

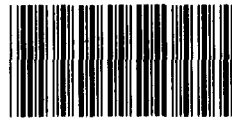
GAO

Report to the Secretary of Health and  
Human Services

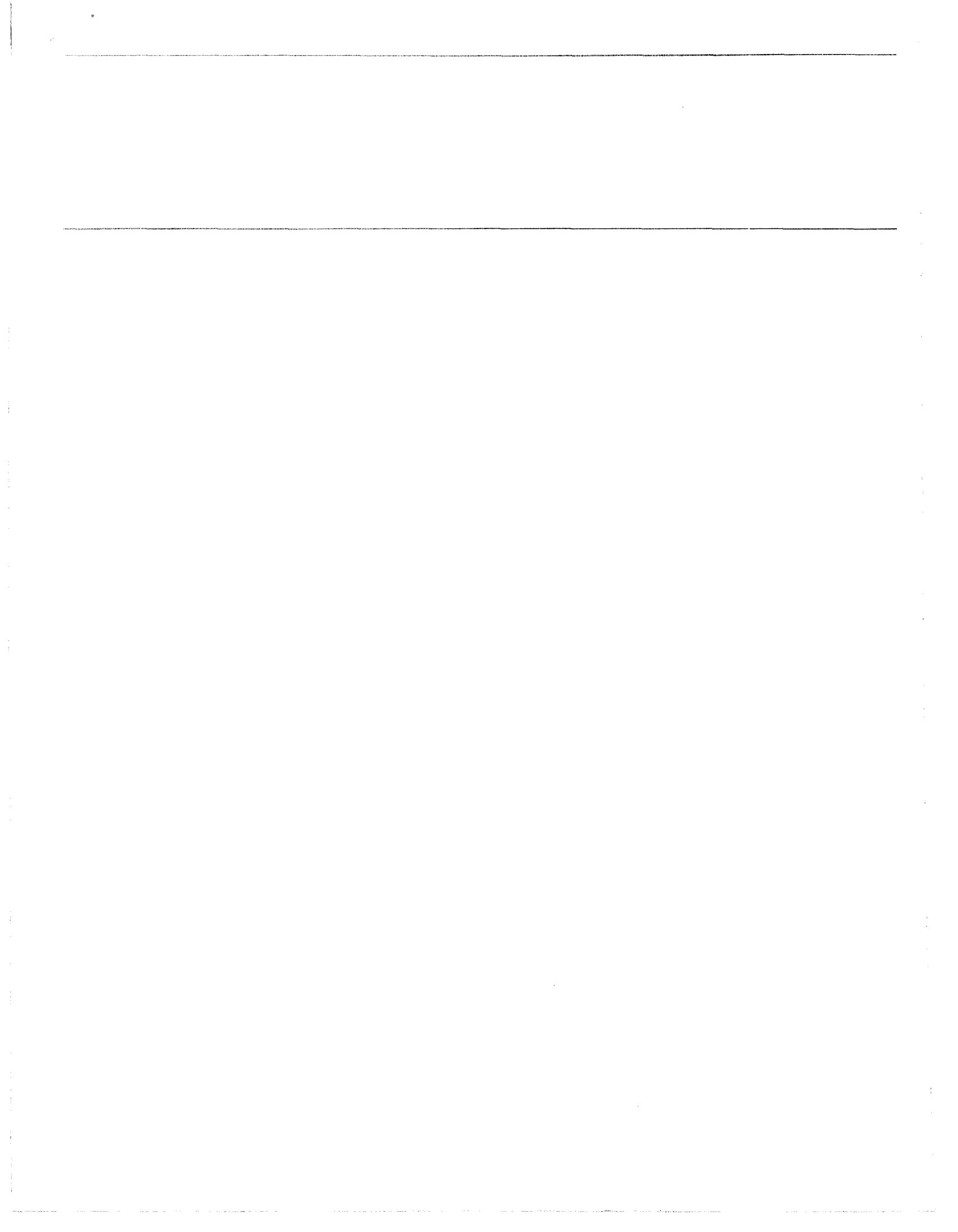
June 1991

MEDICARE

Flawed Data Add  
Millions to Teaching  
Hospital Payments



144038





United States  
General Accounting Office  
Washington, D.C. 20548

Information Management and  
Technology Division

B-242705

June 4, 1991

The Honorable Louis W. Sullivan, M.D.  
The Secretary of Health and  
Human Services

Dear Mr. Secretary:

This report describes weaknesses in data used to calculate supplemental Medicare payments to teaching hospitals. These payments, which amount to \$2 billion a year, are made to hospitals to offset the additional costs of their graduate medical education programs, and are largely influenced by two data elements that hospitals report: the number of medical residents and the number of beds available for patient care. To receive the greatest reimbursement, hospitals try to keep the number of residents high and the number of available beds low.

