U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

Bureau of Health Workforce
Division of Medicine and Dentistry/Graduate Medical Education Branch

Children's Hospitals Graduate Medical Education (CHGME) Payment Program

Announcement Type: New
Funding Opportunity Number: HRSA-16-022

Catalog of Federal Domestic Assistance (CFDA) No. 93.255

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2016

Phase 1: Application Due Date in Grants.gov: July 17, 2015
Phase 2: Supplemental Information Due Date in EHBs: August 6, 2015

Ensure your SAM.gov and Grants.gov registrations and passwords are current immediately!
Deadline extensions are not granted for lack of registration.
Registration in all systems, including SAM.gov and Grants.gov,
may take up to one month to complete.

Release Date: May 18, 2015

Issuance Date: May 18, 2015

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Authority: Section 340E of the Public Health Service Act as amended by the Children's Hospital GME Support Reauthorization Act of 2013

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), Bureau of Health Workforce (BHW), Division of Medicine and Dentistry is accepting applications for fiscal year (FY) 2016 Children's Hospital Graduate Medical Education (CHGME) Payment Program. The purpose of this program is to fund freestanding children's hospitals to support the training of pediatric and other residents in graduate medical education (GME) programs. This program addresses the difference in explicit Federal GME funding between freestanding children's teaching hospitals and other teaching hospitals supported by the Centers of Medicare and Medicaid Services (CMS).

Funding Opportunity Title:	Children's Hospitals Graduate Medical Education (CHGME) Payment Program
Funding Opportunity Number:	HRSA-16-022
Due Date for Applications:	July 17, 2015 in Grants.gov; supplemental information August 6, 2015 in EHB
Anticipated Total Annual Available Funding:	$100,000,000
Estimated Number and Type of Award(s):	55-65 grants
Estimated Award Amount:	Formula awards, varies
Cost Sharing/Match Required:	No
Project Period:	October 1, 2015 through September 30, 2016 (One (1) year)
Eligible Applicants:	Freestanding children's hospitals whose inpatients are predominantly under 18 years of age, participate in an approved graduate medical education program, and have a Medicare provider agreement. [See Section III-1 of this funding opportunity announcement (FOA) for complete eligibility information.]

Application Guide

All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 R&R Two-Tier Application Guide*, available online at http://www.hrsa.gov/grants/apply/applicationguide/sf424rr2guide.pdf except where instructed in this FOA to do otherwise.

Submissions

The CHGME Payment Program requires two submissions during the Federal fiscal year: (1) an initial application to determine *interim payments*, and (2) a reconciliation application to finalize the number of full-time equivalent (FTE) resident counts and subsequently determine *final payments*.

Technical Assistance

CHGME will hold a CHGME FY2016 Initial Application Technical Assistance (TA) webinar on June 30, 2015 from 1-3pm ET. The webinar link is:

https://hrsa.connectsolutions.com/chgmeinitialfy16/

Call in number: 1-877-985-4184
Passcode 13221588

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I. Funding Opportunity Description

1. Purpose

This announcement solicits applications for the Children's Hospitals Graduate Medical Education (CHGME) Payment Program. Federal funding for graduate medical education (GME) is primarily provided by the Centers for Medicare and Medicaid Services (CMS). Prior to the enactment of the CHGME Payment Program, children's teaching hospitals received a disproportionately low amount of Federal GME funding when compared to teaching hospitals that serve adult patients. The purpose of the CHGME Payment Program is to compensate for the disparity in the level of Federal GME funding for freestanding children's teaching hospitals versus other types of teaching hospitals. The CHGME Payment Program is administered by the Bureau of Health Workforce (BHW), Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS).

2. Background

This program is authorized by Section 340E of the Public Health Service Act as amended by the Children's Hospital GME Support Reauthorization Act of 2013. In 1999, Congress addressed the difference of explicit GME funding between freestanding children's teaching hospitals and other teaching hospitals by passing the Healthcare Research and Quality Act, which established the CHGME Payment Program. There have been several amendments, and in April 2014, Congress reauthorized the CHGME Payment Program for a period of five years, expanding eligibility to include certain hospitals (see Section III. Eligibility Information).

The CHGME Payment Program supports the vision, missions and goals of HRSA as well as those of BHW. HRSA's mission is to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs. BHW aims to improve the health status of the population by providing national leadership and resources to develop, distribute and retain a diverse, culturally competent health workforce that provides the highest quality care for all, especially the underserved. BHW oversees several grant programs that support the placement of providers, provide financial support to students in health professions programs, provide continuing education to current health professionals, and foster the development of curricula that promote quality health care.

The nearly 60 freestanding children's teaching hospitals across the country train about 30 percent of the nation's pediatricians, nearly half of all pediatric sub-specialists, and provide valuable training for physicians in many other specialties. These are the physicians who care for America's youngest population – its children. Representing about one percent of all short-term acute care hospitals, these hospitals provide almost 50 percent of the patient care to low-income children, including those covered by Medicaid and those who are uninsured. In addition, these hospitals are regional and national referral centers for critically ill children, often serving as the only source of care for many critical pediatric services. More than 75 percent of inpatient care at

children's hospitals is devoted to children with one or more chronic conditions. This program provides the funding needed to support children's hospitals in providing residency training.[1]

The CHGME Payment Program is designed to support the three prong social missions of freestanding children's teaching hospitals that comply with the social mission of medical education:[2]

- Educate and train future pediatricians, pediatric sub-specialists, and other non-pediatric residents,
- Provide care for vulnerable and underserved children, and
- Conduct innovative and valuable pediatric research.

Funding children's hospitals is at the core of HRSA's mission of improving and expanding culturally competent quality health care and providing care to the underserved.

II. Award Information

1. Type of Application and Award

Type of applications sought: New.

Funding will be provided in the form of a formula grant. The funds available for the CHGME Payment Program are distributed among participating eligible children's hospitals. Hospitals that meet eligibility requirements in Section III.1.b receive funds based on the annual appropriation.

Traditionally CHGME has made two monthly grant payments, one for Direct Medical Education (DME), and one for Indirect Medical Education (IME). Each of the payments is determined by formula, and a hospital receives their proportion of the total CHGME funding based on the calculation of the formula. For direct medical education (DME), the CHGME funding is proportional to the number of residents the hospital trains. For indirect medical education (IME), the CHGME funding is proportional to the number of inpatient discharges, the severity of illness of its inpatients, the number of available beds, as well as the number of residents the hospital trains. Furthermore, the payment formulas account for a hospital's specific wage index, which is the geographic variation in cost, and the labor related share, which is the portion of hospital costs attributable to wages and wage-related costs as determined by CMS regulations.

2. Summary of Funding

This program will provide funding during Federal fiscal year 2016. Approximately $100,000,000 is expected to be available to fund 55-65 awardees. The actual amount of

[1] Supporting Children's Hospitals and Children Health: The Role of the Federal "CHGME" Program. Prepared by The Lewin Group for the National Association of Children's Hospitals, September 5, 2006.
[2] Financing Graduate Medical Education to meet the need of Children and the future of the Pediatrician workforce. Pediatrics, Volume 121, Number 4, April 2008.

funding available will not be determined until enactment of the final FY 2016 Federal budget. This program announcement is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, applications can be processed, and funds can be awarded in a timely manner. The project period is one (1) year.

The FY 2016 President's Budget proposes $100,000,000 towards the CHGME Payment Program for DME funding.

In FY 2015 the Congressional appropriation was $265,000,000. In April 2014, the CHGME program was reauthorized to expand eligibility to "Newly Qualified Hospitals" that meet the eligibility requirements in III.1.b. The reauthorization permits the Secretary, "to make available up to 25 percent of the total amounts in excess of $245,000,000 but "not to exceed $7,000,000" for the purpose of making CHGME payments to these Newly Qualified Hospitals.

