Office of Audit Services
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John F. Kennedy Federal Building
Room 2425
Boston, Massachusetts 02203
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November 5, 2002

CIN: A-01-02-00506

David W. Benfer
President and Chief Executive Officer
Saint Raphael HealthCare System
and Hospital of Saint Raphael
1450 Chapel Street
New Haven, Connecticut 06511

Dear Mr. Benfer:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Review of Graduate Medical Education Costs Claimed by the Hospital of Saint Raphael 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.

In accordance with the principles of the Freedom of Information Act (5 U.S.C 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-01-02-00506 in all correspondence relating to this report.

Sincerely,

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:
Joe Tilghman
Acting Regional Administrator
Centers for Medicare and Medicaid Services
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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 HOSPITAL OF SAINT RAFAEL FOR FISCAL YEAR ENDING SEPTEMBER 30, 1999

JANET REHNQUIST
Inspector General

NOVEMBER 2002
A-01-02-00506

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

BACKGROUND

Since its inception in 1965, the Medicare the program has shared in the costs of educational activities incurred by participating providers. Medicare makes payments for both 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 in approved medical resident training programs 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 Hospital of Saint Raphael (Hospital) is a teaching hospital affiliated with the Yale University School of Medicine. More than 280 resident physicians participate in 21 graduate medical education programs conducted at the Hospital. The Hospital claimed approximately $17.9 million for total GME and IME costs in the 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 $4.6 million in GME and $13.3 million in IME payments in its FY 1999 Medicare cost report.

SUMMARY OF FINDINGS

We found that the Hospital's controls over the proper claiming of resident FTEs were generally adequate, however, we noted that the Hospital erroneously included 3.5 FTEs into its GME computations that did not meet Medicare criteria for reimbursement. Specifically, the GME FTE counts included residents exceeding their initial residency periods without appropriate GME weighting reductions, residents in Medicare non-reimbursable programs, and other recording type errors. The Hospital's inclusion of these erroneous FTEs resulted in the overstatement of its GME FTE counts. As a result, the FY 1999 Medicare cost report was overstated by $77,003.

RECOMMENDATIONS

We recommend:

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

- the Medicare Fiscal Intermediary (FI), Empire Medicare Services, apply the calculated reductions of $77,003 in GME costs to the Hospital's FY 1999 Medicare cost report.

The Hospital, in its September 26, 2002 response to our draft report (see APPENDIX), agreed with our audit findings and recommendations and has developed an action plan to address these issues.

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INTRODUCTION

BACKGROUND

The Hospital of Saint Raphael (Hospital) is a 511-bed acute care hospital located in New Haven, Connecticut. In 1999, more than 280 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 Yale University School of Medicine.

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 cost 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 Fiscal Years (FY) 1994 and 1995 for non-primary care specialties. The Hospital received reimbursement of $4,588,671 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 $13,306,031 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 resident FTEs. During FY 1999, the Hospital reported total weighted FTE counts of 117.24 and 126.47 residents for GME and IME, respectively. During this period, the Hospital's 285 rotating residents comprised 176 Hospital-employed and 109 outside residents 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. However, no individual resident can be counted for more than 1.0 FTE.

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

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

OBJECTIVE, SCOPE, AND METHODOLOGY

[2] 42 CFR 413.86(b)
[3] 42 CFR 413.86(g)
[4] 42 CFR 413.86(h)(1)(i)
[5] 42CFR 413.86(f)(4)
[6] 42 CFR 413.86 (f)
[7] Provider Reimbursement Manual 2405.3
[8] 42 CFR 412.105(f)(ii)
[9] 42 CFR 413.86(f)(3) and (f)(4)

The objective of our audit was to determine the accuracy of the FY 1999 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 that the Hospital is entitled, we:

- Reviewed the results of past GME/IME audits with the Medicare Fiscal Intermediary (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 Hospital officials, and

- Determined the net dollar effect of our audit adjustments to the GME and IME FTE counts by recalculating the Hospital 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 conducted at the Hospital in New Haven, Connecticut from January 2002 through May 2002.

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

FINDINGS AND RECOMMENDATIONS

We found that the Hospital's controls over the proper claiming of resident FTEs were generally adequate, however, we noted that the Hospital erroneously included 3.5 FTEs into its GME computations that did not meet Medicare criteria for reimbursement. Specifically, the GME FTE counts included residents exceeding their initial residency periods without appropriate GME weighting reductions, residents in Medicare non-reimbursable programs, and other recording type errors. The Hospital's inclusion of these erroneous FTEs resulted in the overstatement of its GME FTE counts. As a result, the FY 1999 Medicare cost report was overstated by $77,003. 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**
Completed Initial Residency Periods	**2.13**	**N/A**	**$27,500**	**N/A**	**$27,500**
Three-Year Rolling Average Computations	**N/A**	**N/A**	**$24,944**	**$0**	**$24,944**
Non-Reimbursable Residency Programs	**1.37**	**2.75**	**$15,370**	**$0**	**$15,370**
Misclassified Non-Primary Care Residents	**N/A**	**N/A**	**$9,189**	**$0**	**$9,189**
TOTALS	**3.50**	**2.75**[10]	**$77,003**	**$0**	**$77,003**

COMPLETED INITIAL RESIDENCY PERIODS

We found that the Hospital needs to improve its procedures to provide the proper reduced FTE weighting to residents exceeding their IRP. Under 42 CFR §413.86, IRP is defined as "… 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.