We reviewed these payments because the Medicare program has been identified as an area with potential for mismanagement due to internal control weaknesses. This report discusses (1) the accuracy of resident and bed count data that teaching hospitals submit to the Health Care Financing Administration (HCFA), (2) the effect of inaccurate data on Medicare payments to these hospitals, and (3) the adequacy of HCFA's internal controls over these data. Details of our objectives, scope, and methodology are discussed in appendix I.

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## Results in Brief

The data used to calculate supplemental Medicare payments to teaching hospitals are flawed. As a result, Medicare payments to teaching hospitals are inflated.

Teaching hospitals are overreporting the number of residents at their facilities. During fiscal years 1989 and 1990, Medicare overpaid teaching hospitals at least \$28 million because the hospitals inappropriately counted residents assigned to Department of Defense (DOD) and Department of Veterans Affairs (VA) hospitals. After we brought this to HCFA's attention, the agency began action to collect the overpayments and prevent them from recurring.

In addition, HCFA's guidance for counting available beds is confusing, and efforts to clarify it have not been successful. Consequently, the bed data that teaching hospitals report is not verifiable, and the appropriateness of payments to these hospitals for medical education costs cannot be

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determined. Recognizing these shortcomings, HCFA included in its fiscal year 1992 budget request a legislative proposal to replace the bed count statistic with one that is verifiable.

Moreover, HCFA allows teaching hospitals to exclude beds used to treat sick newborns from their bed count data, which is inconsistent with a federal court decision. By inappropriately excluding certain beds, Medicare has overpaid teaching hospitals at least \$4 million since 1987.

The shortcomings in the data used to calculate supplemental Medicare payments to teaching hospitals constitute material internal control weaknesses under the Federal Managers' Financial Integrity Act of 1982; the law requires that they be reported as such until they are corrected.

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## Background

Medicare is a \$100-billion federal health insurance program for the elderly and disabled authorized by Title XVIII of the Social Security Act. The program provides two basic forms of protection—hospital insurance and supplemental medical insurance. Hospital insurance expenditures are for inpatient hospital services provided to Medicare beneficiaries. These expenditures include payments to all hospitals for their operating costs and capital costs, as well as payments to about 1,200 teaching hospitals for the direct and indirect cost of providing graduate medical education in conjunction with patient care.

Indirect medical education costs are thought to stem from such factors as more diagnostic testing, procedures, and recordkeeping, as well as higher staffing ratios associated with graduate medical education programs. Medicare reimburses teaching hospitals over \$2 billion a year for these costs. The amount of the payment is determined by multiplying the amount a hospital receives for its operating costs by the number of residents per available hospital bed and a statistically estimated factor thought to represent the incremental patient care costs due to providing graduate medical education.

To determine the number of residents, HCFA requires teaching hospitals to count assigned residents on September 1 of each year.<sup>1</sup> A resident may work at more than one teaching hospital on the count day. Each hospital can claim the percentage of a resident's time spent at its

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<sup>1</sup>In its comments on a draft of this report, the Department of Health and Human Services noted that on July 1, 1991, the method for counting residents will change. (See app. II.)

facility, but the total time claimed by all hospitals cannot collectively exceed one full-time-equivalent resident. Hospitals also must report the average number of daily beds available for patient care during the year. To receive the greatest payment, hospitals would need to keep the number of residents high and the number of available beds low.

HCFA contracts with insurance companies called intermediaries to process and settle Medicare payments to hospitals. Under HCFA's guidance, intermediaries use the resident and bed count data submitted by hospitals to establish indirect cost reimbursement rates. Intermediaries later review the accuracy of these counts and the reasonableness of supplemental payments, and collect any overpayments identified. These reviews are conducted 2 to 3 years after the payments are made.

In 1988 HCFA began using a computerized data base containing annual resident assignment information and a computerized matching process to identify instances in which teaching hospitals count residents as more than one full-time equivalent. For fiscal years 1989 and 1990, HCFA identified about 4,400 instances where residents were overreported. HCFA estimates that adjustments to correct this double reporting could save \$176 million.

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## Overpayments Result From Improperly Counted Residents

Teaching hospitals overreport the number of their residents by improperly claiming residents who are actually at DOD and VA facilities. As a result, Medicare overpays these hospitals millions of dollars. These overpayments occur because HCFA does not obtain information on residents working at DOD and VA hospitals on September 1.

