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AAMC Summary and Analysis

FEDERAL FISCAL YEAR 2005 MEDICARE INPATIENT PPS FINAL RULE: PROVISIONS OF INTEREST TO THE ACADEMIC MEDICAL COMMUNITY

On August 11, 2004, the Centers for Medicare and Medicaid Services (CMS) published in the *Federal Register* the final rule containing changes to the Medicare hospital inpatient prospective payment system (PPS) and the PPS payment update for Federal fiscal year (FFY) 2005. See *Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates*. 69 Fed. Reg. 48916. This rule finalizes changes and policies contained in the May 18 proposed rule (69 Fed. Reg. 28196).

The final rule can be obtained by accessing the AAMC's issue brief on this topic at: <http://www.aamc.org/advocacy/library/teachhosp/hosp0054.htm>. Additional information can be found by reviewing the proposed rule as well as the AAMC's comment letter, both of which can be found on the same site.

The final rule contains a number of significant provisions regarding Medicare policies for direct graduate medical education (DGME) and indirect medical education (IME) payments. Foremost among these are the regulations and instructions for implementation of the **Medicare resident limit redistribution program**, mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The final rule also addresses Medicare payments for residents training at nonhospital sites, DGME initial residency period determinations (the so-called "preliminary year" issue), the DGME per resident amount freeze, and the IME payment level.

Other policies and changes of interest to teaching hospitals include the update factor for the inpatient PPS base payment rate, outlier payments, counting beds for purposes of the IME formula, a change relating to the Medicare disproportionate share (DSH) payment methodology, changes to the metropolitan statistical area (MSA) definitions and computation of wage index values, and new services that will receive pass through payments.

As an aside, readers should be aware that the final rule contains a redesignation of the DGME regulations within volume 42 of the Code of Federal Regulations (CFR). Currently the regulations are contained in section 413.86. This section is being divided into nine sections, sections 413.75 through 413.83.

I. RESIDENT LIMIT REDISTRIBUTION PROGRAM (pages 49112-169; 42 C.F.R. §413.79(c)(3))¹

KEY POINTS

- Resident cap reductions and increases are scheduled to go into effect for cost reporting periods occurring on or after July 1, 2005
- Applications to seek increases are due generally by December 1, 2004¹

A. OVERVIEW

The Balanced Budget Act of 1997 (BBA) placed limits on the number of residents teaching hospitals may count for purposes of the calculations associated with DGME and IME payments (so-called resident “limits” or “caps”). There are two caps for each hospital: IME and DGME. While there are exceptions (particularly affecting rural teaching hospitals), the general rule is that a hospital’s resident limit is based on the number of allopathic and osteopathic residents reported for IME and DGME payments on the hospital’s most recent cost report ending on or before December 31, 1996 (42 U.S.C. 1395ww(h)(4)(F)).

The intent of section 422 of the MMA, entitled “Redistribution of Unused Resident Positions,” is to reduce the resident limits for those hospitals that are not fully “using” their caps and “redistribute” these slots to hospitals that demonstrate a need to have their caps increased.

The final rule establishes the process for determining whether, and by what amount, a hospital’s resident cap will be reduced. It also specifies the application process for hospitals seeking increases to their resident caps and the criteria CMS will use to determine which hospitals will receive cap increases. The CMS criteria are particularly important in the event that the cap slot “demand” exceeds “supply.”

¹ Page numbers refer to the August 11, 2004 Federal Register. The CFR citations refer to the redesignated sections.

B. PROCESS FOR REDUCING RESIDENT CAPS
(pages 49112-132; 42 C.F.R. §413.79(c)(3))

KEY POINTS

- Relevant cost reports are those ending on or before September 30, 2002 and those that include July 1, 2003
- Different process depending upon whether the teaching hospital participated in a GME resident limit affiliation agreement as of July 1, 2003
- Limited exceptions associated with new residency programs and residency program expansions

1. Overview

Which hospitals will have their resident caps reduced, and by how much, will be made by comparing cost report resident counts with resident caps in a specific year. The time frame for this comparison differs depending upon whether a hospital was a member of a GME resident limit affiliation agreement as of July 1, 2003.

Hospitals with resident counts that are less than their comparison resident cap will have their caps reduced by 75 percent of the difference between their cap and count. Hospitals could submit a “timely request” for an exception to this process in the limited situations of new residency programs and existing residency program expansions (see discussion below), but with the exception of certain rural hospitals (see next section) these requests were due June 14, 2004.

CMS’ proposed process was also published in an April 30, 2004 and a May 26, 2004 “one time notifications” (OTNs). According to the May 26 OTN, hospitals desiring an exception had to file a “timely request” to CMS by June 14, 2004.²

2. Rural Hospital Exception

Final Rule

The MMA mandates that rural teaching hospitals with less than 250 acute care inpatient beds (based on the bed count reflected on the most recent cost report ending on or before September 30, 2002) are exempt from any cap reductions. The final rule specifies that the determination of whether a hospital is considered “rural” will be based on the metropolitan statistical area (MSA), in which the hospital is located as of July 1, 2005 (the effective date of the resident cap reductions and increases), regardless of any reclassification determinations made in the context of the Medicare wage index.

² The only difference between the two OTNs is that the May 26 OTN extended the deadline for filing timely requests from June 4 to June 14.

Analysis--In the final rule, CMS made a number of changes to the MSA definitions and areas. Accordingly, some hospitals that are currently in a rural area will be considered urban as of October 1, 2004 (the effective date of the new MSA definitions). Some of these hospitals were teaching hospitals and had less than 250 beds; therefore they thought they would be exempted from any resident limit reductions. However, these hospitals are now subject to any resident limit reductions because of their change in status from rural to urban. To the extent that the resident counts for these hospitals are below their corresponding resident caps and they would like to pursue an exception, CMS extended the “timely request” until August 23 for these hospitals only. We understand that very few hospitals might be in this situation.

3. Process for Hospitals That WERE NOT Members of GME Resident Limit Affiliation Agreements as of July 1, 2003

Final Rule

For these hospitals, unless they requested and qualify for an exception (see below), the cap/count comparison will be based on the values reported on the hospital’s most recent cost report ending on or before September 30, 2002.³ (The issue of submitted versus settled cost reports and the role of audits is discussed below.)

If the resident count is less than the applicable resident cap, as of July 1, 2005, the hospital’s resident cap will be reduced permanently by 75 percent of the difference between the resident cap and count.

4. Hospitals That WERE Members of Medicare GME Affiliation Agreements as of July 1, 2003

Background

The BBA permitted CMS to establish a system by which hospitals could elect to apply their resident limits on an aggregate basis. Hospitals that qualify may execute a “Medicare GME affiliation agreement” that sets forth an aggregate resident limit (the sum of the individual hospital limits) as well as the individual hospital resident limits agreed upon by the parties for the term of the agreement. For example, if Hospital A and Hospital B each had resident limits of 100, their aggregate limit would be 200. In the agreement for a particular academic year, they might specify that Hospital A would agree to a resident limit of 90 so that Hospital B could have a limit of 110.

