foregoing, the proposed audit adjustment for the following residents should be reversed:

Program	IME error	GME error
Child Psych	0.151	0.075
Hand Surgery	0.580	0.392
Path-Anatomical	0.170	0.170
Path-Blood Bank	0.137	0.137
Radiology	0.419	0.419
Total	**1.437**	**1.193**

IV. Non-Reimbursable Research Time. DHHS proposes to make audit adjustments with respect to residents spending time in non-patient related research. The Hospital disagrees with certain of the proposed adjustments because the subject residents were providing direct patient care services at the Hospital. Specifically, Resident aa 2566 spent his entire month in a clinical setting and at the bedside of patients. While performing patient care responsibilities, the subject resident conducted patient-specific research (that involved placing gastric mucosal pH catheters into the patients' stomachs pursuant to the Hospital's protocol for gastric alkalization), took call every fourth night, and regularly attended all subject program required educational activities. See Attachment J. The Hospital would also like to point out that the proposed adjustment for Resident aa 2308-2316 should be reversed because Resident aa 2308-2316 was *not* engaged in research at all, but rather participating in the ACGME accredited Surgical Critical Care Program. See Attachment K.

Based on the foregoing, it is the Hospital's position that the proposed audit adjustment for the following residents should be reversed:

Program	IME error	GME error
Surgery Critical Care-aa 2566	.062	0
Surgery aa 2308-2316	.75	0
Total	**0.812**	**0**

II. GRADUATE MEDICAL EDUCATION CORPORATE COMPLIANCE

The Hospital's Department of Medical Education will continue to develop and improve its departmental corporate compliance program. This departmental program will continue to operate as an integral part of the existing overall Hospital Corporate

Compliance Program. Some of the areas that the Department plans to formalize and further develop are: (i) audit and monitoring of resident rotations; (ii) credentialing of residents; (iii) assuring written agreements between off-site providers and the Hospital; and (iv) approval process for research activities. One advantage, which the Department enjoys with respect to compliance, is that its Vice President of Academic Affairs also serves as the Hospital's Corporate Compliance Officer.

III. CONCLUSION

It is the Hospital's hope and expectation that the information provided herein will be sufficiently responsive to any earlier questions or concerns that you and your team of auditors identified as a result of the 99' GME Audit. We also want to assure you that the Hospital is absolutely committed to 100% compliance with the Medicare program graduate medical education requirements. In the event you disagree with any of the positions we have taken in this letter, I would greatly appreciate the opportunity to once again discuss the matter with you, or if you believe additional documentation may be helpful, I would be happy to try to provide it for you. In the meantime, if I can be of further assistance, please do not hesitate to call. We look forward to hearing from you.

Best regards.

Sincerely,

Joan W. Feldman

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The attachments referenced in the appendix are not included as a part of this report as they contain personal and confidential information which may not be releasable under 45 CFR Part 5 (FOIA).