Each year about 11,000 residents enroll in graduate medical education programs offered by DOD and VA hospitals. We obtained the September 1988 and 1989 lists of residents assigned to all 29 DOD and 14 of 135 VA hospitals with teaching programs—these 43 hospitals enroll over 4,000 residents each year—and compared them with the 137,000 resident records in the HCFA data base for the same years.

About 700 of the residents whom the teaching hospitals listed in their September 1 reports were in fact at DOD and VA hospitals on the same day. This overreporting, we estimate, resulted in about \$28 million in

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Medicare overpayments.<sup>2</sup> When asked why the agency does not get DOD and VA resident data, the HCFA official responsible for managing the resident data base told us that he did not realize that teaching hospitals were including these residents in their counts.

After we brought this to their attention, HCFA officials concluded that a significant overpayment problem exists. Accordingly, in a November 30, 1990, letter, HCFA asked DOD and VA to begin providing resident data for their hospitals so that it could begin a computerized matching process to catch instances where hospitals improperly count and claim DOD and VA residents. As of April 1991, HCFA officials were working with DOD and VA officials to develop a process for sharing their resident data. HCFA officials also agreed to have intermediaries reconcile the specific DOD and VA resident data errors we identified and collect any confirmed overpayments.

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## Bed Counts Are Unauditable

HCFA's definition of countable beds is confusing and cannot be uniformly and consistently applied. As a result, counting practices vary widely among hospitals and intermediaries, and it is impossible to either independently verify the reported bed data or determine the appropriateness of supplemental payments.

HCFA's Provider Reimbursement Manual defines an available bed (with some exceptions) as an adult or pediatric bed maintained for lodging inpatients, including beds in intensive, neonatal intensive, and other special-care hospital units. It also states that the definition is intended to capture changes in the size of a facility as beds are added or taken out of service, not day-to-day fluctuations in use of patient rooms or wards. The manual does not say, however, when hospitals should start or stop counting beds that are temporarily unavailable.

To clarify its manual, HCFA issued additional guidance stating that only temporarily closed beds in patient rooms should be counted, not those placed in storage, and that beds should be counted if they could be staffed with nurses and placed in use within 24 to 48 hours. HCFA has also published guidance that requires hospitals to count beds in a completely or partially closed wing of a facility only if they put the beds in

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<sup>2</sup>We computed our cost estimate by multiplying each erroneously counted DOD and VA resident by \$40,000. HCFA developed the \$40,000 cost on the basis of a study of Medicare payments for graduate medical education.

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use when needed. However, the guidance does not state whether hospitals are to count beds that are actually put in use or are capable of being put in use. In its comments on a draft of this report, the Department of Health and Human Services said it will issue the additional guidance that HCFA has published as a revision to the Provider Reimbursement Manual, to help ensure uniformity of application.

Despite HCFA's efforts to clarify its bed counting guidance, hospitals and intermediaries remain confused. The confusion is evident in the responses we received from officials at 11 hospitals and 9 intermediaries. When asked whether they would count stored beds, one hospital and four intermediaries said they would; the rest said they would not. When asked if stored beds should be counted if they could be placed in service within 48 hours, five hospitals and six intermediaries said yes; the rest said no.

HCFA officials stated, and hospital and intermediary officials confirmed, that bed counts reported by hospitals cannot be verified. To address these shortcomings, HCFA has included a legislative proposal in its fiscal year 1992 budget request to replace the available bed count statistic with average daily patient census. Most hospital and intermediary officials interviewed prefer this statistic because hospitals already keep such data as part of their billing systems. Moreover, some intermediaries said they use hospitals' patient census reports to determine the reasonableness of reported bed counts. To replace this statistic, the Congress would have to amend the Social Security Act, which specifies the bed count statistic as part of the indirect cost equation.

Further, HCFA allows hospitals to exclude beds used to treat sick newborns if the beds are located in units not specified in HCFA guidance. This practice is inconsistent with the rationale of a 1987 U. S. Court of Appeals for the District of Columbia decision that HCFA's determination to base Medicare cost reimbursements on the type, not location, of care provided to newborns had no rational basis in law and was arbitrary and capricious.

To determine whether teaching hospitals were excluding beds used to treat sick newborns, we surveyed 11 major teaching hospitals and found that four excluded beds in units that treat sick newborns from their bed counts. By allowing this, the four hospitals have been overpaid by more than \$4 million since 1987. Given that our survey covered only a small fraction of the 1,200 teaching hospitals participating in Medicare, the total amount of these overpayments could be significant.

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In commenting on a draft of this report, the Department of Health and Human Services stated that the court decision is binding only in that particular case, and that the Department's policy is to exclude beds assigned to newborns not in intensive care units. This exclusion stems from longstanding HCFA policy to exclude the costs of these units from the determination of hospitals' total routine costs.