The MMA mandated that the process for determining possible cap reductions be different for hospitals that participate in a Medicare GME affiliation agreement as of July 1, 2003.⁴

³ Note that if a hospital was part of a GME affiliation agreement during this period, the cap reflected on the cost report will be the hospital’s cap pursuant to that agreement.

⁴ The MMA states that the “provisions of clause (i) [programs subject to reduction] shall be applied to hospitals which are members of the same affiliated group . . . as of July 1, 2003.”

Final Rule

Due in large part to the MMA mandate, the process for determining potential cap reductions for hospitals that participated in a GME affiliation group as of July 1, 2003 is much more complicated than the process for other hospitals.

Under the final rule, the process is as follows:

1. Using each hospital's cost report that includes July 1, 2003, the fiscal intermediary (FI) will identify each hospital's IME and DGME resident counts as well as its original IME and DGME resident caps (generally based on 1996 values). [Note: CMS will be identifying the hospital's original cap, NOT the cap pursuant to the July 1, 2003 affiliation agreement]

--Note that the cost reports CMS will be examining may vary according to a hospital's cost reporting year. For June 30 year-end hospitals, the July 1, 2003-June 30, 2004 cost report will be used; for December 31 year-end hospitals, the January 1, 2003-December 31, 2003 cost report will be used.

2. The FI will sum the resident caps from those cost reports from all of the members of the GME affiliation agreement to determine an aggregate cap. The FI will also sum the resident counts from those cost reports to determine an aggregate resident count.
3. If the aggregate count equals or exceeds the aggregate cap, no cap reductions will be made to any hospital member of the affiliated group, even if on a hospital-specific basis, a hospital had trained fewer residents than its cap.
4. If the aggregate count is *less* than the aggregate cap, the following process will occur using cost reports that include July 1, 2003:
 - a. FIs will compare each hospital's resident count to its *affiliated* resident cap (Note, the affiliated cap will reflect any modifications to the affiliation agreement through June 30, 2004)
 - i. If the hospital's resident count is greater than its affiliated cap, no resident cap reduction will occur.
 - ii. For hospitals in which their resident count is *less* than their affiliated cap:
 1. The FI will determine the amount by which the aggregate resident count (for all hospitals in the group, not just those with counts below their caps) is below the corresponding aggregate affiliated resident cap

2. The FI will determine a “pro rata” cap reduction for each hospital that has a resident count less than its affiliated cap. This is accomplished by dividing the amount that the hospital’s resident count is less than its corresponding resident cap by the total resident count that is less than the total cap for all affiliated hospitals under their caps.
3. The pro rata reduction share for each hospital is then multiplied by the aggregate difference between the resident counts and caps for *all* the member hospitals (including hospitals with resident counts greater than their caps) (result of step 1)
4. The hospital’s 1996 cap is then permanently reduced by 75 percent of this amount

Mathematically, this process can be summarized as:

$$[(\text{Hospital affiliated cap} - \text{resident count}) * (\text{the total cap-count calculation for only those hospitals with counts} < \text{caps})] * (\text{the total cap-count calculation for all members of the affiliation group}) * 75\%$$

Analysis--Because the pro rata reduction percentage is multiplied by the cap-count difference for all hospital members of the relevant GME affiliated agreement, the resident caps for GME affiliated hospitals with resident counts less than their affiliated caps are reduced less than they otherwise would be if the calculations were done looking at only individual hospital caps and counts. This is because including hospitals that have resident counts greater than their caps reduces the total by which the group’s resident count is less than the aggregate cap.

Hospitals potentially subject to this calculation should carefully review CMS’s description of this process and the accompanying example on pages 49129-131

5. “Timely Request” Exceptions to the Resident Cap/Count Comparison

[NOTE: With the exception of a small number of rural hospitals (see rural hospital exception, above) “timely requests” for exceptions were due to CMS by June 14, 2004]

Pursuant to the language in the MMA, a hospital whose resident count (for either IME, DGME or both) is below its corresponding resident cap and thus is at risk of having its IME and/or DGME cap reduced has the option of requesting that CMS use its cost report that includes July 1, 2003 for purposes of the cap/count comparison because of an expansion of an existing residency program that was not reflected on its “on or before September 30, 2002 cost report.”

The hospital could also request that its resident count be increased to reflect residents associated with a newly approved program that was not reflected on the cost report that is being used for the cap/count comparison.

- *Expansions of Existing Programs.* The final rule implements the MMA mandate by specifying that if the resident count on a hospital's most recent *settled* cost report is less than the count on a subsequent cost report due to an expansion of a program that existed at the time of the settled cost report, upon submission of a "timely request," and subject to audit, CMS will use the caps and counts from the hospital's cost reporting period that includes **July 1, 2003**.
- *Expansions Due to Newly Approved Programs.* If a hospital had a resident program that was accredited before January 1, 2002 but was not in operation during the cost report ending on or before September 30, 2002 (or July 1, 2003 if it also has submitted a program expansion timely request or was part of a GME resident limit affiliation agreement), upon timely request and audit, CMS will increase the applicable resident count reflected on the relevant cost report by the total number of residents for which the new program was accredited.

Analysis--While all teaching hospitals are eligible for the two exceptions, for hospitals that were members of GME affiliation groups as of July 1, 2003, the exceptions have little meaning. This is because a) in terms of the existing program expansion exception, CMS already is utilizing their cost reports that include July 1, 2003, and b) in terms of the new program exception, it is unlikely that these hospitals will have a new program that was accredited prior to January 1, 2002 but that was not in operation as of July 1, 2003.

The new program expansion applies only if **no** residents of the new program are reflected on the relevant cost report. In response to comments, CMS acknowledged that this policy may hinder a hospital whose relevant cost report reflects residents from the initial year(s) of a new program but not all of the residents because the program has not yet grown to its full complement. While CMS did not modify its exception process to accommodate these situations, the Agency did add an evaluation criterion in the resident limit increase application process (see fuller discussion below) in the event these hospitals apply for additional resident limit slots.

6. The Role of Audits in Resident Limit Reduction Determinations (pages 49115-119, and 49122-123)

Background

The proposed rule discussed the role of audited resident counts and caps in determining whether and to what extent a hospital's resident cap would be reduced. In particular, CMS proposed that final determinations regarding whether and by how much a hospital's resident cap would be reduced would not occur until any cost reports that were under appeal were resolved.

Final Rule

The final rule did NOT finalize the proposed rule process. Rather, the Agency said that it will require that FIs use the latest available cost report or audit data at the time they make their determinations regarding resident limit reductions. Specifically, the final rule says:

- If the relevant cost report (for the period ending on or before September 30, 2002 or including July 1, 2003) has been settled and not appealed, the FI will make its determination based on the resident counts and caps reflected on that cost report.
- If the relevant cost report has been settled, appealed, and a decision rendered, the FI will make its determination based on the resident counts and caps reflected on that cost report.
- If the relevant cost report is settled, but under appeal and a final decision has not been rendered, the FI will use the values reported on the settled cost report (per the Notice of Program Reimbursement (NPR)) without the benefit of the appeal decision.
- If the relevant cost report has never been final settled as of the time the FI needs to make a determination regarding resident limit reductions (generally these will be “as submitted”), these cost reports will be audited by the FI and it is the audited values that will be used in the cap/count comparison.