III. Eligibility Information

1. Eligible Applicants

There are two categories of children's hospitals that may be eligible for CHGME payments in FY 2016, depending on the funding appropriated to the program. New hospitals that are applying for the CHGME program include hospitals that are eligible as a "Newly Qualified Hospital" or hospitals that are new to the CHGME program but qualify under the "Currently Eligible Hospitals" requirements.

a. Currently Eligible Hospitals: Children's hospitals that met the eligibility requirements prior to the Children's Hospital GME Support Reauthorization Act of 2013 remain eligible for the program. These children's hospitals must meet the following criteria:
   1) It participates in an approved graduate medical education (GME) residency training program;
   2) It has a Medicare provider payment agreement;
   3) It is excluded from the Medicare Inpatient Prospective Payment System (IPPS) under section 1886(d)(1)(B)(iii)[3] of the Social Security Act and its accompanying regulations; and
   4) It is a "freestanding" children's hospital.

b. Newly Qualified Hospitals: As per the Children's Hospital GME Support Reauthorization Act of 2013, a freestanding hospital may be eligible for CHGME payments depending on the level of funding appropriated to the program if it meets the following criteria:
   1) It has a Medicare payment agreement and that is excluded from the Medicare inpatient hospital prospective payment system (IPPS) pursuant to section 1886(d)(1)(B) of the Social Security Act and its accompanying regulations;
   2) Its inpatients are predominantly individuals under 18 years of age;

[3] The exclusion of children's hospitals from IPPS set forth under section 1886(d)(1)(B)(iii) of the SSA state this exclusion exists for hospitals "whose inpatients are predominantly individuals under 18 years of age".

3) It has an approved medical residency training program as defined in section 1886(h)(5)(A) of the Social Security Act;
4) It is not otherwise qualified to receive payments under this section or section 1886(h) of the Social Security Act. For those free-standing children's hospitals that met the above requirements as of April 7, 2014, other than the Secretary has not determined an average number of full-time equivalent residents under section 1886(h)(4) of the Social Security Act, the Secretary may establish such number of full-time equivalent residents for the purposes of calculating CHGME program payments.

Any public or private nonprofit and for-profit children's teaching hospital with an accredited residency training program which meets all of the above requirements for either category of eligibility may apply, though final eligibility for "newly qualified hospitals" will depend on appropriated funding levels. Children's hospitals applying for CHGME payment grant funds must be training residents during the Federal fiscal year for which they apply for funds.

2. Cost Sharing/Matching

Cost sharing or matching is not required for this program.

3. Dun and Bradstreet Universal Numbering System Number and System for Award Management (formerly, Central Contractor Registration)

Applicant organizations must obtain a valid DUNS number and provide that number in their application. Applicant also must register with the System for Award Management (SAM) and continue to maintain active SAM registration with current information at all times during which it has an active Federal award, or an application, or plan under consideration by an agency. This does not apply if the applicant is an individual or Federal agency that is exempted from those requirements under 2 CFR 25.110(b) or (c), or has an exception approved by the agency under 2 CFR 25.110(d)).

HRSA may not make an award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements and, if an applicant has not fully complied with the requirements by the time HRSA is ready to make an award, HRSA may determine that the applicant is not qualified to receive an award and use that determination as the basis for making an award to another applicant.

If an applicant/awardee organization has already completed Grants.gov registration for HRSA or another Federal agency, applicants should confirm that it is still active and that the Authorized Organization Representative (AOR) has been approved.

The Grants.gov registration process requires information in three separate systems:

- Dun and Bradstreet (http://fedgov.dnb.com/webform/pages/CCRSearch.jsp)
- System for Award Management (SAM) (https://www.sam.gov)
- Grants.gov (http://www.grants.gov/)

For further details, see Section 3.1 of HRSA's SF-424 R&R Two-Tier Application Guide http://www.hrsa.gov/grants/apply/applicationguide/sf424rr2guide.pdf.

Applicants that fail to allow ample time to complete registration with SAM or Grants.gov will not be eligible for a deadline extension or waiver of the electronic submission requirement.

4. Other

Payments will be determined in compliance with all mandates, rules, regulations, policies, and guidance guiding the program.

Any application that fails to satisfy the deadline requirements referenced in *Section IV.3* will be considered non-responsive and will not be considered for funding under this announcement.

NOTE: Multiple applications from an organization are not allowable.

If for any reason (including submitting to the wrong funding opportunity number or making corrections/updates), an application is submitted more than once prior to the application due date, HRSA will only accept the applicant's **last** validated electronic submission, under the correct funding opportunity number, prior to the Grants.gov application due date as the final and only acceptable application.

Applicants are reminded that failure to include all required documents as part of the application may result in an application being considered incomplete or non-responsive.

Hospitals that are newly qualified to receive CHGME funds as "newly qualified hospitals" under the Children's Hospital GME Support Reauthorization Act of 2013, and that do not already have a CMS cap established and are not able to apply for a CMS cap as a new residency training program, will have a "CHGME cap" established. The "CHGME cap" will be established using the number of FTEs trained during the most recent Medicare cost report period completed on or before April 7, 2014, the date of enactment of the Children's Hospital GME Support Reauthorization Act of 2013, as verified by the CHGME auditors during the FY2016 audit process. This value will be entered on sections 4, 5, and 6, of the HRSA 99-1, on lines 4.06, 5.06, and 6.06 as applicable.

Documentation Recommendations

Hospitals are responsible for the accuracy of application data submitted to HRSA and are subject to audit. Hospitals are not required to submit documentation with their initial application to support resident counts reported on their CHGME Payment Program application. However, hospitals should be prepared to produce documentation in accordance with 42 CFR 413.75(d) in any subsequent audit carried out by the Department or its delegate. The CHGME Payment Program has in place a Resident FTE Assessment (audit) process. Assessment of the resident FTE counts is conducted by auditors each Federal fiscal year between October and March. The results of these FTE assessments are the basis for the hospitals' reconciliation applications. The audit methodology complies with the requirements under 42 CFR 413.75 (d) and parallels a

similar GME audit process carried out by the CMS to adjudicate the number of residents training in adult teaching hospitals. Children's hospitals that do not report resident FTE counts to Medicare are **not exempt** from this policy. The information provided in the application used to support the number of FTE residents for a particular cost reporting period must be certified by an official of the hospital.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA ***requires*** applicants for this FOA to apply electronically through Grants.gov **and** the HRSA Electronic Handbooks (EHBs). Applicants must use a two-tier submission process for the CHGME program following the directions provided at Grants.gov and the HRSA EHBs.

- **Phase 1 – Grants.gov** – Required information must be submitted via Grants.gov with a due date of July 17, 2015 at 11:59 P.M. Eastern Time; and

- **Phase 2 – HRSA EHBs** – Supplemental information (completing data forms HRSA 99; 99-1; 99-2; and 99-5, as well as required Attachments) must be submitted via the HRSA's EHBs with a due date of August 6, 2015 at 5:00 P.M. Eastern Time.

Only applicants who successfully have an application validated in Grants.Gov (Phase 1) by the July 17, 2015 due date may submit the additional information and CHGME data forms in HRSA's EHBs (Phase 2).

Each funding opportunity contains a unique set of forms and only the specific forms package posted with an opportunity will be accepted. Specific instructions for preparing portions of the application that must accompany the SF-424 R&R Two-Tier appear in the Application Format Requirements section below.

2. Content and Form of Application Submission

Unless indicated otherwise in this FOA you must submit the information outlined in the Application Guide in addition to the program specific information below. Applicants should not attach any supporting documentation which contains personal identifying information with the application including rotation schedules, IRIS data, etc. All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 R&R Two-Tier Application Guide,* available online at http://www.hrsa.gov/grants/apply/applicationguide/sf424rr2guide.pdf, except where instructed in the FOA to do otherwise.

See Section 8.5 of the *SF-424 R&R Application Guide,* http://www.hrsa.gov/grants/apply/applicationguide/sf424rr2guide.pdf for the Application Completeness Checklist.

Applications must be complete and submitted prior to the deadline to be considered under this announcement.

Program-Specific Instructions
Neither a project abstract, a project narrative, nor budget information is required for this funding opportunity. In conjunction with the application requirements and instructions in Section 5 of HRSA's *SF-424 R&R Application Guide*, http://www.hrsa.gov/grants/apply/applicationguide/sf424rr2guide.pdf, please note the following:

- **Phase 1. Grants.gov application:** Required information must be complete and successfully validated under the correct funding opportunity number by 11:59 p.m. ET on July 17, 2015.

  The following should be included as part of the Grants.gov submission:
  a) SF-424 R&R cover page
  b) Project/Performance Site Location(s) form; and
  c) Disclosure of Lobbying Activities (SF-LLL), if applicable.