We agree that well-baby costs should be excluded; however, our findings show that, in some instances, costs for treating sick newborns are also being excluded. These findings are analogous to the findings of the U.S. Court of Appeals, which reasoned that healthy newborns receiving only custodial care and generating no routine costs should be distinguished for purposes of Medicare reimbursement from sick newborns who do receive routine hospital care. That decision, as the Department says, is not binding here, but the same reasoning relied on by the court is applicable to the issue we are raising, whether HCFA's exclusion of sick newborns is without legal basis. The Department's policy is clear: however, the Department has not provided a convincing justification for the policy.

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## Control Weaknesses Unreported

The Federal Managers' Financial Integrity Act of 1982 (Public Law 97-255) requires agencies to establish systems of internal control to ensure that obligations and costs comply with applicable law, and that assets are safeguarded against waste, loss, or unauthorized use. Federal agencies must annually report to the Congress material weaknesses in these controls and the status of corrective actions until these weaknesses are corrected.

The weaknesses discussed in this report show that critical HCFA internal controls must be strengthened. The Comptroller General's internal control standards require that internal control techniques be effective, provide the coverage that is needed, and operate when intended. The standards also require that all transactions be clearly documented. Documentation must be purposeful and useful to managers, auditors, and others involved in analyzing operations.<sup>3</sup> HCFA does not meet these standards. HCFA does not have effective techniques for identifying instances in which hospitals improperly claim DOD and VA residents. Further, HCFA's technique for documenting bed counts is not uniformly and consistently applied by hospitals and intermediaries. As a result, counting practices vary widely among hospitals and intermediaries, and it is

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<sup>3</sup>Standards for Internal Controls in the Federal Government, GAO (Washington, D.C.: 1983).



impossible to trace reported bed count data. Moreover, the Department of Health and Human Services' Financial Integrity Act reports need to disclose these weaknesses.

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## Conclusions

Supplemental Medicare payments to teaching hospitals are based on inaccurate and unverifiable data, and are causing Medicare to pay millions more in indirect medical education costs than it should. Moreover, allowing teaching hospitals to exclude some beds used to treat sick newborns from their bed counts is inconsistent with a federal court decision and costs the Medicare program millions each year.

The weaknesses discussed in this report show that stronger internal controls are needed. HCFA needs a valid and reliable method for determining supplemental payments so that their reasonableness can be assured and HCFA can better control Medicare costs. Until this occurs, HCFA and the intermediaries cannot meet their responsibilities to reduce Medicare's risk to waste and abuse.

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## Recommendations

In order to bring this situation under control, we recommend that you direct the Administrator, HCFA, to

- ensure that HCFA (1) implements plans to collect information on residents working at DOD and VA hospitals, (2) uses this information to match against resident data that teaching hospitals submit to HCFA, and (3) reports the results of this effort to you;
- ensure that hospitals count all beds used to treat sick newborns regardless of location as available beds until the bed count statistic is replaced; and
- report the lack of effective internal controls over resident data and the unauditability of available bed data as a material weakness under the Federal Managers' Financial Integrity Act.

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## Agency Comments and Our Evaluation

In its April 15, 1991, comments on a draft of this report, the Department of Health and Human Services agreed with our recommendation that HCFA should collect information on residents working at DOD and VA hospitals and use this information to match against resident data teaching hospitals submit. The Department identified several actions underway to implement this recommendation. However, none of these actions have been completed.

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While the Department disagreed with our conclusion, as well as with HCFA officials, that the number of available beds is an unauditible statistic, it acted on concerns that we raised during the course of our review and has included a legislative proposal to effect a change to average daily census.

The Department disagreed with our recommendation that all beds in units used to treat sick newborns be counted as available beds. The Department believes the cost and beds of well-baby nurseries should continue to be excluded, even if some of the beds are used for sick newborns, because these units generally house healthy newborns whose care is custodial rather than medical. However, the Department agreed to review its policy for counting beds used to treat sick newborns in units separate from well-baby nurseries.

Our recommendation is directed at ensuring that the costs of treating sick newborns are properly accounted for, and should have little effect on HCFA's longstanding policy of excluding well-baby nursery beds based on the results of a 1990 American Hospital Association study that found hospitals generally treat sick newborns in separate units. However, we recognize that there may be instances in which a hospital does not have a separate unit for treating sick newborns and may temporarily place the child in a custodial unit. In these cases, HCFA could allow for the exclusion of these beds if the number of cases is small enough that efforts to determine their costs would outweigh any potential savings to the Medicare program. We have modified this recommendation to address the Department's concern that it would have to count all nursery beds.