CMS states that every effort will be made to complete the audit process so that FIs can notify hospitals of their cap determinations by the July 1, 2005 effective date. However, in the event these audits are not completed by that time, CMS anticipates that they will be completed by December 2005. In these situations, the results of any audits completed between July 1, 2005 and December 2005 will be retroactive to July 1, 2005.

Analysis--CMS states in the preamble that it chose not to finalize the process it articulated in the proposed rule regarding final appeal determinations because the Agency believes that Congress intended that these resident cap increases and decreases be determined expeditiously and with finality given the July 1, 2005 effective date. CMS states it has the authority to make these decisions final because of the language in the MMA stating “there shall be no administrative or judicial review . . . with respect to determinations made [under the resident limit program]” (Section 422 of the MMA). CMS also noted that while hospitals may still appeal resident cap or count determinations made by the FI for the relevant cost reporting period, if those appeal decisions are rendered after the FI has made its resident limit determinations, the impact of the appeal will affect only the IME or DGME payments in the relevant cost reporting period and will not affect the resident limit decision pursuant to section 422.

The AAMC is very concerned about CMS’ final policy. The resident limit reduction determinations that the FI will make are permanent and thus will potentially affect a hospital’s DGME and IME payments every year going forward.

It seems patently unfair that a hospital could have its resident limit permanently reduced because of a resident count determination by an FI that is ultimately increased upon appeal. We are assessing what, if any, options might be available to modify this provision of the rule.

Because of its impact on resident cap determinations, teaching hospitals should carefully review this section of the final rule preamble (pages 49115-119 and 49122-123).

7. Hospitals That Participate in Demonstration Projects or Voluntary Reduction Programs (pages 49156-161; 42 C.F.R. §413.79(c)(5))

Background

The BBA included a Voluntary Resident Reduction Project provision; a group of hospitals in New York had also previously arranged a similar program with CMS. Under both of these programs, participating hospitals that met certain criteria and agreed to reduce their resident counts to certain levels could receive “transition” IME and DGME funding to help offset the IME and DGME payment losses associated with those reductions.

The MMA stated that nothing in the resident limit redistribution program “shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs . . . under a demonstration project approved as of October 31, 2003.” (section 422).

Final Rule

For hospitals that participated in a residency reduction program for a period of time longer than it has been withdrawn from the demonstration program, or if it completed participation, for the cap/count comparison, CMS will use the *higher of* the hospital’s base number of residents⁵ (that is, the number of residents training at the start of the hospital’s participation project) and the resident count that is on the hospital’s most recent cost report ending on or before September 30, 2002.

8. Teaching Hospitals That File Low Utilization Cost Reports (pages 49161-162)

Background

Because of their low volume of Medicare patients, children’s hospitals often file “low utilization” (abbreviated) Medicare cost reports. These reports may or may not include worksheet E-3, Part IV of the cost report that contains information, such as resident counts and caps, that would permit CMS to calculate DGME payments.

Final Rule

⁵ Excluding any dental or podiatry residents since these residents are excluded from the Medicare resident cap determinations but were included as part of the voluntary resident reduction programs.

The final rule specifies that for hospitals that filed low utilization cost reports for their most recent cost reporting period ending on or before September 30, 2002 which did not include Worksheet E-3, Part IV, there will be no resident limit reductions because CMS has no way to determine the cap and count information (since it is contained on worksheet E-3, Part IV). If the low utilization cost report contained Worksheet E-3, Part IV (which some do) then that hospital is subject to potential resident limit reductions.

Analysis--CMS noted that even if a hospital is not subject to the resident limit reductions, it may still apply for a resident limit increase (see below), so long as it files Worksheet E-3, Part IV, with its Medicare cost report for its cost reporting period that includes July 1, 2005 (the effective date of the provision).

In response to a comment urging CMS to emphasize that the resident limit redistribution program applies only to the Medicare program and not to the federal Children's Hospitals GME (CHGME) Payment program, which is administered by the Health Resources and Services Administration (HRSA), CMS stated that it has no authority to limit HRSA's use of CMS' determinations and that all comments on the CHGME program should be directed to HRSA.

9. Summary

- If a hospital did not submit a timely request to CMS by June 14, 2004, the cap/count comparison will be based on the IME and DGME cap values reported on its most recent cost report ending on or before **September 30, 2002**.
- If a hospital submitted a timely request because of a program expansion, and the CMS audits confirms the hospital's position, the cap/count comparison will be based on values reported on the hospital's cost report that includes **July 1, 2003**.
- If the hospital submitted a timely request because of a newly approved program and the CMS audits confirms that the program meets the criteria, CMS will increase the otherwise applicable resident count by the total number of residents for which the new program is accredited.
- The process is much more complicated for hospitals that participated in GME resident limit affiliation agreements for the July 1, 2003-June 30, 2004 period, but the base of that process is the cost report period that includes **July 1, 2003**.

C. PROCESS FOR ALLOCATING CAP INCREASES
(pages 49132-156; 42 C.F.R. §413.79(c)(5))

KEY POINTS

- Applications are due to CMS by December 1, 2004 or March 1, 2005 (if the hospital is in the midst of a resident limit redistribution audit.) Each application must include one or more CMS evaluation form(s) (attached to this summary)
- An evaluation form must be submitted for each residency program for which the hospital intends to use the cap increase
- The evaluation forms are residency program-specific, but any additional slots, once granted, are hospital-specific; that is, they will result in an increase to the hospital's overall resident cap
- The three-year rolling average and prior year IRB cap will not apply to resident counts associated with the additional cap slots
- Hospitals that have their caps reduced may apply to "get back" those cap slots

1. Background

The MMA sets forth several key requirements for distributing additional cap slots to qualifying hospitals. First, hospitals may receive no more than 25 additional cap slots. Second, hospitals must demonstrate the likelihood that the cap slot positions will be filled within three cost reporting periods beginning on or after July 1, 2005 ("demonstrated likelihood" requirement). Third, CMS must distribute the slots to hospitals according to the following priority order ("priority categories"): hospitals in rural areas, hospitals in small urban areas, hospitals in which the relevant residency program is in a specialty for which there are no other residency programs in the state and, finally, all other hospitals. The MMA also authorizes CMS to determine cap distributions within the priority categories. This last provision is necessary in the event that the cap slot "demand" exceeds the corresponding "supply."

2. "Demonstrated Likelihood" Requirement

The final rule sets forth three options by which an applying hospital can meet the "demonstrated likelihood" requirement.

1. Starting a new residency program on or after July 1, 2005,
2. Expanding a current residency program on or after July 1, 2005, and/or

3. Having a resident count that exceeds the current cap.

Each of these options requires that hospitals submit documentation to support the hospital's assertion.

