Attachment A

CMS Evaluation Form

As Part of the Application for the Increase in a Hospital's FTE Cap(s) under Section 5503 of the Affordable Care Act

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 CY 2011 Hospital Outpatient Prospective Payment System Final Rule in order to complete its application for the increase in its FTE cap(s) under section 5503 of the Affordable Care Act, Pub. L. 111-148.

NAME OF HOSPITAL: _____

MEDICARE PROVIDER NUMBER: _____

NAME OF MEDICARE CONTRACTOR: _____

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 subcriterion.)

□ A1: Demonstrated Likelihood Criterion 1. The hospital is training residents in excess of its FTE resident cap(s), or does not have sufficient room under its current FTE cap(s), and the hospital intends to use the additional FTEs for a new residency program that it intends to start on or after July 1, 2011 (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, 2011). Under this criterion, the hospital must select one of the following:

(1) Hospital will establish a newly approved residency program. (Under this selection, the hospital must 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 January 21, 2011. (The hospital must attach a copy.)

□ 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 January 21, 2011. (The hospital must attach a copy.)

□ 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). (The hospital must attach a copy.)

□ The hospital may submit documentation demonstrating that it has made a commitment to start a new program.

(2) Hospital will likely fill the slots requested. (The hospital must select at least one of the following, if applicable.)

□ The hospital does not have sufficient room under its FTE cap, or is exceeding its FTE cap, and the hospital's existing residency programs had a combined resident fill rate of at least 85 percent in each of program years 2007 through 2009. (The hospital must attach documentation.)

□ The hospital does not have sufficient room under its FTE cap, or is exceeding its FTE cap, and the specialty program for which the hospital is applying has a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. (The hospital must attach documentation.)

□ The hospital is training residents in excess of its direct GME FTE cap, or IME FTE cap, or both. The hospital must submit a copy of the Medicare cost report that has been most recently submitted to the Medicare contractor by March 23, 2010, documenting on Worksheet E, Part A, Worksheet E-3, Part IV, and Worksheet E-3, Part VI, the resident counts and FTE resident caps for both direct GME and IME.

□ A2: Demonstrated Likelihood Criterion 2. The hospital is training residents in excess of its FTE cap(s), or does not have sufficient room under its FTE cap(s), and the hospital intends to use the additional FTEs to expand an existing residency training program within the hospital's first three cost reporting periods beginning on or after July 1, 2011.

(1) Hospital intends to expand an existing program. Under this selection, the hospital must 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. (The hospital must attach documentation.)

□ 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. (The hospital must attach documentation.)

□ The hospital has submitted an institutional review document or program information form for the expansion of the existing residency training program by January 21, 2011. (The hospital must attach documentation.)

(2) Hospital will likely fill the slots of the expanded existing residency program. Under this selection, the hospital must check at least one of the following, if applicable:

□ The hospital does not have sufficient room under its FTE cap, or is exceeding its FTE cap, and the hospital has other previously established residency programs, with a resident fill rate of at least 85 percent in each of program years 2007 through 2009.) (The hospital must attach documentation.)

□ The hospital does not have sufficient room under its FTE cap, or is exceeding its FTE cap, and the hospital is expanding an existing program in a particular specialty with a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. (The hospital must attach documentation.)

□ The hospital is training residents in excess of its direct GME FTE cap, or IME FTE cap, or both. The hospital must submit a copy of the Medicare cost report that has been most recently submitted to the Medicare contractor by March 23, 2010, documenting on Worksheet E, Part A, Worksheet E-3, Part IV, and Worksheet E-3, Part VI, the resident counts and FTE resident caps for both direct GME and IME.

Section B. Level Priority Category

(Place an "X" in the appropriate box that is applicable to the level priority category that describes the applicant hospital.)

- *First Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND it is an urban hospital that has or will have as of July 1, 2011, a rural training track.
- *Second Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile.
- *Third Level Priority Category:* The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, AND the hospital is an urban hospital that has or will have as of July 1, 2011, a rural training track.
- *Fourth Level Priority Category:* The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, OR the hospital is located in a rural area.

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.)

- Evaluation Criterion One. *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.* 5 POINTS.

- Evaluation Criterion Two. *The hospital will use additional slots to establish a new geriatrics residency program, or to add residents to an existing geriatrics program.* 5 POINTS.

- Evaluation Criterion Three. *The hospital will use additional slots to establish a new or expand an existing primary care program with a demonstrated focus on training residents to pursue careers in primary care, rather than in non-primary subspecialties of those primary care programs (for example, the hospital has an internal medicine program with a designated primary care track).* 3 POINTS.

- Evaluation Criterion Four. *The hospital will use all the additional slots to establish a new or expand an existing primary care residency program or general surgery program*. – 5 POINTS.

- Evaluation Criterion Five. *The hospital is located in a Primary Care HPSA*. 2 POINTS.

- Evaluation Criterion Six. *The hospital is in a rural area (as defined under section 1886(d)(2)(D)(ii) of the Act) and is or will be on or after July 1, 2011, a training site for a rural track residency program (as specified under §413.79(k)), but is unable to count all of the FTE residents training in the rural track because the rural hospital's FTE cap is lower than its unweighted count of allopathic or osteopathic FTE residents as of portions of cost reporting periods on or after July 1, 2011.* 1 POINT.

