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HEALTH INDUSTRY ALERT

REDUCTIONS IN RESIDENT FTE CAPS: A CRITICAL JUNE 4, 2004, DEADLINE FOR SOME HOSPITALS

This is the second in our series of *Health Industry Alerts* regarding important Medicare Graduate Medical Education (GME) and Indirect Medical Education (IME) payment issues. In this *Alert*, we discuss the upcoming redistribution of full time equivalent (FTE) residents required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and addressed in the recently promulgated FY 2005 inpatient prospective payment system (PPS) proposed rulemaking.

The Medicare Program limits the amount of GME and IME payments to hospitals by applying limits, or "caps," on the numbers of residents that hospitals can include in calculating such payments. These caps, often referred to as the "1996 caps," are generally based on Medicare's count of FTE residents that were trained at each hospital in its 1996 cost reporting period. As might be expected, the numbers of residents trained by many hospitals have changed since 1996, so some hospitals now train more residents, and some fewer, than are included in their caps.

Under section 422 of the MMA, Medicare will reduce the caps of hospitals that are not "using" all of the available FTEs under their caps, and will redistribute the FTEs that are taken away from such hospitals to certain hospitals that are exceeding their caps.[1] In general, if a hospital's FTE resident count was less than its FTE resident cap for its most recent cost reporting period ending before September 30, 2002, its cap will be permanently reduced by 75 percent of the difference between the two.

The changes in GME and IME payments that will be caused by the reduction and redistribution of the caps will be effective for portions of cost reporting periods occurring on or after July 1, 2005. However, as described below, and depending on the specifics of an individual hospital's situation, the hospital may be able to reduce the impact of a cap reduction, or perhaps avoid one altogether, if it acts quickly.

Specifically, the Centers for Medicare & Medicaid Services (CMS) intends to base its decisions on reducing hospitals' FTE caps on each hospital's most recent cost reporting period

[1] Section 422 does not apply to rural hospitals with fewer than 250 acute care inpatient beds.

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ending on or before September 30, 2002, for which a cost report has been settled or submitted subject to audit. Therefore, if a hospital's actual FTE count was lower than its cap for that cost reporting period, it is at risk for having its cap, and its IME and GME payments, reduced. However, if a hospital has undergone an expansion of an existing residency program that is not reflected in its most recent settled cost report, it may ask CMS to use the FTE counts in its cost report for the period including July 1, 2003, to determine whether and to what extent its caps will be reduced.

Significantly, any hospital interested in submitting such a request must do so on or before June 4, 2004. In general, a hospital will benefit from submitting such a request if (1) its resident FTE counts were below its caps for the last cost reporting period that ended before September 30, 2002, and (2) its resident FTE counts for the cost reporting period including July 1, 2003, exceeded the resident FTE counts in its most recently *settled* cost report.

If you think that your hospital might benefit from submitting a request for CMS to use its cost reporting period including July 1, 2003, instead of its most recent period ending on or before September 30, 2002, as its reference period, we urge you to contact us immediately. We have included a questionnaire that may assist you in evaluating whether your hospital is likely to benefit from submitting such a request.

The MMA also includes a special provision involving new residency programs meeting somewhat narrow criteria. If a hospital had a new residency program accredited before January 1, 2002, but did not operate that program during the applicable reference period (i.e., the most recent cost reporting period ending on or before September 30, 2002, or the cost reporting period including July 1, 2003), the hospital can request that the accredited residents attributable to the new program be added to its FTE reference resident count for that period. Such a request must also be submitted to the intermediary on or before the June 4, 2004, deadline. (Note, however, that the following questionnaire does not pertain to a newly approved program request.)

As you know, GME and IME reimbursement issues are very complex, and the new statutory and programmatic provisions regarding the redistribution of the FTE caps are particularly complex. The goal of this *Health Industry Alert* is to bring the June 4, 2004, deadline to your attention, not to provide a thorough analysis of the new redistribution provisions of the MMA.