The CMS Evaluation Form contains the demonstrated likelihood requirements, as well as the documentation requirements (see attached).

The final rule clarified and modified the demonstrated likelihood requirements that were originally proposed:

- Eliminated the option that would permit hospitals to meet the demonstrated likelihood if they could document that they maintained a residency program that is at risk of losing accreditation because of an insufficient resident complement
- Eliminated the requirement that hospitals submit employment contracts for residents who are, or will be, participating in the residency programs
- Defined residency match as a “national process administered by the National Residency Matching Program (NRMP), the San Francisco Matching Program, the American Osteopathic Association Residency Match Program, or the Urology Matching Program . . .” (page 49136)
- In addition to relying on national fill rates, permits hospitals to document that their state or MSA meets the resident fill rate requirements that are specified in the regulations
- Defined resident fill rate as the “number of residents training in a program as compared to the number of accredited slots in that program as of June 30 of that year” (page 49136)
- Lowered the national, state, MSA, and hospital-level residency fill rate requirements from 95 percent to 85 percent
- Added the American Board of Medical Specialties (ABMS) as a certifying body for residency programs (in addition to the ACGME and AOA)

3. Priority Categories for Distributing Cap Slots (pages 49143-145)

Because of the interplay between a hospital's geographic location and whether it is operating the only specialty training program in a state, cap slots will be distributed according to the following priority categories:

1. The hospital is located in a rural area and has the only specialty program in the state
2. The hospital is located in a rural area
3. The hospital is located in a small urban area (less than one million population) and has the only specialty program in the state
4. The hospital is located in a small urban area

5. The hospital has the only specialty training program in the state
6. The hospital meets none of the statutory priority criteria

According to the final rule, rural (not located in an MSA) and small urban (MSA with less than one million population) designations are based on those in effect as of July 1, 2005 (69 Fed. Reg. at 49114). The final rule also clarifies that, so long as the program is accredited, residency programs at federal facilities or military hospitals are included in the determination as to whether the specialty training program is the only one in the state (69 Fed. Reg. at 49145).

4. Evaluation Criteria

In the event that the number of requested cap slots exceeds the number of available cap slots for distribution within a given priority category, CMS has devised a “scoring scheme” to determine which hospitals should receive cap slots first. Under the scheme, hospitals and their associated residency programs would receive one point for each of 15 criteria that they meet.

The 15 evaluation criteria are set forth in CMS’ Evaluation Form. Readers will note that the last five criteria (evaluation criteria 11-15) were not included in the proposed rule. CMS added these criteria in response to comments they received.

In their applications, hospitals must include an evaluation form for each residency program which supports their request for additional cap slots.

5. Summary

NOTE: HOSPITALS CONTEMPLATING SUBMITTING AN APPLICATION SHOULD READ PAGES 49132-49169 OF THE FINAL RULE CAREFULLY TO ENSURE THEY ARE SUBMITTING A FULL AND COMPLETE APPLICATION

Hospitals wishing to apply for additional cap slots must do the following:

1. Submit an application, with accompanying CMS evaluation form(s), to the CMS central office and the appropriate CMS regional office by **December 1, 2004** (March 1, 2005 for those hospitals undergoing audit for purposes of section 422 which are not completed as of December 1, 2004). Note: If your hospital is undergoing an audit, but has all of the information it needs for the application, it would be advisable to submit an application by the December 1, 2004 deadline.

CMS Central Office Address:

Centers for Medicare and Medicaid Services (CMS)
Director, Division of Acute Care
7500 Security Blvd
Mail Stop C4-08-06
Baltimore, MD 21244

CMS Regional Offices Addresses: See page 49169 of the August 11 Final Rule

2. The application (CMS does NOT provide a form) must contain the following (see page 49169):

- Name and Medicare provider number of the hospital
- Total number of cap slots requested (no more than 25) for both DGME and IME caps
- DGME and IME resident counts as well as DGME and IME resident caps as reported on the hospital's most recent *as-filed* cost report
- A completed copy of the CMS Evaluation Form for each residency program for which the hospital intends to use the requested increase in FTE residents

■ The CMS evaluation form can be obtained from the CMS web site at: <http://www.cms.hhs.gov/forms/acms20024.pdf>

- Source documentation to support the assertions made by the hospital on the CMS evaluation form.
- The following attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report:

"I hereby certify that I understand that misrepresentation or falsification of any information contained in this application may be punishable by criminal, civil, and administrative action, fine and/or imprisonment under federal law. Furthermore, I understand that if services identified in this application were provided or procured through payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil, and administrative action, fines and /or imprisonment may result. I also certify that, to the best of my knowledge and belief, it is a true, correct, and complete application prepared from the books and records of the hospital in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding Medicare payment to hospitals for the training of interns and residents"

Note: While the CMS evaluation form must be completed at the residency-program level, the final rule emphasizes that any additional cap slots granted are at the hospital level: "The section 422 caps, as well as the adjusted 1996 FTE caps, are applied to FTE residents counted by the hospital in all programs in the aggregate, not on a program-specific basis." (page 49142).

6. IME and DGME Payment Methodologies for Redistributed Resident Slots (pages 49088-090, and 49153-155)

The final rule implements the MMA requirement that FTE resident counts associated with the redistributed resident slots (referred to by CMS as the "section 422 cap") have different IME and DGME payment formulas as compared to the payment methodology associated with the hospital's previous resident count:

IME: The IME payment multiplier for the redistributed resident slots will be 0.66, which equates roughly to a 2.7 percent IME adjustment

DGME: Redistributed resident slots will be paid based on the hospital's locality adjusted national average per resident amount (PRA) (as opposed to its hospital-specific PRA)

Importantly, in response to comments, the final rule rescinded its proposal to subject the additional slots to the three-year rolling average resident count and the IRB cap (see pages 49153-155).

7. Additional Resident Cap Slots and GME Resident Limit Affiliation Agreements (pages 49142-143)

The final rule specifies that any additional slots that a hospital receives pursuant to the resident limit redistribution program may NOT be aggregated and applied to the resident caps of any other hospitals.

II. RESIDENT TRAINING AT NONHOSPITAL SITES (pages 49176-182; 42 C.F.R. §413.78(c))

KEY POINTS

- Hospitals may choose not to have written agreements with nonhospital sites so long as they pay “all or substantially all” of the nonhospital site training costs by the end of the third month following the month in which the training occurred.
- During CY 2004, hospitals may claim all family practice residents training at nonhospital sites regardless of the financial arrangement between the hospital and nonhospital site, so long as the other requirements are met.

Background

Teaching hospitals are allowed to claim residents training in nonhospital sites for DGME and IME payments so long as the teaching hospital incurs “all or substantially all” of the costs of the residency training in those sites and the resident count does not exceed the hospital's resident cap. Through 1998, “all or substantially all” the training costs was defined to be the resident's stipend and benefits. Effective in 1999, CMS changed the definition to include supervisory physician costs, if any.