The Department disagreed that a material weakness exists regarding internal controls over resident data. The Department said it is taking steps with the aid of DOD and VA to incorporate resident data for these agencies into HCFA's computerized data base. We agree that when implemented these steps should help eliminate the problem of improperly counted residents. However, as of April 1991, Department officials were still negotiating with DOD and VA officials to develop a method for exchanging resident data. Until these data are available in HCFA's data base, a material weakness exists that should be reported.

The Department also disagreed that a material weakness exists regarding the auditability of bed data. Although the Department agreed that problems exist in auditing these data, it believes the problems exist

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in the law, not in the manner in which HCFA implements it. The Department said the law created a process for counting beds that makes it difficult to validate actual bed counts through an audit or determine if an overstatement of cost exists. This position does not relieve the Department of its responsibility to report weaknesses regarding the auditability of bed data. The Office of Management and Budget has established four criteria that agencies are to use to determine whether weaknesses should be reported. These include determining whether (1) the weakness merits the attention of the relevant congressional oversight committee; (2) the weakness exists in a major program or activity; (3) the weakness could result in a loss of \$10 million or more; or (4) its omission from the agency's report could reflect adversely on the management integrity of the agency.

We believe the unauditability of available bed data meet all four criteria, and that the Department should report the condition as a material weakness until it is corrected. The Department's comments are included in appendix II.

In commenting on a draft of this report, the Department of Veterans Affairs said it was cooperating with HCFA to provide data regarding residents on board as of September 1 of any given year. The Department also said its officials were negotiating with HCFA to develop a meaningful yet simple information exchange to comply with our recommendation. The Department's comments are included in appendix III.

The Department of Defense reviewed a draft of this report and concurred in our findings and recommendations without further comment. The Department's response is included in appendix IV.

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As you know, the head of a federal agency is required by 31 U.S.C. 720 to submit a written statement on actions taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of this letter, and to the House and Senate Committee on Appropriations with the agency's first request for appropriations made more than 60 days after the date of this letter.

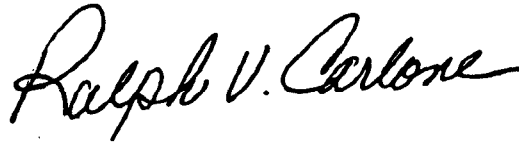
We are sending copies of this report to the Chairmen of the House Committee on Appropriations, Senate Committee on Governmental Affairs,

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and House Committee on Government Operations; and to the Administrator, Health Care Financing Administration. We will also make copies available to others upon request.

This report was prepared under the direction of Frank W. Reilly, Director, Human Resources Information Systems, who can be reached at (202)275-4659. Other major contributors are listed in appendix V.

Sincerely yours,

A handwritten signature in cursive script that reads "Ralph V. Carlone". The signature is written in black ink and is positioned above the typed name and title.

Ralph V. Carlone  
Assistant Comptroller General



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**Abbreviations**

DOD	Department of Defense
GAO	General Accounting Office
HCFA	Health Care Finance Association
IMTEC	Information Management and Technology Division
VA	Department of Veterans Affairs

# Objectives, Scope, and Methodology

Our objectives were to determine (1) the accuracy of resident and bed count data that teaching hospitals submit to HCFA, (2) the effect of inaccurate data on Medicare payments to these hospitals, and (3) the adequacy of HCFA's internal controls over these data. Our review was conducted between October 1989 and December 1990 at the Department of Health and Human Services, Health Care Financing Administration headquarters in Baltimore, Maryland; regional offices in San Francisco, California, and Chicago, Illinois; and at the Departments of Defense and Veterans Affairs headquarters in Washington, D.C. Our review was conducted in accordance with generally accepted government auditing standards.

To determine the extent of errors in resident and bed data submitted by hospitals, we reviewed applicable Medicare program legislation and HCFA regulations and guidance on how hospitals and intermediaries are to count residents and beds. We also reviewed policies and procedures hospitals and intermediaries use to count residents and beds. In addition, we analyzed data maintained by HCFA in its resident data base to calculate the extent to which residents were being over counted.

Because HCFA reviews resident data that teaching hospitals report to identify overreporting among teaching hospitals, we focused our effort on examining the effectiveness of HCFA's techniques for identifying instances in which teaching hospitals improperly include DOD and VA residents in their reported counts. We selected 14 VA hospitals located near hospitals where HCFA found extensive resident over-counting and obtained their September 1988 and 1989 resident lists. In addition, we obtained resident lists for all 29 DOD hospitals with teaching programs.