- **Phase 2. HRSA's EHBs:** registration and applications must be complete and successfully submitted by your organization's Authorizing Official by **5:00 PM ET on August 6, 2015**. Please note that applicants can only begin Phase 2 in HRSA's EHBs after Phase 1 in Grants.gov has been completed by the applicable due date and HRSA has assigned the application a tracking number.

  Copies of HRSA 99; 99-1; 99-2; 99-5 are included in the FOA for your reference (Attachment A). **Do not include these tables as part of the Grants.gov application submission** since you will be entering the data online in the HRSA EHBs by accessing the CHGME web application as part of Phase 2.

  The CHGME application includes four forms which are available electronically in the EHBs:

  a) HRSA 99: Demographic and Contact Information Form
  b) HRSA 99-1: Determination of Weighted and Unweighted resident FTE count form
  c) HRSA 99-2: Determination of Indirect Medical Education Data Related to the Teaching of Residents
  d) HRSA 99-5: Application Checklist

i. *Attachments*

Please provide the following items to complete the content of the application. **Each attachment must be clearly labeled**, and is to be submitted during Phase 2 of the application, directly in the EHBs:

Attachment 1 – If the hospital files a full Medicare Cost report with CMS, attach Worksheet E3 part IV or Worksheet E-4 of the Medicare Cost Reports for each of the Medicare Cost Report periods (where applicable).

Attachment 2 – Medicare Affiliation agreements when the hospital utilizes such agreements to increase/decrease its 1996 FTE resident cap, including a letter indicating that the affiliation agreements were filed with CMS prior to July 1 of that affiliation agreement's academic year.

Attachment 3 – Documents providing support of additions or reductions to resident FTE cap, if applicable.

Attachment 4 – Evidence of non-profit status, if applicable.

Attachment 5 – Delinquency on Federal debt explanation, if applicable.

3. Submission Dates and Times

Application Due Date
The due dates for applications under this FOA are as follows:

- Grants.gov (Phase 1): July 17, 2015 at 11:59 P.M. ET
- HRSA EHBs (Phase 2): August 6, 2015 at 5:00 P.M. ET.

See Section 8.2.5 – Summary of e-mails from Grants.gov of HRSA's *SF-424 R&R Application Guide*, http://www.hrsa.gov/grants/apply/applicationguide/sf424rr2guide.pdf for additional information.

4. Intergovernmental Review

The CHGME Payment Program is not subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. See Section 5.1 ii of HRSA's *SF-424 R&R Application Guide*, http://www.hrsa.gov/grants/apply/applicationguide/sf424rr2guide.pdf for additional information.

5. Funding Restrictions

It is anticipated that funds awarded under this grant will be for direct graduate medical expenses only for a project period of up to one (1) year. If Congress appropriates additional funds, then funds will be awarded for direct **and** indirect graduate medical expenses. Funding is dependent on the availability of funds and will be determined based on Congressional appropriated dollars.

The General Provisions in Division G of the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235), apply to this program. Please see Section 4.1 of HRSA's *SF-424 R&R Application Guide*, http://www.hrsa.gov/grants/apply/applicationguide/sf424rr2guide.pdf for additional information. Note that these or other restrictions will apply in FY 2016, as required by law.

V. Application Review Information

1. Review Criteria

This is a formula-based grant payment program that does not require submission of a project narrative for review by a review committee. HRSA is responsible for the review of each application for eligibility, completeness and accuracy (including the data reported on all tables), and compliance with the requirements outlined in this FOA. Application review is conducted at HRSA and an independent assessment of FTE residents' count is conducted by fiscal intermediaries. The CHGME Payment Program legislative mandate states that "the Secretary shall determine any changes to the number of residents reported by a hospital in the application of the hospital for the current fiscal year to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts." The assessment of the FTE resident counts by fiscal intermediaries occurs within a six-month period of time from start of the Federal Fiscal Year to the spring of the same Federal Fiscal Year, to allow for reconciliation of payments within the appropriation year for which payments are made. The FTE assessment of residents is carried out by CHGME fiscal intermediaries each fiscal year, and each of the children's hospitals participating in the program is subject to this assessment.

2. Review and Selection Process

The funds appropriated for the CHGME Payment Program are distributed among participating institutions as a formula payment based grant. Program data reported on HRSA forms are used to determine funding and administer the program. All required tables must be submitted electronically in the HRSA EHBs with the Phase 2 submission. **Applications received without the appropriate tables will be deemed non-responsive to the FOA and will not be considered for funding under this announcement.**

3. Anticipated Announcement and Award Dates

It is anticipated that awards, subject to availability of funds, will be announced prior to the start date of October 1, 2015. For "newly qualified" hospitals the reauthorization permits the Secretary, "to make available up to 25 percent of the total amounts in excess of $245,000,000" but "not to exceed $7,000,000." "Newly qualified" hospitals will not receive their payment, if any, until after the annual appropriation has been made, which may be after October, and only if the annual appropriation is funded at $245,000,000 or more for FY2016.

VI. Award Administration Information

1. Award Notices

The Notice of Award (NoA) will be sent in October 2015. See Section 6.4 of HRSA's *SF-424 R&R Application Guide,* http://www.hrsa.gov/grants/apply/applicationguide/sf424rr2guide.pdf for additional information.

2. Administrative and National Policy Requirements

See Section 2 of HRSA's *SF-424 R&R Application Guide*, http://www.hrsa.gov/grants/apply/applicationguide/sf424rr2guide.pdf

3. Reporting

The successful applicant under this FOA must comply with Section 7 of HRSA's *SF-424 R&R Application Guide*, http://www.hrsa.gov/grants/apply/applicationguide/sf424rr2guide.pdf and the following reporting and review activities:

a. Audit Requirements

The Department of Health and Human Services (HHS), or any other authorized Federal agency, may conduct an audit to determine whether the applicant has complied with all governing laws and regulations in its application for funding. Any and all information submitted to HHS by an applicant or participating hospital during or after the award of funds is subject to review in an audit.

In addition, a Resident FTE Assessment will be conducted between October and May of each fiscal year. A CHGME Fiscal Intermediary (FI) is assigned to each children's hospital currently receiving CHGME Payment Program funding. The CHGME FI conducts an assessment of resident FTE counts reported by the children's hospital in its initial application (HRSA 99-1) for CHGME Payment Program funding to determine any changes to those resident FTE counts prior to the CHGME Payment Program reconciliation application cycle. The CHGME FI follows a detailed protocol based on CMS rules and regulations designed to ensure that each resident FTE claimed by the children's hospital is documented in accordance with 42 CFR 413.75(d). Resident counts are based on the number of residents training at the hospital complex and certain non-hospital/non-provider settings/sites throughout the hospital's fiscal year. Residents are counted as FTEs based on the total time necessary to fill a full-time residency slot for the year. Eligible hospitals are subjected to the terms of the Full-Time Equivalent Assessment Process Guidance and Assessments which is available electronically via the CHGME Payment Program web site.

b. Progress Reports

For this program, Government Performance and Results Act performance data tables are submitted as part of the reconciliation application, using the HRSA 99-4 form.

c. Performance Reports

The awardee must submit a performance report to HRSA on an annual basis through the BHW Performance Management Handbook (BPMH) system. All BHW grantees are required to collect and report performance data so that HRSA can meet its obligations under the Government Performance and Results Modernization Act of 2010 (GPRA). For the CHGME program, the performance report will be completed

based on prior academic year data. Required measures include, but are not limited to: program characteristics, individual resident demographics, experiential training details, curriculum enhancement and development, and discharge data. An overview of the required performance measures as well as a detailed instruction manual for performance reporting, are available at the following site: http://bhw.hrsa.gov/grants/reporting/.

VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this FOA by contacting:

Jamie King, Chief, Health Professions Branch
HRSA Division of Grants Management Operations, OFAM
Parklawn Building, Room 10SWH03
5600 Fishers Lane
Rockville, MD 20857
Telephone: 301-443-5461
Fax: 301-443-6343
E-mail: JKing@hrsa.gov

Additional information related to the overall program issues and technical assistance regarding this funding announcement may be obtained by contacting:

Anna Maria Padlan
Division of Medicine and Dentistry
Bureau of Health Workforce, HRSA
Parklawn Building, Room 12C-06
5600 Fishers Lane
Rockville, MD 20857
Telephone: 301-443-1058
Fax: 301-443-1879
E-mail: APadlan@hrsa.gov

Applicants may need assistance when working online to submit their application forms electronically. Applicants should always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding Federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
E-mail: support@grants.gov
iPortal: https://grants-portal.psc.gov/Welcome.aspx?pt=Grants

Successful applicants/awardees may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting information in HRSA's EHBs, contact the HRSA Contact Center, Monday-Friday, 8:00 a.m. to 8:00 p.m. ET:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
Web: http://www.hrsa.gov/about/contact/ehbhelp.aspx

VIII. Other Information

Technical Assistance

CHGME will hold a CHGME FY2016 Initial Application Technical Assistance (TA) webinar on June 30, 2015 from 1-3pm ET. The webinar link is:

https://hrsa.connectsolutions.com/chgmeinitialfy16/

Call in number: 1-877-985-4184
Passcode 13221588.