In addition, there must be a written agreement between the hospital and nonhospital site setting forth the hospital's obligations, including that the hospital will incur the costs of the residents' stipends and fringe benefits at the nonhospital site, that the hospital must provide "reasonable compensation" to the nonhospital site for physician supervisory activities, and specify the compensation amount. (see 42 C.F.R. §413.78(e)(3)(ii)).

Final Rule

A. Written Agreements

The final rule permits hospitals to demonstrate that they are meeting their commitment to incur the training costs at nonhospital sites in one of two ways: 1) there is a written agreement (as currently required), OR 2) the hospital pays the costs associated with the training program in the nonhospital setting(s) by the end of the third month following a month in which the training in the nonhospital setting(s) occurred (see (see 42 C.F.R. §413.78(e)(3)).

Analysis--While still insufficient for most teaching hospitals, the three-month payment time frame in the final rule reflects a lengthening of the proposed rule timeframe, which would have required the payments to be made by the end of the month following a month in which training occurred.

The final rule preamble also reconfirmed that non-monetary, in-kind compensation would fulfill a hospital's supervisory cost requirement. Like monetary compensation, these types of arrangements, which, according to the final rule could include continuing education or office space provided to supervisory physicians, would need to be described in the written agreement or provided by the end of the third month following the month in which the training occurs (see 69 Fed. Reg. at 49182)

Finally, teaching hospitals should also be aware that in the final rule preamble CMS writes that the written agreement must be signed "before the hospital may begin to count residents training at the nonhospital site." (42 Fed. Reg. at 49181).

B. Moratorium on Teaching Hospital Disallowances for Family Practice Residents Training at Nonhospital Sites (pages 49176-182)

Many hospitals have entered into agreements with nonhospital sites that state that the supervising physician is "volunteering" their time and therefore the hospital is not incurring any supervisory costs. CMS has stated that if there are supervisory costs, the hospital must pay those costs regardless of what the agreement says. There have been disagreements between providers and CMS as to when supervisory costs do and do not exist.

To that end, the MMA included a provision that provided for calendar year 2004, hospitals may claim family practice residents training at nonhospital sites regardless of the financial arrangement between the hospital and nonhospital site, so long as the other requirements were met.

In other words, CMS could not make any disallowances for family practice residents regardless of whether the hospital paid supervisory costs. This provision applies to family practice residents only.

CMS implemented the MMA requirement in a “one time notification” (CR 3071, Transmittal 61, March 12, 2004). The OTN states, as reiterated in the final rule, that CMS will not make any disallowances for any family practice residents training in nonhospital sites during 2004, as well as any previous year cost reports that are settled during 2004.

It is worth noting, however, that CMS seems to provide some leeway with regards to volunteer physicians who are solo practitioners:

“We note further that, in the case of a solo practitioner, compensation at the practice is based solely and directly on the number of patients that the solo practitioner treats and for which the solo practitioner bills. Section 1886(h)(4)(E) of the Act requires that hospitals pay all or substantially all of the cost of training at the nonhospital site in order to count the FTE residents at that site. In this instance, we recognize that there are no costs associated with the supervisory teaching physician’s time because the physician is not receiving compensation in any form or from any source while conducting teaching activities. Under these circumstances, we acknowledge that no direct or in-kind payment needs to be made to the supervising physician in order for the hospital to incur all or substantially all of the costs of the training program in the nonhospital setting, and to count the FTE residents’ training time in the nonhospital setting.” (69 Fed. Reg. at 49182)

CMS also noted that the MMA required the HHS Office of Inspector General (OIG) to conduct a study on the appropriateness of alternative methodologies for payment of residency training in nonhospital settings and to submit a report to the Congress on the results of the study, along with any recommendations, by December 8, 2004. CMS said it would consider additional policy changes depending upon the findings in the OIG’s report.

III. OTHER CHANGES AFFECTING DIRECT GRADUATE MEDICAL EDUCATION (DGME) PAYMENTS

A. DGME INITIAL RESIDENCY PERIOD (IRP) DETERMINATIONS FOR SPECIALTIES REQUIRING A GENERAL CLINICAL TRAINING YEAR (pages 49179-174; 42 C.F.R. §413.79(a)(10))

KEY POINT

- The IRP for residents who “simultaneously match” to post-graduate year (PGY) 1 and PGY 2 programs will be determined by the PGY 2 specialty IRP

Background

Initial residency periods (IRPs) are used, in part, to determine Medicare DGME payments. Residents are counted as 1.0 full time equivalents (FTEs) during the number of years required to achieve first board eligibility (known as the IRP), though no resident can be counted as a 1.0 FTE for more than five years. For any training beyond the IRP, residents are counted as 0.5 FTEs.

Certain specialties (for example, radiology, anesthesiology, dermatology, neurology, psychiatry, ophthalmology, and physical medicine and rehabilitation) require that residents spend a year in general clinical training, with the remaining years being devoted to specialty-specific training. The general clinical year requirement can be met through one of two pathways: by 1) spending the first year in internal medicine, family medicine, pediatrics, or surgery, or 2) participating in a one-year, freestanding “transitional year” program. A large number of residents meet the general clinical year requirement by entering a preliminary year internal medicine program before entering their specialty of choice. Residents are accepted for only one year into a preliminary year program with the understanding that in their second year they will enter a training program in a discipline in which they wish to ultimately specialize.

According to CMS in the proposed rule, the IRP for these residents is determined based on the specialty of the first residency program they enter, rather than the second year program, which reflects their intended specialty of training. Thus, a resident who enrolls in a preliminary year internal medicine program is assigned the internal medicine IRP of three years. For a resident who intends to train in radiology, this means that for the first three years of training (preliminary medicine year plus two years of radiology), the resident is counted as a 1.0 FTE and that for the required years four and five of radiology training, the resident is counted as only a 0.5 FTE. By contrast, a resident who meets the general clinical year requirement through a “transitional year” program is assigned an IRP based on the specialty in which the resident is training in the second year--for residents entering radiology, this would be five years.

Final Rule

Under the final rule, effective with cost reporting periods beginning on or after October 1, 2004, if a hospital can document that a resident simultaneously matched for one year of training in a particular specialty residency program and for a subsequent period of training in a different specialty program, the resident’s IRP will be determined based on the period of board eligibility associated with the second program.

Analysis--This is a significant clarification and we were pleased to see it in the final rule. However, the AAMC continues to believe that the best solution is that for residents whose first year of training is completed in a program that provides a general clinical year of training, an IRP should be assigned based on the specialty the resident enters in the second year of training. Hospitals should also note that the effective date of this provision is Oct 1, 2004.

B. DGME PER RESIDENT AMOUNTS (pages 49175-176; 42 C.F.R. §413.77(d)(2))

Background

DGME payments are based on hospital-specific “per resident amounts” (PRAs). The PRAs are based on a hospital’s GME costs in a base year (generally 1984) trended to the current year by an inflation factor (the CPI-u). The Medicare DGME payment is based on Medicare’s share (calculated as Medicare inpatient days divided by total inpatient days) of the PRA amount.

