REVIEW OF INTERN AND RESIDENT FTE COUNTS FOR DIRECT AND INDIRECT GRADUATE MEDICAL EDUCATION COSTS AT BARNES-JEWISH HOSPITAL, ST. LOUIS, MISSOURI
The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

**Office of Audit Services**

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

**Office of Evaluation and Inspections**

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

**Office of Investigations**

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

**Office of Counsel to the Inspector General**

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.
Ms. Sheila Butler  
Manager, BJC Reimbursement  
BJC HealthCare, Room 140  
4353 Clayton Avenue  
St. Louis, Missouri 63110

Dear Ms. Butler:

This report provides the results of our limited review of medical education payments made to Barnes-Jewish Hospital, St. Louis, Missouri under the Medicare program. The purpose of the review was to determine the accuracy of intern and resident full-time equivalents (FTEs) used by Barnes-Jewish Hospital (the Hospital) for claiming direct graduate medical education (GME) and indirect graduate medical education (IME) costs. The review covered FTEs claimed for the Hospital’s fiscal year ended December 31, 1998, for which the hospital claimed costs of $53,112,612.

Our review did not show a need to revise the FTE counts or change control procedures for developing the counts. Therefore, we have no recommendations for the Hospital to address.

INTRODUCTION

BACKGROUND

Barnes-Jewish Hospital at Washington University Medical Center, a 911-bed nonprofit teaching hospital located in St. Louis, Missouri, is the largest hospital in Missouri. The Hospital has a 1,600 member medical staff composed of full-time academic faculty and community physicians of Washington University School of Medicine. The medical staff is supported by more than 850 residents, interns and fellows.

Since the inception of Medicare in 1965, the program has shared in the costs of educational activities incurred by participating providers. Medicare now makes two different types of payments – GME and IME.
Under Sections 1886 (a)(4) and (d)(1)(A) of the Social Security Act (the Act) and 42 Code of Federal Regulations (CFR) 412.113, GME costs are excluded from the definition of a hospital’s operating costs and, accordingly, are not included in the calculation of payment rates under the hospital inpatient prospective payment system (PPS) or in the calculation of the rate-of-increase limit for hospitals excluded from the PPS. Regulations at 42 CFR 413.85 (b) define approved educational activities to mean formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities include approved training programs for physicians, nurses, and certain allied health professionals. Under Section 1886(h) of the Act and 42 CFR 413.86, hospitals are paid for direct GME costs based on Medicare’s share of a hospital-specific per resident amount multiplied by the number of FTE residents.

The IME payments are oriented towards services to Medicare patients. Medicare has made payments to hospitals under Section 1886(d) of the Act on the basis of the PPS since 1983. Under the PPS, hospitals receive a predetermined payment for each Medicare discharge. Section 1886(d)(5)(B) of the Act specifically directs the Secretary to provide an additional payment under the inpatient PPS to hospitals for IME. This additional payment, which reflects the higher operating costs associated with medical education, is based in part on the applicable indirect IME adjustment factor. The adjustment factor is calculated by using a hospital’s ratio of residents-to-beds in the formula set forth at Section 1886(d)(5)(B) and specified in regulations at 42 CFR 412.105. The IME payment is usually viewed as an “add-on” to the basic PPS payment.

Both GME and IME payments are calculated annually based on formulas which are driven by the number of FTEs and the proportion of Medicare days of care. Thus, the amount of Medicare funds received by each hospital is determined, in large part, by the number of FTE residents at each hospital and the proportion of training time residents spend in the institution.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our audit was conducted in accordance with generally accepted government auditing standards. The audit objective was to determine the accuracy of intern and resident FTEs used by the Hospital for claiming GME and IME costs under the Medicare program. The audit covered GME and IME FTEs used to claim $53,112,612 in medical education payments for the Hospital’s fiscal year ended December 31, 1998.

To accomplish our objectives, we reviewed the GME and IME related audit work performed by the Fiscal Intermediary for Barnes-Jewish Hospital for FYE 12/31/98. To verify the calculation of the Hospital FTE’s, the Fiscal Intermediary:

- Determined that all programs were approved.
- Determined if the FTE’s were properly weighted for residents who exceeded the residency period of their program specialty.
- Verified the allowability of FTEs for those from foreign medical schools.
- Tested rotation schedules against summary rotation schedules.
- Compared rotation schedules with the Internal Resident Information System (IRIS).
During our on-site review at the Hospital we:

- Determined if the FTE's were properly weighted for residents who exceeded the residency period of their program specialty.
- Tested rotation schedules against Washington University payroll records and determined that FTEs for GME and IME did not include any time that residents were working on research.
- Tested rotation schedules against rotation summaries.
- Compared rotation schedules with the IRIS.
- Discussed the results of our audit with the Hospital.

Consideration of the internal control structure was limited to those controls concerning the accumulation of FTEs reported on the Hospital's cost report, because the objective of our review did not require a complete understanding or assessment of the internal control structure at the Hospital.

Fieldwork was performed at the Hospital administrative offices and at the Fiscal Intermediary's St. Louis branch office from October to December 2001.

**FINDINGS AND RECOMMENDATIONS**

The Hospital's Medicare cost report, as audited by the Fiscal Intermediary, showed an unweighted resident count of 554.57 FTEs and costs of $19,480,459, and $33,632,153 for GME and IME respectively. Total medical education costs were $53,112,612.

Our review showed the reported FTE counts for IME and GME costs were acceptable and there was no need to change the counts or revise controls over development of the counts. Therefore, this report contains no recommendations for the Hospital to address.

****

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent information contained therein is not subject to exemptions of the Act (see CFR Part 5). As such, within ten business days after the final report is issued, it will be posted on the world-wide-web at http://www.hhs.gov/ocr/hipaa/hipaa, as amended.

To facilitate identification, please refer to Common Identification Number A-07-02-02096 in all correspondence relating to this report.

Sincerely,

James P. Aasmundstad
Regional Inspector General
for Audit Services