- Evaluation Criterion Seven. *The hospital is requesting slots to expand an existing program(s) for which the hospital can demonstrate that more than 50 percent of residents completing the program(s) go on to practice in a rural area or a Primary Care HPSA or a Medically Underserved Area (MUA)* 1 POINT.

- Evaluation Criterion Eight. *The hospital is requesting slots to expand an existing emergency medicine program in which the residents train in Primary Care HPSAs*. 1 POINT.

Application Process and CMS Central Office and Regional Office Mailing Addresses for Receiving Increases in FTE Resident Caps

In order for hospitals to be considered for increases in their FTE resident caps, each qualifying hospital must submit a timely application. The following information must be submitted on applications to receive an increase in FTE resident caps:

- The name and Medicare provider number of the hospital.
- The name of the Medicare contractor to which the hospital submits its Medicare cost report.
- The total number of requested FTE resident slots for direct GME or IME, or both, up to 75 direct GME FTE and 75 IME FTE per hospital.
- 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.
- Source documentation to support the assertions made by the hospital on the CMS Evaluation Form.
- FTE resident counts for direct GME and IME and FTE resident caps for direct GME and IME reported by the hospital in the most recent cost report submitted to the Medicare contractor by March 23, 2010. (Include copies of Worksheets E, Part A, E-3, Part IV, and if a hospital received an increase to its FTE cap(s) under section 422 of the MMA, a copy of E-3, Part VI).
- As part of its application, for purposes of computing the primary care average under section 1886(h)(8)(B)(ii)(I) of the Affordable Care Act, the hospital must include the documentation that it used to arrive at its direct GME and IME primary care FTE

counts, including a copy of Worksheet E-3, Part IV for direct GME, and if the hospital has an OB/GYN program, the rotation schedules corresponding to the three most recent cost reporting periods ending prior to March 23, 2010 (and submitted to the Medicare contractor by March 23, 2010) for OB/GYN, and the rotation schedules for all primary care residency programs used to establish the IME primary care FTE count corresponding to the three most recent cost reporting periods ending prior to March 23, 2010.

- An attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report, of the following information:

"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 were 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."

The completed application and supporting documentation (as described above) must be submitted to the CMS Central Office and the CMS Regional Office for the region in which the applicant hospital is located. The application must be received on or

before January 21, 2011. The addresses of the CMS Central Office and Regional Offices are listed below.

CMS Central and CMS Regional Office Mailing Addresses for Applications for Increases in FTE Resident Caps:

Central Office

Centers for Medicare and Medicaid Services (CMS)
Director, Division of Acute Care
7500 Security Boulevard
Mail Stop C4-08-06
Baltimore, Maryland 21244
(410) 786-4548

Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont):

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region I
JFK Federal Building
Room 23275
Boston, MA 02203
Phone: (617) 565-1331

Region II (New York, New Jersey, U.S. Virgin Islands, and Puerto Rico):

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator,
Division of Financial Management and Fee for Service Operations
Region II
26 Federal Plaza, 38th Floor
New York, NY 10278
Phone: (212) 616-2545

Region III (Delaware, Maryland, Pennsylvania, Virginia and West Virginia, and the District of Columbia):

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator,
Division of Financial Management and Fee for Service Operations

Region III
Public Ledger Building, Suite 216
150 South Independence Mall West
Philadelphia, PA 19106
Phone: (215) 861-4140

Region IV (Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, and Tennessee):

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator,
Division of Financial Management and Fee for Service Operations

Region IV
Atlanta Federal Center
61 Forsyth Street, S.W., Suite 4T20
Atlanta, GA 30303-8909
Phone: (404) 562-7300

Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin):

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator,
Division of Financial Management and Fee for Service Operations

Region V
233 North Michigan Avenue, Suite 600
Chicago, IL 60601
Phone: (312) 886-6432

Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas):

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator,
Division of Financial Management and Fee for Service Operations

Region VI
1301 Young Street, Suite 714
Dallas, TX 75202
Phone: (214) 767-6423

Region VII (Iowa, Kansas, Missouri, and Nebraska):

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator,
Division of Financial Management and Fee for Service Operations

Region VII
Richard Bolling Federal Building
Room 235
601 East 12th Street
Kansas City, MO 64106
(816) 564-1843

Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming):

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator,
Division of Financial Management and Fee for Service Operations

Region VIII
Colorado State Bank Building
1600 Broadway, Suite 700
Denver, CO 80202
Phone: (303) 844-2111

Region IX (Arizona, California, Hawaii, and Nevada and Territories of American Samoa, Guam and the Commonwealth of the Northern Mariana Islands):

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator,
Division of Financial Management and Fee for Service Operations

Region IX
90 7th Street, Suite 5-300 (SW)
San Francisco, CA 94103-6708
Phone: (415) 744-3501

Region X (Alaska, Idaho, Oregon, and Washington):
Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Medicare Financial Management
Region X
2201 Sixth Avenue, MS/RX-46
Seattle, WA 98121
Phone: (206) 615-2094