The Balanced Budget Relief Act of 1999 mandated the creation of a “locality-adjusted” national average PRA and a PRA “floor” and “ceiling.” Hospitals with PRAs below 70 percent of their locality adjusted national average had their PRAs increased to the 70 percent level (the Benefits Improvement and Protection Act of 2000 increased the level to 85 percent). The BBRA also mandated that PRAs not be updated in federal fiscal years 2001 and 2002 for teaching hospitals with PRAs greater than 140 percent of their locality adjusted national average PRA as well as receiving reduced updates for FFYs 2003 through 2005.

Final Rule

The final rule implements the MMA requirement to freeze, from FFYs 2004-2013, the annual update of the PRAs of hospitals with PRAs greater than 140 percent of their locality-adjusted national average.

C. IRP DETERMINATIONS FOR GERIATRIC RESIDENCY PROGRAMS (pages 49174-175; 42 C.F.R. §413.79(a)(2))

Final Rule

Pursuant to a mandate in the MMA, the final rule provides that, effective October 1, 2004, for residents who train in an approved geriatrics residency program that requires completion of two years of training to initially become board eligible in that specialty, the two years spent in the geriatrics program are treated as part of the resident’s geriatric IRP.

IV. OTHER CHANGES ASSOCIATED WITH INDIRECT MEDICAL EDUCATION (IME) PAYMENTS

A. LEVEL OF THE IME ADJUSTMENT (page 49088; 42 C.F.R. §412.105(d))

Background

The IME payment adjustment for each hospital is determined according to the following formula:

$$\text{“c” times } ((1 + \text{IRB})^{0.405} - 1)$$

Where c is a multiplier that is set forth in the Medicare statute and IRB is the hospital's ratio of interns/residents-to-beds (IRB).

Final Rule

The final rule implements the IME multipliers through FFY 2008, as set forth in the MMA:

Federal Fiscal Year	IME Multiplier	IME Adjustment
2005	1.42	5.8%
2006	1.37	5.55%
2007	1.32	5.35%
2008	1.35	5.5%

Analysis--It is important to remember that these multipliers and adjustment levels do not apply to the resident count associated with the additional cap slots granted under the resident limit redistribution program ("redistributed resident count." or "section 422 cap") (see discussion above). The multiplier associated with the redistributed resident count is 0.66.

B. COUNTING BEDS FOR IME PAYMENT PURPOSES (pages 49093-098)

Background

A key component of the IME payment formula is a teaching hospital's intern/resident-to-bed ratio (IRB). The number of beds that a teaching hospital has, therefore, affects its IRB ratio which, in turn, affects its IME adjustment. Under Medicare, the bed count is determined by dividing the number of available bed days during a hospital's cost reporting period by the number of days in the cost reporting period. 42 C.F.R. §412.105(b). The proposed rule makes a number of changes that would affect the "bed day" component of this calculation.

The Medicare regulations and Provider Reimbursement Manual⁶ prescribe specific rules for determining an "available bed day."

Final Rule

The final rule finalizes, effective October 1, 2004, a number changes that were originally proposed in the FY 2004 proposed rule (68 Fed. Reg. 27154 (May 19, 2003):

⁶ See section 2405.3, Part I of the Provider Reimbursement Manual.

- Bed days in a unit that was occupied to provide an inpatient PPS level of care for at least one day during the three preceding months are included in the available bed day count for a month.
- Bed days for any bed within a unit that would otherwise be considered occupied should be excluded from the available bed day count for the current month if the bed has remained unavailable (could not be made available for patient occupancy within 24 hours) for 30 consecutive days, or if the bed is used to provide outpatient observation services or swing-bed skilled nursing care.
- Observation and swing-beds days are excluded from bed day counts unless a patient receiving outpatient observation services in a bed that is generally used to provide hospital inpatient acute care services is ultimately admitted.

V. OTHER CHANGES OF IMPORT TO TEACHING HOSPITALS

A. INPATIENT PPS UPDATE (pages 49078--082)

Final Rule

As mandated by the MMA, for hospitals that submit data on 10 measures of quality care the inpatient PPS update will be the full market basket increase, established in the final rule as 3.3 percent. Hospitals that do not submit quality data will receive an update of market basket minus 0.4 percentage points, or 2.9 percent.

Analysis--Linking the level of a hospital's inpatient PPS payment with its submission of quality data is a new concept. The ten quality indicators relate to Heart Attack (Acute Myocardial Infarction), Heart Failure and Pneumonia.

The program for the annual payment update is being referred to as the Reporting Hospital Quality Data for the Annual Payment Update (RHQDAPU). The procedures for participating in the RHQDAPU can be found on the Qnet Exchange Web site at <http://www.qnetexchange.org>

The final rule did not make any changes to the data submission process. However, the following changes and clarifications have been made to the validation process:

- CMS will be utilizing Clinical Data Abstraction Contractors (CDAC) to validate the quality data submitted to the Clinical Data Warehouse. CDAC will reabstract data that was submitted to the Data Warehouse by the hospitals and randomly sample the percent agreement at the element level between the data originally submitted and the data reabstracted by the CDAC. In order to be eligible for the market basket update in FFY 2006 and 2007, a hospital must achieve an 80% agreement between the two data sets.
- There was concern on behalf of the hospital community that hospitals should not be penalized for any technical or operational problems due to the new validation process.

In response, CMS has created an appeal process that will allow each hospital to review their validation results with their local Quality Improvement Organization (QIO). If the QIO is in agreement with the hospital's appeal the appeal is forwarded to the CDAC for review and correction.

**B. OUTLIER PAYMENT THRESHOLD
(Pages 50122-25)**

Background

Under the Medicare inpatient outlier policy, if the costs of a particular Medicare case exceed the relevant diagnosis-related group (DRG) operating and capital payment (including any disproportionate share, IME, or new technology add-on payments) plus a fixed-loss cost threshold, determined by CMS, the hospital will receive an outlier payment. This payment equals 80 percent of the case's costs above the threshold calculation. The cost threshold is set at a level that is intended to result in outlier payments that are between five and six percent of total PPS expenditures. Outlier payments are budget-neutral and therefore the Agency reduces the inpatient standardized amount by 5.1 percent and each year estimates a cost threshold that will result in outlier payments that equal 5.1 percent.

Final Rule

Under the final rule, the threshold for FFY 2005 will be \$25,800. This threshold is below the FFY threshold of \$31,000 and significantly below the proposed rule threshold of \$35,085.

Analysis--The lowered threshold will allow teaching hospitals additional monies to help offset the losses associated with high cost Medicare patients.

**C. PATIENT DAYS IN THE MEDICARE DISPROPORTIONATE SHARE
FORMULA (pages 49099-099)**

Background

The Medicare inpatient PPS provides for additional payments to hospitals that serve a disproportionate share (DSH) of low-income patients. A key component of the DSH payment formula is a hospital's "DSH patient percentage" (DPP). It is computed according to the following formula:

$$\text{DSH Patient Percentage} = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid Days}}{\text{Total Patient Days}}$$

Final Rule

The final rule finalizes, effective October 1, 2004, two changes that were originally proposed in the FY 2004 proposed rule (68 Fed. Reg. 27154 (May 19, 2003):

- Patient days associated with dual-eligible beneficiaries will be included in the Medicare fraction of the DPP formula, whether or not the beneficiary has exhausted Medicare Part a hospital coverage.
- Patient days associated with Medicare Advantage patients will be included in the Medicare fraction of the DPP formula.