While most residents training beyond their IRP were properly weighted, we identified 2.13 FTEs, representing 14 residents, who were incorrectly weighted in full. Generally, these residents completed an initial residency at other hospitals prior to training at the Hospital. As such, we identified a GME overstatement of $27,500 on the Medicare cost report.

[10] Medicare limits the amount of FTEs claimed to the lesser of the actual FTEs to the FY 1996 claimed FTEs. Because of this cap, the overstated 2.75 IME FTE counts we identified had no impact on the IME reimbursement.

THREE-YEAR ROLLING AVERAGE COMPUTATIONS

We found that the Hospital did not fully adhere to Medicare instructions for computing the three-year rolling average required for computing GME reimbursement. Medicare instructions from Provider Reimbursement Manual §3633.4 require hospitals to compute a three-year rolling average by recording, in this case, the FYs 1999, 1998, and 1997 weighted FTE counts for GME on cost report Worksheet E-3, Part A. However, we found that the Hospital's as filed FY 1999 Cost Report included incorrect FTE counts for FYs 1998 and 1997. We obtained the correct FTE counts from the FI and computed a $24,944 overstatement of GME costs.

NON-REIMBURSABLE RESIDENCY PROGRAMS

We found that the Hospital did not have procedures in place to exclude from its GME FTE counts those residents who were in residency programs not reimbursable under the Medicare program. 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 GME (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, counting toward certification of the participant in a recognized specialty or subspecialty.

We identified four residents, representing 1.37 FTEs GME, who were in two non-reimbursable programs during FY 1999. These programs are summarized below:

Cardiology Fellowship – (0.12 FTE GME) The Hospital's accreditation for this program was withdrawn as of June 30, 1999. One resident in this program continued to be included in the FTE count for the period July through September 1999.

Ultrasound - (1.25 FTE GME) This Hospital-sponsored program was not accredited in FY 1999. The FTEs for the three residents participating in this program were erroneously included in the FY 1999 cost report.

As a result, we found that the Hospital had overstated its FY 1999 GME claim for reimbursement by $15,370.

MISCLASSIFIED NON-PRIMARY CARE RESIDENTS

We found that the Hospital did not fully adhere to Medicare cost report instructions requiring hospitals to classify residents by primary and non-primary care specialties. Because per resident reimbursement amounts differ for these categories, Provider

Reimbursement Manual §3633.4 instructs hospitals to separately report weighted FTEs by primary and non-primary care specialties on cost report Worksheet E-3, Part A. However, we found that the Hospital misclassified 4.42 FTEs of non-primary care residents into the primary care category. As a result, GME reimbursement was overstated by $9,189 on the FY 1999 Medicare cost report.

RECOMMENDATIONS

We recommend:

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

- the FI, Empire Medicare Services, apply the calculated reductions of $77,003 in GME costs to the Hospital's FY 1999 Medicare cost report.

AUDITEE RESPONSE

In its September 26, 2002 response to our draft report (see APPENDIX), the Hospital concurred with our findings and recommendations. In its response, the Hospital described its corrective action plan to improve communications, data collection, and internal controls procedures to ensure that resident FTE counts are computed in accordance with Medicare requirements. In addition, the Hospital proposed additional adjustments to its GME and IME FTE counts. Such adjustments reflected omissions and corrections made by the Hospital to its IRIS file and cost report.

OIG COMMENTS

We commend the Hospital on its developing a corrective action plan to resolve the issues identified in our report.

In regard to the additional adjustments proposed by the Hospital, we found that such adjustments were proposed in correspondence with the FI subsequent to the initial filing of the Hospital's cost report. We suggest the Hospital continue to pursue these issues with the FI. We did, however, review the supporting documentation for two oral surgery residents included in our audit. These residents were claimed at a 0.5 FTE GME weighting, but, according to the Hospital, should have been claimed at full weight. We found that these residents had completed a residency program in general dentistry prior to commencing the oral surgery program and were appropriately claimed at the reduced GME weighting.

OTHER MATTERS

In the course of our audit work, we found that the Hospital had misstated the correct intern and resident to bed ratio used in its IME reimbursement computations. Medicare instructions require a hospital to use the lower of the current year's intern and resident to bed ratio or the prior year's (FY 1998) ratio. Instead, we found that the Hospital

mistakenly used the FY 1997 intern and resident to bed ratio. We brought this matter to the attention of the FI for resolution since it may have a financial impact on the IME payment calculation for FY 1999.