IX. Tips for Writing a Strong Application

See Section 5.7 of HRSA's *SF-424 R&R Application Guide*,
http://www.hrsa.gov/grants/apply/applicationguide/sf424rr2guide.pdf
In addition, BHW has developed a number of recorded webcasts with information that may assist applicants in preparing a competitive application. These webcasts can be accessed at: http://bhw.hrsa.gov/grants/technicalassistance/index.html.

APPENDIX A

CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION
PAYMENT PROGRAM APPLICATION PACKAGE
FOR GRANT PAYMENTS

Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0247
Expiration Date: 06/30/2017

Bureau of Health Professions

Dear Applicant:

The Children's Hospitals Graduate Medical Education (CHGME) Payment Program application package, including all applicable forms, guidance and instructions, is available on-line within Health Resources and Services Administration's Electronic Handbook (EHB). It is very important to thoroughly read the detailed application guidance and instructions before completing the required application forms. The material contains information related to submission of both the initial and reconciliation applications. A sample of the application is available on-line at http://bhpr.hrsa.gov/childrenshospitalgme/apply/index.html

Your completed application must be submitted through the EHB following the guidance provided in the "Application Cycle and Deadlines" section of the application package. Applications must be received by the stated deadlines to be considered for CHGME Payment Program funding.

If you have questions regarding the application, please call the Graduate Medical Education Branch at 301-443-1058 or e-mail at childrenshospitalgme@hrsa.gov.

Sincerely yours,

/s/

Rebecca Spitzgo
Associate Administrator

Enclosures

Children's Hospitals Graduate Medical Education (CHGME) Payment Program Application Package

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Section I

Overview of the CHGME Payment Program

Introduction

In 1999, Congress addressed the disparity of explicit graduate medical education (GME) funding between freestanding children's teaching hospitals and other teaching hospitals by passing the Healthcare Research and Quality Act, which established the Children's Hospitals Graduate Medical Education (CHGME) Payment Program. The act was signed on December 6, 1999 and the legislation authorized the program for Federal fiscal year (FY) 2000 and FY 2001. On October 17, 2000, the Children's Health Act of 2000 amended the Healthcare Research and Quality Act of 1999 extending the CHGME Payment Program through FY 2005. On December 23, 2004, additional amendments under Public Law 108-490 were made to Section 340E of the Public Health Service Act affecting the CHGME Payment Program. In October 2006, the Children's Hospital GME Support Reauthorization Act of 2006 reauthorized the CHGME Payment Program through FY 2011. In April 2014, the Children's Hospital GME Support Reauthorization Act of 2013 reauthorized the CHGME Payment Program through FY2018, and included a provision to allow newly qualified hospitals to apply for CHGME funding. The Program continues to operate through an appropriation. There are more than 50 freestanding children's teaching hospitals across the country that train about 30 percent of the Nation's pediatricians, nearly half of pediatric sub-specialists, and provide valuable training for physicians in many other specialties. These are the physicians who care for America's youngest population – its children. Almost 50 percent of the patient care that children's teaching hospitals provide is for low-income children, including those covered by Medicaid and those who are uninsured. In addition, these hospitals are regional and national referral centers for very sick children, often serving as the only source of care for many critical pediatric services. More than 75 percent of inpatient care at children's hospitals is devoted to children with one or more chronic conditions.

The CHGME Payment Program provides a more adequate level of support for GME training in U.S. children's teaching hospitals that have a separate Medicare provider number. These hospitals receive relatively little funding from Medicare for GME. Funding received by other teaching hospitals from Medicare was expected to exceed more than $10 billion in FY 2012.

In FY 2014, the CHGME Payment Program appropriation provided GME support to 54 children's hospitals in 30 states, the District of Columbia and Puerto Rico, supporting more than 4,500 un-weighted resident full-time equivalents (FTEs) training in these hospitals. Since the inception of this program, the program has disbursed more than $2.5 billion in Federal GME support to freestanding children's teaching hospitals.

Administration

The CHGME Payment Program is administered by the Graduate Medical Education Training Branch (GMETB) of the Division of Medicine and Dentistry (DMD), Bureau of Health Professions (BHPr), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS). The objective of the GMEB is to provide the assistance that freestanding children's hospitals need to ensure a future pediatric workforce that will treat U.S. children and to protect the safety net hospitals that address the needs of the underserved.

Questions regarding the CHGME Payment Program should be directed to the:

Department of Health and Human Services
Health Resources and Services Administration
Bureau of Health Professions
Division of Medicine and Dentistry
Graduate Medical Education Training Branch
Parklawn Building
5600 Fishers Lane Room 12C-06
Rockville, Maryland 20857

Telephone: 301-443-1058 Fax: 301-443-1879

Section II

Application Cycle and Deadlines

For hospitals to be considered for CHGME Payment Program funding, they must comply with statutory eligibility requirements described herein and participate in the CHGME Payment Program's application cycle, which consists of specific processes for any given FY. These processes are guided by the CHGME Payment Program's statutes and are described below.

Initial Application

For children's hospitals, meeting all statutory and eligibility requirements, to receive CHGME Payment Program funding, they must submit a completed initial application for CHGME Payment Program funding in accordance with the established deadlines noted below. During the initial application process, eligible children's hospitals provide the CHGME Payment Program with information relevant to the interim determination of payments.

Initial applications for CHGME Payment Program funding must include the following forms:

i. HRSA 99: Demographic and Contact Information
ii. HRSA 99-1: Determination of Weighted and Unweighted Resident FTE Counts
iii. HRSA 99-2: Determination of Indirect Medical Education Data Related to the Teaching of Residents
iv. HRSA 99-5: Application Checklist

Applications accepted for review must be completed following the application guidance and instructions provided herein, submitted in English and include the above completed forms and supporting documentation as identified in the HRSA 99-5 (Application Checklist). The forms HRSA 99, HRSA 99-1, HRSA 99-2, and HRSA 99-5 must be submitted electronically through the secure EHB web-application system.

Interim Payment Determination and Disbursement (Based Upon the Initial Application)

In accordance with CHGME Payment Program statutory requirements, information provided by participating children's hospitals in their initial applications for CHGME Payment Program funding is used by the CHGME Payment Program to calculate payments for all eligible children's hospitals prior to the beginning of the FY (October 1st) for which children's hospitals have applied for CHGME Payment Program funding. CHGME payments, allocated to eligible children's hospitals, are a function of the number of resident full-time equivalents (FTEs) participating in approved medical residency programs, inpatient discharges, case mix index, and the number of inpatient available beds, as reported by children's hospitals in their initial applications for CHGME Payment Program funding. Payments are awarded for direct medical

education (DME) and indirect medical education (IME) expenses, respectively. DME and IME payment calculations are subject to all rules, regulations, and policies governing the CHGME Payment Program.

On or after October 1st of the FY for which eligible children's hospitals have applied for CHGME Payment Program funding, the CHGME Payment Program will begin making interim payments. CHGME Program payments to eligible children's hospitals will be contingent upon the passage of the DHHS' budget for the given FY by the President. Children's hospitals will be notified, in writing, of the Secretary's interim payment determination. In accordance with CHGME Payment Program statutes, payments will reflect a 25 percent withholding from each interim installment (payment) for both DME and IME payments, as necessary, to ensure that a hospital will not be overpaid on an interim basis.

Assessment of Resident FTE Counts Reported in Initial Applications

The CHGME Payment Program statute, Public Law 106-310, mandates that "the Secretary shall determine any changes to the number of residents reported by a hospital in the *(initial)* application of the hospital for the current FY for both direct and indirect expense amounts." Therefore, prior to the end of the FY for which children's hospitals have applied for CHGME Payment Program funding, the Secretary must determine *(reconcile)* any changes to the number of resident FTEs reported by a hospital in its initial application for the current FY, which will impact final payments made by the CHGME Payment Program to all eligible children's hospitals. This determination is done by conducting a comprehensive assessment of the resident FTE counts claimed by children's hospitals in their initial applications for CHGME Payment Program funding.