**D. MEDICARE WAGE INDEX CHANGES
(pages 49026--070)**

Background

The Medicare hospital wage index adjusts DRG payments to reflect differences in labor costs across geographic areas. The wage index is calculated and assigned to hospitals based on the labor market area in which the hospital is located. The proportion of the PPS standardized rate to which the wage index is applied is known as the “labor-related share.”

Final Rule

The FFY 2005 wage index will be based on data from FFY 2001 hospital cost reports. The final rule also adopts a number of significant changes to the hospital wage index computations. These changes include the adoption of revised metropolitan statistical areas (MSAs), the implementation of an occupational mix adjustment, an adjustment for the out-migration of hospital employees and significant changes to the rules surrounding geographic reclassifications.

- Effective October 1, 2005 CMS will adopt new definitions of labor market areas based on 2000 census data.

For hospitals that experience a decrease in their wage index solely because of the new labor market areas (but not due to any other reasons – such as a decline in a hospital’s average hourly wage), CMS will implement, for FY 2005 only, a blended wage index consisting of 50 percent of the wage index value using the new MSAs and 50 percent of the wage index using the old MSAs.

As a result of adopting these changes, a number of hospitals currently classified as “urban” would become “rural” in 2005. Moving from an MSA to the rural statewide average generally results in a significant decline in these hospitals’ wage indices. CMS will allow current “urban” hospitals that would be redesignated as “rural” due to the new labor market areas to maintain the wage index of the MSA where they are currently assigned for three years. The Agency will also provide these hospitals with a three-year transition from their urban DSH status to a rural DSH status.

- Beginning October 1, the agency will implement a blended wage index that incorporates a 10 percent adjustment to reflect the occupational mix of hospital employees.

Specifically, a hospital's wage index will consist of 10 percent of an average hourly wage adjusted for occupational mix, and 90 percent of an average hourly wage unadjusted for occupational mix.

Hospitals can find their FY 2005 hospital-specific blended wage index in Table 2 (beginning on page 49295) of the final rule.

**E. PAYMENTS FOR NEW TECHNOLOGIES
(pages 49000-026 and 49084-; 42 C.F.R. §412.87 and §412.88)**

Background

Pursuant to a provision in Benefits Improvement and Protection Act of 2000, in the September 7, 2001 final rule (66 Fed. Reg. 46902), CMS established a methodology that would provide additional payments to hospitals for new technologies that they use that are not yet reflected in the DRG payment system. In order to qualify for the additional payments the new service must meet thresholds related to "new," "significant improvement" over the current service, and "inadequate payment" under the DRG system. (See the September 7, 2001 final rule for a more complete discussion of these criteria.)

Final Rule

Two items will receive new technology add-on payments in FY 2005: 1) Kinetra®, an implantable neurostimulator to treat patients with essential tremor and Parkinson's disease, and 2) InSync® Defibrillator System, a cardiac resynchronization therapy with defibrillation (CRT-D) for patients with congestive heart failure and ventricular arrhythmias. In addition, InFUSE™ a bone graft fusion device approved for use in single-level, anterior lumbar spinal fusions, will continue to receive add-on payments. Xigris® will no longer receive add-on payments.

Inpatient payments will not be reduced to finance these new technologies. Previously, payments for new technologies were done on a budget neutral basis--such that increased funding for the technology was offset by decreased funding for all other inpatient services. Beginning in FY 2005, the MMA provides new money for add-on payments under the inpatient PPS. In addition, the MMA lowers the cost threshold for new technologies to qualify for new technology payments to the lesser of 75 percent of the standardized amount (increased to reflect the difference between costs and charges) or 75 percent of one standard deviation for the DRG involved.

VI. AAMC STAFF CONTACT INFORMATION

If you have any questions regarding the final rule or this summary, please contact Karen Fisher, kfisher@aamc.org, 202-862-6140.

CMS EVALUATION FORM

AS PART OF THE APPLICATION FOR THE INCREASE IN A HOSPITAL'S FTE CAP(S) UNDER SECTION 422 OF THE MEDICARE MODERNIZATION ACT OF 2003

Directions: Please fill out the information below for each residency program for which the applicant hospital intends to use the increase in its FTE cap(s). The applicant hospital is responsible for complying with the other requirements listed in the FY 2005 hospital inpatient prospective payment system rule in order to complete its application for the increase in its FTE cap(s) under section 422 of Public Law 108-173.

Name of Hospital _____

Medicare Provider Number _____

Name of Specialty Training Program _____

Check one

- Allopathic Program
 Osteopathic Program

Number of FTE Slots Requested for Program

Direct GME _____

IME _____

Section A: Demonstrated Likelihood of Filling the FTE Slots

(Place an "X" in the box for the applicable criterion and subcriteria.)

A1: Demonstrated Likelihood Criterion 1. The hospital intends to use the additional FTEs to establish a new residency program (*listed above*) on or after July 1, 2005 (*that is, a newly approved program that begins training residents at any point within the hospital's first three cost reporting periods beginning on or after July 1, 2005*).

- (1)** Hospital will establish this newly approved residency program. (*Check at least one of the following, if applicable.*)
- Application for approval of the new residency program has been submitted to the ACGME, AOA, or the ABMS by December 1, 2004. (*Copy attached.*)
 - The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program by December 1, 2004. (*Copy attached.*)
 - The hospital has received written correspondence from the ACGME, AOA, or ABMS acknowledging receipt of the application for the new program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). (*Copy attached.*)
- (2)** Hospital will likely fill the slots requested. (*Check at least one of the following, if applicable.*)
- The hospital's existing residency programs had a resident fill rate of at least 85 percent in each of program years 2001 through 2003. (*Documentation attached.*)
 - The specialty program (*listed above*) has a resident fill rate either nationally, within the State, or within the MSA in which the hospital is located, of at least 85 percent. (*Documentation attached.*)