APPENDIX

Saint Raphael Healthcare System

1450 Chapel Street
New Haven, Connecticut 06511

David W. Benfer, FACHE
President and Chief Executive Officer
Saint Raphael Healthcare System and
Hospital of Saint Raphael
(203) 789-3020 Fax: (203) 867-5235

September 26, 2002

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services
Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203

Dear Mr. Armstrong:

The Hospital of Saint Raphael is in receipt of your draft report regarding the Graduate Medical Education program for the fiscal year ended September 30, 1999. We have carefully reviewed the contents of your draft report and have prepared responses to your audit findings and action plans in accordance with your recommendations.

We would like to thank you and your staff for your cooperative efforts in this evaluation and assisting the hospital in improving our processes in this area.

Please contact Gary F. Brudnicki at (203) 789-3713 should you require additional information.

Sincerely,

David W. Benfer
President and Chief Executive Officer

/jfm
cc: Mr. Robert Champagne
U.S. Department of Health and Human Services
Office of Inspector General
Office of Audit Services
William R. Cohen Federal Building
135 High Street
Hartford, CT 06103

Hospital of Saint Raphael
Responses to Draft Audit Report Findings
Fiscal Year Ended 9/30/99

The Hospital of Saint Raphael has reviewed your audit findings which resulted in a recommendation of a 3.6 FTE and 3.5 FTE reduction to the reported IME and DME FTEs for the fiscal year ended 9/30/99. In addition to your findings, we believe there are additional issues that need to be addressed, either by the OIG or the Fiscal Intermediary (FI). Included below are additional issues, some of which were brought to the FI's attention in our February 6, 2002 letter, that still remain open.

These issues are summarized below and the detail supporting documentation is incorporated into the attached schedule. We believe the FTE count should change as follows:

	IME	DME
Residents omitted from original cost report	1.34	.79
Elimination "Internship" programs from the IRP count	0	1.16
Resident corrections to the IRIS filing	-1.41	-.41
Total proposed changes	-.07	1.55

1. **Cardiothoracic and Podiatric Residency Programs**

   The Hospital of Saint Raphael inadvertently omitted 1.0 FTE in an approved Cardiothoracic Residency Program, and .34 FTEs in an approved Podiatric Residency Program. These Resident changes were submitted to our Fiscal Intermediary in our letter dated February 6, 2002. The OIG auditors stated they were only auditing the cost report as initially filed and did not review these issues.

2. **Oral Surgery and Radiology Programs (counting of initial residency period/IRP)**

   We believe, based upon a review of the Medicare regulations, that Residents entering an Internship program prior to beginning a Residency program should not have their "Internship" programs counted for the IRP. We believe that the one year "General Dentistry" and "Transitional" Residency programs meet the definition of Internship programs. The impact on the Resident counts for Direct Medical Education (DME) would be an increase of .5 FTEs and .66 FTEs for Oral Surgery and Radiology, respectively.

3. **Other corrections to IRIS filing**

   There were additional corrections to the initial IRIS filing which will result in net reductions to the IME and DME count by -1.41 FTEs and -.41 FTEs, respectively.

September 27, 2002

HOSPITAL OF SAINT RAPHAEL

OIG RECOMMENDATIONS AND ACTION PLAN TO OIG RECOMMENDATIONS

The Hospital of Saint Raphael (HSR) has reviewed the OIG recommendations which are identified below followed by the Hospital's action plan.

1. OIG Recommendations

OIG recommended that the Hospital strengthen its procedures to ensure that Resident FTE counts are computed in accordance with Medicare requirements (executive summary). The OIG findings and recommendations (page 4 and 5) goes on to state that the Hospital incorrectly included Residents in Medicare non-reimbursable programs, Residents exceeding their initial residency periods without appropriate GME weighting reductions, misclassified Non-Primary Care Residents, and other recording type errors. The OIG states that Residents exceeding their initial residency period must be weighted at a reduced .5 factor. The report also states the Hospital did not include the correct FTE counts for the prior years relating to the three year rolling average.

The action plan, as identified below, incorporates three components, all of which must work in unison to effectively implement the OIG recommendations. The three components are identified below.

2. Action Plan to OIG Recommendations

- The Hospital has revised its data collection procedures for all Residents to ensure a complete history from medical school forward to incorporate all prior training and the specific identification of prior approved training programs. The Housestaff department has become an additional resource in reviewing this documentation. The programs will now require Residents to explain and report any undocumented time after medical school. This will mitigate a substantial portion of the errors noted regarding the count towards the initial residency periods.

- The Hospital has significantly improved the communication between the teaching departments and Finance. This has resulted in an improved understanding of the federal regulations regarding Medicare reimbursement. The understanding of the reimbursement issues, including approved programs; research activity and time spent in allowable settings, has been in-serviced among all the teaching programs.

- Finance has incorporated additional steps to validate the data collection and reporting process. Finance will be reviewing the rotation schedules, approval letters, and agreements to work in outside settings, to eliminate reporting errors and ensure compliance. Finance will also be receiving on-going reimbursement training either internally or through external means to remain compliant. The correct reporting of the prior year Resident counts relating to the three year rolling average has also been a focus of the Finance Department in its internal training sessions.