We used a computerized matching process to identify instances in which residents working at DOD and VA hospitals were included in hospital counts. We found 996 instances in which residents working at DOD and VA hospitals were reported by nongovernment hospitals. Because the DOD and VA resident lists showed only residents assigned to hospitals during the month of September, we sent a questionnaire to each DOD and VA hospital where matches occurred and asked them to verify the residents' assignment status on September 1. On the basis of the information provided by DOD and VA hospitals, we determined that 703 were at DOD and VA hospitals and 227 were not. We could not determine the status of the remaining 66 residents.

Because ambiguous bed count criteria prevented us from determining whether hospital-supplied bed counts contained errors, we administered



a questionnaire to 11 major teaching hospitals located in Arizona, California, Florida, Illinois, New York, and Texas. These hospitals were identified by intermediaries as being representative of all teaching hospitals. The questionnaire solicited information on (1) how hospitals determine which beds to count as available under a variety of circumstances, (2) when they start or stop counting beds removed from or placed into service, and (3) why they count or exclude beds used to treat sick newborns.

We also administered a questionnaire to the Blue Cross Blue Shield Association in Chicago, Illinois, and auditors at the 9 intermediaries who oversee the 11 surveyed teaching hospitals. The questionnaire differed from the hospital questionnaire only in that it omitted questions on hospital demographics and included questions about guidance intermediaries provide to teaching hospitals.

In addition, we interviewed hospital and intermediary officials who completed our questionnaire and collected local available bed policies and procedures, newborn admission criteria, 1987 through 1990 cost report data, and other pertinent information. We discussed the results of our survey with selected Medicare experts and with HCFA officials responsible for available bed policies and procedures, quality control, and cost report settlements.

To determine the adequacy of HCFA's controls over resident and bed data, we compared internal control standards and requirements published in GAO's Standards for Internal Controls in the Federal Government to HCFA's standards and requirements for its resident data base. We also examined methods and procedures intermediaries use to review resident and bed counts.

# Comments From the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR 15 1988

Mr. Ralph V. Carlone  
Assistant Comptroller General  
United States General  
Accounting Office  
Washington, D.C. 20548

Dear Mr. Carlone:

Enclosed are the Department's comments on your draft report, "Medicare: Flawed Data Add Millions to Teaching Hospital Payments." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "R. Kusserow".

Richard P. Kusserow  
Inspector General

Enclosure

Comments of the Department of Health and Human Services  
on the General Accounting Office Draft Report,  
"Medicare: Flawed Data Add Millions to  
Teaching Hospital Payments"

Overview

GAO describes weaknesses in data used to calculate payments to teaching hospitals and contends that data used to calculate Medicare payments to teaching hospitals are flawed. As a result, GAO believes Medicare payments to teaching hospitals are inflated. During fiscal years 1989 and 1990, Medicare allegedly overpaid teaching hospitals at least \$28 million because the hospitals inappropriately counted residents assigned to Department of Defense (DoD) and Department of Veterans Affairs (VA) hospitals.

GAO also contends that the Health Care Financing Administration's (HCFA's) guidance for counting available beds is confusing, and efforts to clarify it have not been successful. Consequently, GAO states that the bed data teaching hospitals report is not verifiable and the appropriateness of payments to these hospitals for medical education costs cannot be determined.

GAO takes issue with our direction as to whether hospitals are to count beds in completely or partially closed wings of a hospital based on whether they are actually put in use when needed or are only capable of being put in use if needed. In a letter dated September 9, 1988, Blue Cross and Blue Shield Association (BCBSA) requested guidance from HCFA on this issue. Our response was that beds contained in a completely or partially closed wing of a facility are not counted if the area in which the beds are contained is not included in a hospital's depreciable plant assets subject to capital-related cost reimbursement during a cost reporting period. Furthermore, we went on to respond that, if the area in which the beds are contained is included in a hospital's depreciable plant assets and the beds can be adequately covered by either employed nurses or nurses from the nurse registry, the beds in these areas must be counted. In this situation, the beds are considered "available" and must be counted even though it may take 24 to 48 hours to get nurses on duty from the registry. Although this policy requires a judgment as to the amount of time it will take to make a bed available, we believe the intent of the policy is clear.