The CHGME Payment Program has contracted with fiscal intermediaries (hereinafter CHGME FIs) to carry out an assessment of resident FTE counts (hereinafter the "Resident FTE Assessment Program") reflected in participating children's hospitals initial applications for CHGME Payment Program funding to determine any changes to the resident FTE counts initially reported. An assessment of resident FTE counts reported by children's hospitals in their initial applications for CHGME Payment Program funding is performed regardless of the type(s) of Medicare cost report (MCR) the hospital files (e.g., full, low- or no-utilization) for purposes of receiving CHGME Payment Program funding. This process is designed to assess resident FTE counts for all children's hospitals in an equitable fashion and within CHGME Payment Program time constraints.

The Resident FTE Assessment Program requires participating children's hospitals to comply with requests from the CHGME FIs, within the time constraints provided, as any changes to resident FTE counts in one children's hospital's application for CHGME Payment Program funding affects the distribution of funds among all eligible children's hospitals. To minimize public burden, CHGME FIs use and build upon work previously conducted by CHGME and/or Medicare FIs in prior years. The CHGME Payment Program has made available several guidance documents on the CHGME Payment Program's website at http://bhpr.hrsa.gov/childrenshospitalgme/apply/index.html which provide further information

about the Resident FTE Assessment Program and documentation recommendations related to the assessment of resident FTE counts.

At the conclusion of the Resident FTE Assessment Program, the CHGME FIs will forward final assessment reports to the respective children's hospitals, the Medicare FIs, and the CHGME Payment Program explaining the results of the review. The assessment reports include CHGME FI-generated HRSA 99-1's, which children's hospitals must use to complete their reconciliation applications (see Reconciliation Application below). The assessment reports may also include supporting documentation including, but not limited to: adjustment reports, updates to the intern and resident database, adjustments to the Centers for Medicare and Medicaid Services (CMS) form 2552-10 Worksheet E-4 (2552-96 Worksheet E-3, Part IV), or letters to the Medicare Administrative Contractor (MAC) requesting the reopening of one or more MCRs.

Reconciliation Application

During the third quarter of each FY (typically April 1st) for which payments are being made, the CHGME Payment Program will release a reconciliation application for use by participating children's hospitals to report changes in the resident FTE counts reported in their initial applications for CHGME Payment Program funding. For children's hospitals to continue receiving CHGME Payment Program funding, they must submit a completed reconciliation application for CHGME Payment Program funding in accordance with established deadlines noted below. The resident FTE counts reported by children's hospitals in their reconciliation applications must be for the same MCR period(s) identified in the hospital's initial application for the subject FY and consistent with those reported in the CHGME FIs FTE final assessment report to be accepted by the CHGME Payment Program.

The resident FTE counts from the final assessment reports are used to determine the final amounts payable to children's hospitals for the current FY for both DME and IME. Children's hospitals whose resident FTE counts have not changed are not exempt from completing and submitting a CHGME Payment Program reconciliation application.

Reconciliation applications for CHGME Payment Program funding must include the following forms:

i. HRSA 99: Hospital Demographic and Contact Information
ii. HRSA 99-1: Determination of Weighted and Unweighted Resident FTE Counts
iii. HRSA 99-2: Determination of Indirect Medical Education Data Related to the Teaching of Residents
iv. HRSA 99-4: Government Performance and Results Act Tables
v. HRSA 99-5: Application Checklist

Applications accepted for review must be completed following the application guidance and instructions provided herein, submitted in English and include the above completed forms and supporting documentation as identified in the HRSA 99-5 (Application Checklist). The forms

HRSA 99, HRSA 99-1, HRSA 99-2, HRSA 99-4 and HRSA 99-5 must be submitted electronically through the secure EHB web-application system.

If a children's hospital fails to complete and return a reconciliation application according to the terms and conditions of the CHGME Payment Program, the DHHS may suspend the award, pending corrective action, or may terminate the award for cause.

Children's hospitals that were not eligible to participate or did not apply for funding during the initial application process for a given FY are not eligible to apply for and receive funding during the reconciliation application process for the same FY. These hospitals must wait until the next (initial) application cycle to apply for CHGME Payment Program funding.

Final Payment Determination and Disbursement (Based Upon the Reconciliation Application)

The Secretary will determine any balance due or any overpayment made to individual hospitals following the determination of changes, if any, to the number of resident FTEs reported by children's hospitals in their reconciliation applications as a result of the Resident FTE Assessment Program. Children's hospitals will be notified, in writing, of the Secretary's final reconciliation payment determination during the fourth quarter (July 1st – September 30th) of the FY in which payments are being made.

Children's hospitals that have been notified of an overpayment will have 30 days to return the overpayment to the DHHS without accrual of interest. Children's hospitals that fail to return overpayments within the specified timeframe will accrue and be responsible for any interest.

Reconciliation payments will be made to individual hospitals on or before the end of the FY (September 30th) in which payments are being made. The Secretary will include in the reconciliation payments funding initially withheld in accordance with statutory requirements. All hospitals, whether or not they report changes to their resident FTE counts during the reconciliation process, can expect changes to their final payment determination as a result of resident FTE count changes reported by other participating children's hospitals. This is due to the methodology used to determine CHGME Payment Program payments. More detailed information is available on the CHGME Payment Program payment methodology in Section V of this application package. Information on the payment formulas is also available on the CHGME Payment Program website at http://bhpr.hrsa.gov/childrenshospitalgme/apply/index.html.

The DME and IME payment calculations are subject to all rules and regulations governing the CHGME Payment Program statute, including the June 19, 2000 Federal Register notice for DME, the July 20, 2001 Federal Register notice for IME, §422 of the Medicare Modernization Act (MMA) of 2003, and Sections 5503, 5504, 5505, and 5506 of the Affordable Care Act (ACA) of 2010 and all accompanying policies and regulations.

At the end of the FY, the CHGME Payment Program may make a final payment to distribute any remaining funds, including those funds that have been returned to the DHHS during the course of the FY as a result of overpayment or hospitals' loss of eligibility.

Section III

Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0247
Expiration Date: 06/30/2017

CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM

APPLICATION FORMS

Public Burden Statement

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0247. Public reporting burden for this collection of information is estimated to average XX hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10C-03I, Rockville, Maryland, 20857.

OMB No. 0915-0247
Expiration Date: 06/30/2017

CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM

APPLICATION FORM HRSA 99

Public Burden Statement

Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0247
Expiration Date: 06/30/2017

Children's Hospitals Graduate Medical Education Payment Program
Demographic and Contact Information

Name of Applicant: City, State:

Medicare Provider Number:

FFY in which Applying for CHGME PP Funding: FFY

Type of Application (check box to the left): Initial Application Reconciliation Application

1. **Contact and business information for the applicant hospital.**

   Official Name of the Hospital: _____

   Physical Address of the Hospital: _____

   Tax ID: County where hospital is physically located:

   Medicare Provider Number: D&B D.U.N.S. Number:

   Hospital Website: _____

2. **Contact information for the individual to be notified if the application is funded.**

   Name: _____

   Title: _____

   Mailing Address: _____

   Telephone Number: _____

   Email Address: _____

3. **Contact information for the individual authorized to submit the application for the applicant institution.**

   Name: _____

   Title: _____

   Mailing Address: _____

   Telephone Number: _____

   Email Address: _____

   Certification: _____

Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0247
Expiration Date: 06/30/2017

Children's Hospitals Graduate Medical Education Payment Program
Demographic and Contact Information

Name of Applicant:
City, State:
Medicare Provider Number:
FFY in which Applying for CHGME PP Funding: FFY

Type of Application (check box to the left): **Initial Application** ☐ **Reconciliation Application** ☐

4. Contact information for the Director of Graduate Medical Education.

Name: _____
Title: _____
Mailing Address: _____
Telephone Number: _____
Email Address: _____

5. Contact information for the individual who can provide the documentation for the information submitted since, like all Federal programs, this proposal is subject to audit.

Name: _____
Title: _____
Mailing Address: _____
Telephone Number: _____
Email Address: _____

6. Contact information for the individual who prepared and/or completed this application package for the applicant hospital and can answer questions related to the information submitted.