ANALYSIS OF WHETHER TO SUBMIT A REQUEST FOR A DIFFERENT FTE REFERENCE PERIOD

PART I – HELPFUL INFORMATION

The following documents and/or information may help you complete this questionnaire:

- Cost report for most recent cost reporting period ending on or before September 30, 2002, that was settled or submitted (subject to audit) as of April 30, 2004

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- Cost report for cost reporting period including July 1, 2003 (if this cost report has not been completed, drafts or estimates of the figures that are likely to be included in the cost report may be used for purposes of this questionnaire)

- Most recently settled cost report as of April 30, 2004 (in other words, the cost report for the most recent period for which a hospital has received a Notice of Program Reimbursement).

PART II – WILL THE HOSPITAL BE SUBJECT TO FTE CAP REDUCTIONS?

Applicable GME Resident Limit for cost reporting period ending on or before September 30, 2002 (i.e., the hospital's 1996 FTE cap for GME purposes, listed on worksheet E-3, Part IV, line 3.04)	(1)_____
Reference GME Resident Level for cost reporting period ending on or before September 30, 2002 (in other words, the unweighted allopathic and osteopathic FTE count for GME purposes for residents training in the hospital for the relevant period, generally listed on worksheet E-3, Part IV, line 3.05)	(2)_____
Subtract line (2) from line (1) – If line (1) is greater than line (2), your hospital may be at risk for a permanent reduction in its GME cap	(3)_____
Applicable IME Resident Limit for cost reporting period ending on or before September 30, 2002 (i.e., the hospital's 1996 FTE cap for IME purposes, listed on worksheet E, Part A, line 3.07)	(4)_____
Reference IME Resident Level for cost reporting period ending on or before September 30, 2002 (in other words, the unweighted allopathic and osteopathic FTE count for IME purposes for residents training in the hospital for the relevant period, generally listed on worksheet E, Part A, line 3.08)	(5)_____
Subtract line (5) from line (4) – If line (4) is greater than line (5), your hospital may be at risk for a permanent reduction in its IME cap	(6)_____

If the amounts listed in lines (3) and/or (6) are both equal to or less than zero, it is generally likely that the hospital will not be subject to a reduction in its FTE caps (however, if you think that your hospital's FTE counts for this period might be reduced on audit, or if your 1996 FTE caps are under appeal, we urge you to contact us for additional information). Conversely, however, if the amounts listed in lines (3) and/or (6) are greater than zero, it is generally likely that the hospital will be subject to a reduction in its FTE caps (unless it is a rural hospital with fewer than 250 beds). In this case, you should evaluate whether the hospital's resident counts for the period including July 1, 2003, are greater than the amounts reflected in its most recently settled cost report.

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PART III – SHOULD THE HOSPITAL REQUEST THAT CMS USE THE PERIOD INCLUDING JULY 1, 2003?

Reference GME Resident Level for cost reporting period including July 1, 2003 (generally listed on worksheet E-3, Part IV, line 3.05)	(7)_____
Reference GME Resident Level for most recently settled cost report (generally listed on worksheet E-3, Part IV, line 3.05)	(8)_____
Subtract line (8) from line (7) – If line (7) is greater than line (8) **and also**[2] greater than line (2), your hospital might benefit from submitting a request to your intermediary by June 4, 2004	(9)_____
Reference IME Resident Level for cost reporting period including July 1, 2003 (generally listed on worksheet E, Part A, line 3.08)	(10)_____
Reference IME Resident Level for most recently settled cost report (generally listed on worksheet E, Part A, line 3.08)	(11)_____
Subtract line (11) from line (10) – If line (10) is greater than line (11) and **also**[2] greater than line (5), your hospital might benefit from submitting a request to your intermediary by June 4, 2004	(12)_____

If these worksheets lead you to believe that your hospital might benefit from requesting that its cost report for the period including July 1, 2003, be used to determine redistribution issues, please contact us.

CONTACT INFORMATION

If you have any questions about this Alert, about any other redistribution issues that are addressed in the FY 2005 PPS proposed rulemaking, or about general GME or IME reimbursement issues, or if you require representation before the Provider Reimbursement Review Board or the intermediary on related matters, please contact:

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[2] Note that if your hospital's resident FTE count increased from the most recently settled cost report to the most recent cost reporting period ending prior to September 30, 2002, but then decreased for the cost reporting period including July 1, 2003, the hospital would not benefit from requesting that the period including July 1, 2003, be used to determine any redistribution of FTEs.

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