GAO bases its conclusion that our bed count policy is flawed on its finding that some of the intermediaries and hospitals it contacted are confused about whether to count beds stored in locations other than in patient rooms. The draft report states that one hospital and four intermediaries surveyed indicated they would count stored

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beds, and five hospitals and six intermediaries responded they would count stored beds if they could be placed in service within 48 hours. Section 2405.3(G) of the Provider Reimbursement Manual (PRM) states: ". . . to be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patient rooms or wards (i.e., not in corridors or temporary beds)." Furthermore, BCBSA's letter (cited above) specifically asked whether, based on this PRM language, a bed placed in storage (either away from the provider site or just out of the patient room or ward) should not be counted. Our response was that ". . . beds that are not housed in patient rooms or wards should not be counted as available." While GAO's finding indicates that our policy of not counting beds stored in locations other than patient rooms may not be uniformly applied, we disagree with its conclusion that this finding indicates a flaw in the policy itself. We should point out that BCBSA informed us that following its receipt of our responses to these questions, it issued an Administrative Bulletin to their local subsidiaries informing them of our responses. We will issue these instructions as a revision to the PRM to further ensure uniformity in their application.

The draft report states that we are allowing hospitals to exclude beds used to treat sick newborns contrary to a 1987 U.S. Court of Appeals decision. Our exclusion of nursery beds in units other than neonatal intensive care units stems from longstanding HCFA policy to exclude the costs of these units from the determination of hospitals' total routine costs. We note that the 1987 decision is binding only in that particular case, and our current policy is to exclude beds assigned to newborns that are not in intensive care units. This policy was explained to GAO personnel on several occasions, consequently we do not understand the basis for its statement that we have not provided any reason as to why hospitals are allowed to exclude these beds.

GAO Recommendation

In order to bring this situation under control, we recommend that the Secretary of Health and Human Services direct the Administrator, HCFA to:

- ensure that HCFA (1) implements plans to collect information on residents working at DOD and VA hospitals, (2) uses this information to match against resident data that teaching hospitals submit to HCFA, and (3) report the results of this effort to the Secretary of Health and Human Services;

Appendix II  
Comments From the Department of Health  
and Human Services

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Department Comment

We agree. On November 30, 1990, letters were sent to DoD and VA officials explaining HCFA's needs for resident data, and the potential affect this information can have on Medicare program payments. Subsequently, meetings were conducted with both the VA and DoD to discuss the specific information HCFA requires from their hospitals and the procedures that have been established for this purpose. Further discussions with these agencies are planned in the near future. Also, on February 20, 1991, instructions were issued advising intermediaries to reconcile reporting of resident physicians in DoD and VA facilities and to collect any confirmed overpayments.

Additionally we are developing an application system (Interns and Residents Information System (IRIS)) to capture correct intern and resident data for each teaching hospital. The intent of IRIS is to identify duplicate reporting of intern and resident data on a national basis, identifying both inter-fiscal intermediary and intra-fiscal intermediary duplications.

GAO Recommendation

-- examine alternatives to using the available bed statistic, such as average daily patient census, and take whatever steps are necessary to implement the preferred alternative;

Department Comment

We support this recommendation and would note that we undertook such an examination prior to GAO's study. While we disagree with GAO's opinion that available beds is an unauditible statistic, we do recognize that ambiguous situations may arise, and this is one of several reasons for our interest in an alternative measure. We would note that the President's FY 1992 Budget includes a legislative proposal to effect a change to average daily census. We must, however, wait for congressional action on this issue, as the law currently states that the indirect medical education (IME) adjustment is based on a formula that depends, in part, on the number of beds.

GAO Recommendation

-- ensure that hospitals count all beds in units that treat sick newborns as available beds regardless of location until the bed count statistic is replaced; and

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Department Comment

This recommendation would essentially require that all nursery beds be counted if any bed within the nursery is used to treat sick newborns. As noted above, doing so would be contrary to longstanding cost reporting policy, and we do not support such a change. The costs of nursery units were excluded from hospitals' total routine costs because, in general, these units house healthy newborns whose care is custodial rather than medical. The policy of excluding nursery beds stems from this principle, and is consistently applied in all calculations of bed size, including instances where a hospital wishes to include as many beds as possible (e.g., in order to qualify for rural referral center status and disproportionate share payments). We intend to review our policy in this area to determine whether we should revise our regulations to count the units that are separate from the well-baby nursery, do not qualify as neonatal intensive care, but do provide routine service level of care. However, the ramifications of such a change on other aspects of the program must be given further consideration. We do not agree with this recommendation as drafted since we do not believe that either the costs or beds of the well-baby nursery should be counted, even if some of the beds are used for sick newborns.

GAO Recommendation

-- report the lack of effective internal controls over resident data and the unauditability of available bed data as a material weakness under the Federal Managers' Financial Integrity Act.

Department Comment

We disagree that a material weakness exists.

HCFA's policy interpretation of what constitutes bed days and our audit policy concerning these data are consistent with legislation and regulations governing the subject. Written guidelines are as clear and comprehensive as can reasonably be expected. It would, for example, not be reasonable to list every possible condition or exception in a set of instructions.