Name: _____
Title: _____
Mailing Address: _____
Telephone Number: _____
Email Address: _____

Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0247
Expiration Date: 06/30/2017

CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM

APPLICATION FORM HRSA 99-1

Public Burden Statement

Children's Hospitals Graduate Medical Education Payment Program
Determination of Weighted and Unweighted Resident FTE Counts

Name of Applicant:					
City:		**State:**		**Zip Code:**	
Medicare Provider Number:					
Fiscal Year in which applying for funding:		**FFY**			
Type of Application (check box to the left)	**_____Initial Application**		**_____Reconciliation Application**		
Are you a new children's hospital that has not completed three full Medicare cost reporting periods? (Please place 'n' for no or 'y' for yes in the cell to the right)					

Section 1	**DETERMINATION OF RESIDENT FTE CAP FOR THE HOSPITAL'S MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE DECEMBER 31, 1996**		**To be completed by hospital**	**For CHGME FI Use Only**	
			HOSPITAL DATA	**MCR DATA**	**FI DATA**
1.01	Inclusive dates of the subject cost reporting period	*(From)*	*10/01/1995*		
		(To)	*09/30/1996*		
1.02	Status of MCR		S/R/P		
1.03	Unweighted resident FTE count for allopathic and osteopathic programs (from the 1996 cap year)		0.00	0.00	0.00
Section 2	**AVERAGE OF UNWEIGHTED RESIDENT FTE COUNTS**		**HOSPITAL DATA**	**MCR DATA**	**FI DATA**
2.01	Total unweighted resident FTE count for the hospital's most recently completed cost reporting period		0.00	0.00	0.00
2.02	Total unweighted resident FTE count for the hospital's prior cost reporting period		0.00	0.00	0.00
2.03	Total unweighted resident FTE count for the hospital's penultimate cost reporting		0.00	0.00	0.00
2.04	Rolling average of unweighted resident FTE count		0.00	0.00	0.00
2.05	Add On: Unweighted resident FTE count meeting the criteria for an exception		0.00	0.00	0.00
2.06	Adjusted rolling average of unweighted resident FTE count		0.00	0.00	0.00
2.07	Add On: Unweighted resident FTE count from MMA §422		0.00	0.00	0.00
2.08	**Grand Total: Unweighted resident FTE Count**		0.00	0.00	0.00
Section 3	**AVERAGE OF WEIGHTED RESIDENT FTE COUNTS**		**HOSPITAL DATA**	**MCR DATA**	**FI DATA**
3.01	Total weighted resident FTE count for the hospital's most recently completed cost reporting period		0.00	0.00	0.00
3.02	Total weighted resident FTE count for the hospital's prior cost reporting period		0.00	0.00	0.00
3.03	Total weighted resident FTE count for the hospital's penultimate cost reporting period		0.00	0.00	0.00
3.04	Rolling average of weighted resident FTE count		0.00	0.00	0.00
3.05	Add On: Weighted resident FTE count meeting the criteria for an exception		0.00	0.00	0.00
3.06	Adjusted rolling average of weighted resident FTE count		0.00	0.00	0.00
3.07	Add On: Weighted resident FTE count from MMA §422		0.00	0.00	0.00
3.08	**Grand Total: Weighted resident FTE Count**		0.00	0.00	0.00

Children's Hospitals Graduate Medical Education Payment Program
Determination of Weighted and Unweighted Resident FTE Counts

Name of Applicant:	**0**				
City:	**0**	**State:**	**0**	**Zip Code**	**0**
Medicare Provider Number	**0**				
Fiscal Year in which applying for funding:		**FFY**			
Type of Application (check box to the left)		**_____Initial Application**		**___Reconciliation Application**	

Section 4	DETERMINATION OF FTE RESIDENT COUNT FOR THE HOSPITAL'S MOST RECENTLY COMPLETED COST REPORTING PERIOD	HOSPITAL DATA		For CHGME FI Use Only	
		1996 CAP YEAR	§422 of the MMA	MCR DATA	FI DATA
4.01	Inclusive dates of the subject cost reporting period *(From)*				
	(To)				
4.02	Status of MCR				
4.03	Unweighted resident FTE count for allopathic and osteopathic programs (from the 1996 cap year)	0.00		0.00	0.00
4.04	**Addition** (to the cap) for the unweighted resident FTE count for allopathic and osteopathic programs due to **42 CFR 413.79(e)** (add-on)	0.00		0.00	0.00
4.04a	**Reduction** (to the cap) for the unweighted resident FTE count for allopathic and osteopathic programs due to **§ 422 of the MMA**	0.00		0.00	0.00
4.04b	**Reduction** (to the cap) for the unweighted resident FTE count for allopathic and osteopathic programs due to **§ 5503 of ACA**	0.00		0.00	0.00
4.05	**Adjustment** (plus or minus) for the unweighted resident FTE count for allopathic and osteopathic programs for **affiliated programs**	0.00		0.00	0.00
4.05a	**Addition** (to the cap) for the unweighted resident FTE count for allopathic and osteopathic programs due to **§ 5503 of ACA**	0.00		0.00	0.00
4.05b	**Addition** (to the cap) for the unweighted resident FTE count for allopathic and osteopathic programs due to **§ 5506 of ACA** (add-on)	0.00		0.00	0.00
4.06	FTE adjusted cap	0.00	0.00	0.00	0.00
4.07	Unweighted resident FTE count for allopathic and osteopathic programs.	0.00	0.00	0.00	0.00
4.08	Enter the lesser of lines 4.06 and 4.07	0.00	0.00	0.00	0.00
4.09	Unweighted resident FTE count for allopathic and osteopathic residents in their initial residency period	0.00	0.00	0.00	0.00
4.10	Unweighted resident FTE count for allopathic and osteopathic residents beyond their initial residency period	0.00	0.00	0.00	0.00
4.11	Weighted resident FTE count for allopathic an osteopathic residents beyond their initial residency period	0.00	0.00	0.00	0.00
4.12	Weighted resident FTE count for allopathic osteopathic programs	0.00	0.00	0.00	0.00
4.13	Weighted resident FTE count for allopathic and osteopathic programs following application of the resident FTE adjusted cap	0.00	0.00	0.00	0.00
4.14	Unweighted resident FTE count for dental and podiatric programs	0.00		0.00	0.00
4.15	Unweighted resident FTE count for dental and podiatric residents in their initial residency period	0.00		0.00	0.00
4.16	Unweighted resident FTE count for dental and podiatric resident beyond their initial residency period	0.00		0.00	0.00
4.17	Weighted resident FTE count for dental and podiatric residents beyond their initial residency period	0.00		0.00	0.00
4.18	Weighted resident FTE count for dental and podiatric programs	0.00		0.00	0.00
4.19	Total unweighted resident FTE count	0.00	0.00	0.00	0.00
4.20	Total weighted resident FTE count	0.00	0.00	0.00	0.00

OMB N0. 0915-0247
Expiration Date: 06/30/2017

Children's Hospitals Graduate Medical Education Payment Program
Determination of Weighted and Unweighted Resident FTE Counts

Name of Applicant:	**0**				
City:	**0**	**State:**	**0**	**Zip Code:**	**0**
Medicare Provider Number:	**0**				
Fiscal Year in which applying for funding:		**FFY**			
Type of Application (check box to the left)		**____Initial Application**		**_____Reconciliation Application**	