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- A2: Demonstrated Likelihood Criterion 2.** The applying hospital intends to use the additional FTEs to expand the existing residency training program that is listed above (that is, to increase the number of FTE resident slots in the program) on or after July 1, 2005, and before July 1, 2008.
- (1)** Hospital intends to expand an existing program. *(Check at least one of the following, if applicable.)*
- The appropriate accrediting body (the ACGME, AOA, or ABMS) has approved the hospital's expansion of the number of FTE residents in the program. *(Documentation attached.)*
 - The American Osteopathic Association Residency Match Program has accepted or will be accepting the hospital's participation in the match for the existing program that will include additional resident slots in that residency training program. *(Documentation attached.)*
 - The hospital has submitted an institutional review document or program information form for the expansion of the existing residency training program by December 1, 2004. *(Copy attached.)*
- (2)** Hospital will likely fill the slots of the expanded residency program. *(Check at least one of the following, if applicable.)*
- Hospital has other previously established residency programs with a resident fill rate of at least 85 percent in each of program years 2001 through 2003. *(Documentation attached.)*
 - Hospital is expanding an existing program in a particular specialty with a resident fill rate either nationally, within the State, or within the MSA in which the hospital is located, of at least 85 percent. *(Documentation attached.)*
 - Hospital is expanding a program in order to train residents that need a program because another hospital in the State has closed a similar program, and the applying hospital received a temporary adjustment to its FTE cap(s) (under the requirements of §413.79(h)). *(Documentation attached.)*
- A3: Demonstrated Likelihood Criterion 3.** Hospital is applying for an increase in its FTE resident cap because the hospital is already training residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both. *(Copies of EACH of the following attached.)*
- Copies of the most recent as-submitted Medicare cost report documenting on Worksheet E, Part A and Worksheet E3, Part IV the resident count and FTE resident cap for both direct GME and IME for the relevant cost reporting periods.
 - Copies of the 2004 residency match information concerning the number of residents at the hospital in its existing programs, OR resident fill rate information for all programs at the hospital in 2004.
 - Copies of the most recent accreditation letters on all of the hospital's training programs in which the hospital trains and counts FTE residents for direct GME and IME.

Section B. Level Priority Category

(Place an "X" in the box for the applicable criterion and subcriteria.)

- B1: First Level Priority Category.** The hospital is a rural hospital as of October 1, 2004 and the request is for the only specialty training program in the State (for the program requested on this *CMS Evaluation Form*).
- B2: Second Level Priority Category.** The hospital is a rural hospital as of October 1, 2004.
- B3: Third Level Priority Category.** The hospital is in an other than large urban area as of October 1, 2004, and the request is for the only specialty program in the State (for the program requested on this *CMS Evaluation Form*).
- B4: Fourth Level Priority Category.** The hospital is in an other than large urban area, as of October 1, 2004.
- B5: Fifth Level Priority Category.** The hospital request is for the only specialty training program in the State (for the program requested on this *CMS Evaluation Form*).
- B6: Sixth Level Priority Category.** The hospital meets none of the statutory priority criteria.

Section C. Evaluation Criteria

(Place an "X" in the box for each criterion that is appropriate for the applicant hospital and for the program for which the increase in the FTE cap is requested.)

- C1: Evaluation Criterion 1.** The hospital that is requesting the increase in its FTE resident cap(s) has a Medicare inpatient utilization over 60 percent, as reflected in at least two of the hospital's last three most recent audited cost reporting periods for which there is a settled cost report.
- C2: Evaluation Criterion 2.** The hospital needs the additional slots to establish a new geriatrics residency program, or to add residents to an existing geriatrics program.
- C3: Evaluation Criterion 3.** The hospital does not qualify for an adjustment to its FTE caps under existing §413.86(g)(12) for a rural track residency program, but is applying for an increase in its FTE resident cap(s) under section 1886(h)(7)(B) of the Act because it rotates (or in the case of a new program, will rotate) residents for at least 25 percent of the duration of the residency program to any one (or in combination thereof) of the following: a rural area, as defined in section 1886(d)(2)(D)(ii) of the Act and §412.62(f)(1)(iii) of the regulations; a rural health clinic (RHC), as defined in section 1861(aa)(1) of the Act and §491.2 of the regulations; or a Federally Qualified Health Center (FQHC), as defined in section 1861(a)(3) of the Act and §405.2401(b) of the regulations.
- C4: Evaluation Criterion 4.** In portions of cost reporting periods prior to July 1, 2005, the hospital qualified for a temporary adjustment to its FTE cap under existing §413.86(g)(9) because it was training displaced residents from either a closed program or a closed hospital, and, even after the temporary adjustment, the hospital continues to train residents in the specialty(ies) of the displaced residents and is above the hospital's direct GME FTE cap or IME FTE cap, or both, for that reason.
- C5: Evaluation Criterion 5.** The hospital is above its FTE caps because it was awaiting accreditation of a new program from the ACGME or the AOA during the base period for its FTE cap(s) but was not eligible to receive a new program adjustment as stated under existing §413.86(g)(6)(ii).
- C6: Evaluation Criterion 6.** The hospital is above its FTE resident caps because, despite qualifying for an FTE cap adjustment for a new program under §413.86(g)(6)(i) or (g)(6)(ii), it was unable to "grow" its program to the full complement of residents for which the program was accredited before the hospital's FTE resident cap was permanently set beginning with the fourth program year of the new program.

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- C7: Evaluation Criterion 7.** The hospital is located in any one (or in combination thereof) of the following: a geographic HPSA, as defined in 42 CFR 5.2; a population HPSA, (*also defined at 42 CFR 5.2*); or a Medicare physician scarcity county, as defined under section 413 of Public Law 108-173.
- C8: Evaluation Criterion 8.** The hospital is in a rural area (as defined under section 1886(d)(2)(D)(ii) of the Act) and is a training site for a rural track residency program (as specified under §413.86(g)(12), but is unable to count all of the FTE residents training at the rural hospital in the rural track because the rural hospital's FTE cap is lower than the hospital's unweighted count of allopathic or osteopathic FTE residents beginning with portions of cost reporting periods on or after July 1, 2005.
- C9: Evaluation Criterion 9.** The hospital is affiliated with a historically Black medical college.
- C10: Evaluation Criterion 10.** The hospital is training residents in residency program(s) sponsored by a medical school(s) that is designated as a Center of Excellence for Underserved Minorities (COE) under section 736 of the Public Health Service Act in FY 2003.
- C11: Evaluation Criterion 11.** The hospital needs the additional slots to establish a new primary care residency program, or to expand an existing primary care residency program, as primary care is defined under §413.86(b).
- C12: Evaluation Criterion 12.** The hospital is above its direct GME and/or IME FTE cap on the count of residents, as stated in the Medicare cost report on the Worksheet E, Part A or the Worksheet E3, Part IV, in the hospital's most recently as submitted Medicare Cost Report.
- C13: Evaluation Criterion 13.** The hospital's FTE resident cap was reduced under section 1886(h)(7)(A)(i) of the Act because the resident level in its reference cost report equaled or was above its FTE resident cap as it knew its FTE resident cap to be at that time, but as a result of a resolution to an appeal concerning the FTE resident cap, the FTE resident cap was later increased to an amount that is greater than the reference resident level.
- C14: Evaluation Criterion 14.** The hospital is above its cap and needs the additional slots to establish a new emergency medicine residency program or expand an existing emergency medicine residency program. The emergency medicine residency program includes training in bio-terrorism preparedness.
- C15: Evaluation Criterion 15.** The hospital's FTE resident cap was reduced under section 1886(h)(7)(A)(i) and:
- The hospital started a new program(s) that was accredited before January 1, 2002,
 - The new program was in operation during the reference cost reporting period, and
 - The program has been in operation (training residents) for 3 or fewer years by July 1, 2003.