The law itself, however, has created a process of counting beds which is not inherently resistant to internal controls. In response to the law, HCFA has issued instructions and guidance pertaining to the audit and determination of bed day counts, and intermediaries have scrutinized this area. It is difficult to validate the actual bed count throughout the cost report period through

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an audit performed several months after the close of a cost report period. Because of the difficulty of validating the actual bed day count, it is similarly difficult to determine whether or not there is an overstatement of cost. Nevertheless, our guidelines for identifying available beds are reasonably clear, and where questions may arise, can be applied effectively.

GAO acknowledged problems inherent in the auditing of available bed data and has recommended a change to the law to correct this problem. There is general agreement as to the existence of a problem. However, our position is that the problem exists in the law; not in the manner in which HCFA implements it.

We also disagree that a material weakness exists regarding the identification of VA and DoD physician residents. HCFA was previously unaware of the circumstances concerning VA and DoD resident physicians, i.e., that they are counted in the payment calculations for VA and DoD hospitals.

HCFA, once apprised of the situation, began taking steps, with the aid of the VA and DoD, to incorporate resident physician counts for these entities into our national system. This system identifies and tracks residents that may relocate anywhere in the country during the academic year. These steps should eliminate the problem identified by GAO involving improperly counted residents.

#### Technical Comments

The report refers to our policy of counting residents based on where they are working on September 1. The September 4, 1990 final rule on changes to the prospective payment system (55 FR 36059) provided that, effective for cost reporting periods beginning on or after July 1, 1991, the number of residents is to be based on the total time necessary to fill a residency slot throughout the year. GAO's report should note this change.

Another technical point relates to GAO's statement that the IME adjustment is paid on an annual lump-sum basis. This is incorrect. Payment for IME is made as part of the diagnosis related group payment on an individual case basis, in accordance with 42 CFR 412.116. The amount of the payment is subject to adjustment based on the intermediary's final determination of the resident-to-bed ratio for the cost reporting period under 42 CFR 412.118(h).

# Comments From the Department of Veterans Affairs



THE SECRETARY OF VETERANS AFFAIRS  
WASHINGTON

APR 5 1991

Mr. Ralph V. Carlone  
Assistant Comptroller General  
Information Management and  
Technology Division  
U.S. General Accounting Office  
Washington, DC 20548

Dear Mr. Carlone:

Thank you for the opportunity to comment on the General Accounting Office (GAO) draft report, Medicare: Flawed Data Add Millions to Teaching Hospital Payments (GAO/IMTEC-91-31). Although your recommendations are addressed to the Secretary of Health and Human Services, there is an underlying call for assistance from the Department of Veterans Affairs (VA). I agree we must curtail waste in Federal programs and am pleased that VA can participate in lowering our nation's Medicare costs.

As we agreed at the exit conference, the Veterans Health Services and Research Administration (VHS&RA) is cooperating with the Health Care Financing Administration (HCFA) to provide data regarding residents on board as of September 1 of any given year. VHS&RA officials are negotiating with HCFA officials on a technical level to develop the most meaningful yet simple information exchange to enable HCFA to comply with your recommendation.

I appreciate being asked to comment on your draft report.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "Edward J. Derwinski".

Edward J. Derwinski

EJD/jev



# Comments From the Department of Defense



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

9 APR 1991


Mr. Ralph V. Carlone  
Assistant Comptroller General  
Information Management and  
Technology Division  
U.S. General Accounting Office  
Washington, DC 20548

Dear Mr. Carlone:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report, "MEDICARE: Flawed Data Add Millions to Teaching Hospital Payments," dated February 26, 1991 (GAO Code 510487/OSD Case 8618).

The DoD has reviewed the report and concurs without further comment. The Department appreciates the opportunity to review the report in draft form.

Sincerely,

  
Enrique Mendez, Jr., M.D.  
*for*

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# Major Contributors to This Report

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**Information  
Management and  
Technology Division,  
Washington, D.C.**

Thomas J. Jurkiewicz, Assistant Director  
Kim F. White, Staff Evaluator

---

**Chicago Regional  
Office**

David A. Arseneau, Staff Evaluator

---

**Cincinnati Regional  
Office**

Wenona U. Johnson, Staff Evaluator

---

**San Francisco  
Regional Office**

Thomas P. Monahan, Regional Management Representative  
Samuel H. Scrutchins, Evaluator-in-Charge  
Elizabeth A. Olivarez, Staff Evaluator  
Jonathan M. Silverman, Reports Analyst

---

**Office of General  
Counsel**

Stefanie G. Weldon, Senior Attorney

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