Section 5	DETERMINATION OF FTE RESIDENT COUNT FOR THE HOSPITAL'S PRIOR COST REPORTING PERIOD		HOSPITAL DATA	For CHGME FI Use Only	
			1996 Cap Year	MCR DATA	FI DATA
5.01	Inclusive dates of the subject cost reporting period	*(From)*	*10/01/2009*	*10/01/2009*	
		(To)	*09/30/2010*	*09/30/2010*	
5.02	Status of MCR		S	S	S
5.03	Unweighted resident FTE count for allopathic and osteopathic programs (from the 1996 cap year)		0.00	0.00	0.00
5.04	**Addition** (to the cap) for the unweighted resident FTE count for allopathic and osteopathic programs due to **42 CFR 413.79(e)** (add-on)		0.00	0.00	0.00
5.04a	**Reduction** (to the cap) for the unweighted resident FTE count for allopathic and osteopathic programs due to **§ 422 of the MMA**		0.00	0.00	0.00
5.04b	**Reduction** (to the cap) for the unweighted resident FTE count for allopathic and osteopathic programs due to **§ 5503 of ACA**		0.00	0.00	0.00
5.05	**Adjustment** (plus or minus) for the unweighted resident FTE count for allopathic and osteopathic programs for **affiliated programs**		0.00	0.00	0.00
5.05a	**Addition** (to the cap) for the unweighted resident FTE count for allopathic and osteopathic programs due to **§ 5503 of ACA**		0.00	0.00	0.00
5.05b	**Addition** (to the cap) for the unweighted resident FTE count for allopathic and osteopathic programs due to **§ 5506 of ACA** (add-on)		0.00	0.00	0.00
5.06	FTE adjusted cap		0.00	0.00	0.00
5.07	Unweighted resident FTE count for allopathic and osteopathic programs.		0.00	0.00	0.00
5.08	Enter the lesser of lines 5.06 and 5.07		0.00	0.00	0.00
5.09	Unweighted resident FTE count for allopathic and osteopathic residents in their initial residency period		0.00	0.00	0.00
5.10	Unweighted resident FTE count for allopathic and osteopathic residents beyond their initial residency period		0.00	0.00	0.00
5.11	Weighted resident FTE count for allopathic an osteopathic residents beyond their initial residency period		0.00	0.00	0.00
5.12	Weighted resident FTE count for allopathic osteopathic programs		0.00	0.00	0.00
5.13	Weighted resident FTE count for allopathic and osteopathic programs following application of the resident FTE adjusted cap		0.00	0.00	0.00
5.14	Unweighted resident FTE count for dental and podiatric programs		0.00	0.00	0.00
5.15	Unweighted resident FTE count for dental and podiatric residents in their initial residency period		0.00	0.00	0.00
5.16	Unweighted resident FTE count for dental and podiatric resident beyond their initial residency period		0.00	0.00	0.00
5.17	Weighted resident FTE count for dental and podiatric residents beyond their initial residency period		0.00	0.00	0.00
5.18	Weighted resident FTE count for dental and podiatric programs		0.00	0.00	0.00
5.19	Total unweighted resident FTE count		0.00	0.00	0.00
5.20	Total weighted resident FTE count		0.00	0.00	0.00

Created in MS Excel 7.0

Children's Hospitals Graduate Medical Education Payment Program
Determination of Weighted and Unweighted Resident FTE Counts

Name of Applicant:	**0**				
City:	**0**	**State:**	**0**	**Zip Code:**	**0**
Medicare Provider Number	**0**				
Fiscal Year in which applying for funding:		**FFY**			
Type of Application (check box to the left)		**____Initial Application**		**_____Reconciliation Application**	

Section 6	DETERMINATION OF FTE RESIDENT COUNT FOR THE HOSPITAL'S PENULTIMATE COST REPORTING PERIOD		HOSPITAL DATA	For CHGME FI Use Only	
			1996 Cap Year	MCR DATA	FI DATA
6.01	Inclusive dates of the subject cost reporting period	*(From)*	*10/01/2008*	*10/01/2008*	
		(To)	*09/30/2009*	*09/30/2009*	
6.02	Status of MCR				
6.03	Unweighted resident FTE count for allopathic and osteopathic programs (from the 1996 cap year)		0.00	0.00	0.00
6.04	**Addition** (to the cap) for the unweighted resident FTE count for allopathic and osteopathic programs due to **42 CFR 413.79(e)** (add-on)		0.00	0.00	0.00
6.04a	**Reduction** (to the cap) for the unweighted resident FTE count for allopathic and osteopathic programs due to **§ 422 of the MMA**		0.00	0.00	0.00
6.04b	**Reduction** (to the cap) for the unweighted resident FTE count for allopathic and osteopathic programs due to **§ 5503 of ACA**		0.00	0.00	0.00
6.05	**Adjustment** (plus or minus) for the unweighted resident FTE count for allopathic and osteopathic programs for **affiliated programs**		0.00	0.00	0.00
6.05a	**Addition** (to the cap) for the unweighted resident FTE count for allopathic and osteopathic programs due to **§ 5503 of ACA**		0.00	0.00	0.00
6.05b	**Addition** (to the cap) for the unweighted resident FTE count for allopathic and osteopathic programs due to **§ 5506 of ACA** (add-on)		0.00	0.00	0.00
6.06	FTE adjusted cap		0.00	0.00	0.00
6.07	Unweighted resident FTE count for allopathic and osteopathic programs.		0.00	0.00	0.00
6.08	Enter the lesser of lines 6.06 and 6.07		0.00	0.00	0.00
6.09	Unweighted resident FTE count for allopathic and osteopathic residents in their initial residency period		0.00	0.00	0.00
6.10	Unweighted resident FTE count for allopathic and osteopathic residents beyond their initial residency period		0.00	0.00	0.00
6.11	Weighted resident FTE count for allopathic an osteopathic residents beyond their initial residency period		0.00	0.00	0.00
6.12	Weighted resident FTE count for allopathic osteopathic programs		0.00	0.00	0.00
6.13	Weighted resident FTE count for allopathic and osteopathic programs following application of the resident FTE adjusted cap		0.00	0.00	0.00
6.14	Unweighted resident FTE count for dental and podiatric programs		0.00	0.00	0.00
6.15	Unweighted resident FTE count for dental and podiatric residents in their initial residency period		0.00	0.00	0.00
6.16	Unweighted resident FTE count for dental and podiatric resident beyond their initial residency period		0.00	0.00	0.00
6.17	Weighted resident FTE count for dental and podiatric residents beyond their initial residency period		0.00	0.00	0.00
6.18	Weighted resident FTE count for dental and podiatric programs		0.00	0.00	0.00
6.19	Total unweighted resident FTE count		0.00	0.00	0.00
6.20	Total weighted resident FTE count		0.00	0.00	0.00

Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0247
Expiration Date: 06/30/2017

CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM

APPLICATION FORM HRSA 99-2

Public Burden Statement

Department of Health and Human Services
Health Resources and Services Administration

OMB N0. 0915-0247
Expiration Date: 06/30/2017

Children's Hospitals Graduate Medical Education Payment Program
Determination of Indirect Medical Education Data
Related to the Teaching of Residents

Name of Applicant:		**0**					
City	**0**	**State**	**0**			**Zip Code:**	**0**
Medicare Provider Number		**0**					
Fiscal Year in which Applying for Funding:			**FFY**				
Type of Application (check box to the left)			**___Initial Application**			**_____Reconciliation Application**	

Inpatient Data for the Current Medicare Cost Report (MCR) Period

1.01	Inclusive dates of the current MCR period	*From:*		*To:*		
1.02	Number of Inpatient Days					
1.03	Number of Inpatient Discharges					
1.04	Case Mix Index (CMI)					
	Hospitals that elect not to submit a CMI are required to initial the box to the left acknowledging their ineligibility for IME payments. The initials to the left must be consistent with the signature on HRSA 99-3.					

IRB Ratio for the Current MCR Period

1.05	3-year adjusted unweighted resident FTE rolling average for the current MCR period	0.00
1.06	Bed count for the current MCR period	0
1.07	IRB ratio for the current MCR period	0.000000

IRB Ratio for the Previous MCR Period

1.08	Inclusive dates of the previous MCR period	*From:*		*To:*		
1.09	Unweighted resident FTE count for the previous MCR period	0.00				
1.10	Bed count for previous MCR period	0.00				
1.11	IRB ratio for the previous MCR period	0.000000				

IRB Cap

1.12	IRB Cap (lesser of 1.07 or 1.11)	0.000000

§422 of the MMA IRB Ratio for the Current MCR Period

1.13	§422 of the MMA unweighted resident FTE count for the current MCR period	0.00
1.14	Bed count for the current MCR period	0.00
1.15	§422 of the MMA IRB ratio for the current MCR period	0.000000

Outpatient Data

1.16	Number of Ambulatory Surgery Visits	0.00
1.17	Number of Radiology Visits	0.00
1.18	Number of Urgent Care Visits	0.00
1.19	Number of Emergency Department Visits	0.00
1.20	Number of Clinic Visits	0.00

Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0247
Expiration Date: 06/30/2017

CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM

APPLICATION FORM HRSA 99-4

Public Burden Statement

Department of Health and Human Services
Health Resources and Services Administration

OMB N0. 0915-0247
Expiration Date: 06/30/2017

Children's Hospitals Graduate Medical Education Payment Program
Government Performance and Results Act (GPRA) Tables

Name of Applicant:	#REF!				
City:	#REF!	**State:**	#REF!	**Zip Code:**	#REF!
Medicare Provider Number:	#REF!				
Fiscal Year in which applying for funding:	FFY	#REF!			
Type of Application (check box to the left)	For submission with Reconciliation Applicatio				

Table 1. Number of FTE Residents Enrolled in Approved Residency Programs Supported by or Rotating at the Children's Hospital

	Number of FTE Residents Enrolled in Approved Residency Programs	*Family Medicine Residents*	*General Internal Medicine Resident*	*Preventive Medicine Residents*	*Geriatric Medicine Residents*	*Osteopathic General Practice Residents*	*General Surgery Residents*	*All Other Non-Pediatric Resident*	*General Pediatric Residents*	*Subspecialty Pediatric Residents (Fellows)*	*Total Non-Pediatric Resident*	*Total*
1.01	**Sponsored by the Children's Hospital and Rotating at the Children's Hospital**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.02	**Sponsored by the Children's Hospital and Rotating at Non-Provider sites**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.03	**Sponsored by Other Hospitals and Rotating at the Children's Hospital**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.04	**Sum of Lines 1.01 through 1.03 (above)**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.05	**Sponsored by the Children's Hospital and Rotating at Other Hospitals**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

OMB N0. 0915-0247
Expiration Date: 06/30/2017

Children's Hospitals Graduate Medical Education Payment Program
Government Performance and Results Act (GPRA) Tables

Name of Applicant:	#REF!				
City:	#REF!	**State:**	#REF!	**Zip Code:**	#REF!
Medicare Provider Number	#REF!				
Fiscal Year in which applying for funding:	F	#REF!			
Type of Application (check box to the left)		**For submission with Reconciliation Application only.**			

Table 2. Hospital's Total and Operating Margins

Total Margins	
Operating Margins	

Table 3. Hospital's Allowable Operating Expenses

Total Allowable Operating Expenses	

Table 4. Hospital's Revenue, Gross Revenue and Expenses Attributed to Patient Care

Revenue and Expense Type	*Inpatient*	*Outpatient*
1. Hospital's gross revenue attributed to Medicaid & SCHIP		
2. Hospital's gross revenue attributed to Medicare		
3. Hospital's gross revenue attributed to self-pay		
4. Hospital's gross revenue attributed to other sources		
5. Hospital's total gross revenue attributed to patient care	$0.00	$0.00
6. Hospital's total expenses attributed to uncompensated care		
7. Hospital's total expenses attributed to charity care		

Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0247
Expiration Date: 06/30/2017

CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM

APPLICATION FORM HRSA 99-5

Public Burden Statement

Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0247
Expiration Date: 06/30/2017

Children's Hospitals Graduate Medical Education Payment Program
Application Checklist

Name of Applicant:

Medicare Provider Number:

FFY in which Applying for CHGME PP Funding: **FFY**

Type of Application (check box to the left): **Initial Application** **Reconciliation Application**

Application Forms and Supporting Documentation	This Column to be Completed by the Applicant Hospital	This Column to be Completed by the CHGME PP
	Is the Listed Item Completed and Attached?	
Forms and Supporting Documentation Required to be Submitted by All Participating Hospitals		
HRSA-99 (2 pages)	Yes No	Yes No ☐
HRSA 99-1 (4 pages)	Yes No	Yes No ☐
HRSA 99-2 (1 page)	☐ Yes No ☐	☐ Yes No ☐
HRSA 99-4 (2 pages) – Required at Reconciliation only	☐ Yes No ☐	☐ Yes No ☐
HRSA 99-5 (1 page)	☐ Yes No ☐	☐ Yes No ☐
Computer Disk Containing Completed HRSA Forms	☐ Yes No ☐	☐ Yes No ☐
One (1) Copy of the Hospital's Completed Application Package. The copy should include all required forms and supporting documentation s presented in the original package.	☐ Yes No ☐	☐ Yes No ☐
Additional Supporting Documentation **The forms and supporting documentation listed below may not applicable to all hospitals. Hospitals should contact their CHGME PP regional manager for assistance and/or clarification.**		
Cover letter detailing any issues that may impact the processing or approval of the children's hospital's application for CHGME PP funding.	Yes No	Yes No
CMS 2552-96 MCR Worksheet E-3, Part IV(s) Required for each cost reporting period identified in the HRSA 99-1 in which the hospital filed a full MCR.	☐ Yes No ☐	☐ Yes No ☐
Affiliation Agreement for an Aggregate Cap Required for each cost reporting period identified in the HRSA 99-1 in which the hospital established a Medicare GME Affiliation Agreement. Please ensure that the most recent version/update is provided (i.e., reflecting any adjustments made to the agreement during the academic year).	☐ Yes No ☐	☐ Yes No ☐
CMS Letter(s) addressing changes to the Hospital's 1996 Base Year Cap as a result of §422 of the MMA and/or §5503 of the ACA (increases and/or decreases).	Yes No	Yes No
Payment Information Form Applicable only to (1) hospitals, which have not previously participated in the CHGME PP and (2) hospitals in which financial institution information has changed since submission of its last application.	☐ Yes No ☐	☐ Yes No ☐

Section IV

Hospital Eligibility

Eligibility Criteria

According to Public Law 106-310, a children's teaching hospital must meet the following eligibility criteria for CHGME Payment Program funding. The hospital must:

1. participate in an approved GME program;
2. have a Medicare Provider Agreement;
3. be excluded from the Medicare inpatient prospective payment system (PPS) under section 1886(d)(1)(B)(iii) of the Social Security Act, and its accompanying regulations[(1)]; and
4. operate as a "freestanding" children's teaching hospital, as defined by the CHGME Payment Program .[(2)]

As per the Children's Hospital GME Support Reauthorization Act of 2013, a freestanding hospital that meets the following criteria may be eligible as a newly qualified hospital for CHGME payments depending on the level of funding appropriated to the program:

1. It has a Medicare payment agreement and is excluded from the Medicare inpatient hospital prospective payment system (IPPS) pursuant to section 1886(d)(1)(B) of the Social Security Act and its accompanying regulations;
2. Its inpatients are predominantly individuals under 18 years of age;
3. It is not otherwise qualified to receive payments under this section or section 1886(H) of the Social Security Act.

[(1)] A hospital with a 3300 series Medicare provider number would meet this criterion (i.e., 55-3300).

[(2)]A children's teaching hospital is considered "freestanding" if it does not operate under a Medicare hospital provider number assigned to a larger health care entity that receives Medicare GME payments.

Additional references:

- *Social Security Act, Section 1886*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*

Changes in Eligibility

A hospital remains eligible for CHGME Payment Program funding as long as it meets the eligibility criteria listed above and trains residents as a "freestanding" children's hospital during the FY for which CHGME Program payments are being made.

If a hospital becomes ineligible for payments:

1. it must notify the CHGME Payment Program immediately of the change in status and the date of the change; and
2. it will be liable for the reimbursement, with interest, of any funds received during the period of ineligibility.

Additional references:

- *CHGME Payment Program, Federal Register Notice, March 1, 2001 (66 FR 12940)*

Section V

Payment Methodology

Payment Methodology

CHGME Payment Program funding to individual children's hospitals is based upon a number of variables, including the rolling average of weighted and un-weighted resident FTE counts, which are used to calculate DME and IME payments, respectively. Payment variables and calculations are subject to all rules and regulations governing the CHGME Payment Program statute, including the June 19, 2000 *Federal Register Notice* for DME *(65 FR 37985),* the March 1, 2001 *Federal Register Notice (66 FR 12940),* the July 20, 2001 *Federal Register Notice* for IME *(66 FR 37980),* the October 22, 2003 *Federal Register Notice (68 FR 60396),* §422 of the MMA of 2003, as well as and Sections 5503, 5504, 5505, and 5506 of the ACA of 2010 and all accompanying policies and regulations.

The rolling average is the average of the resident FTE counts reported by the children's hospital for the [(1)]:

1. most recently filed MCR (or the most recently completed MCR period); and
2. the prior two years.

[(1)] CHGME Payment Program funding to a children's hospital that has not completed three (3) MCR periods will be based upon the hospital's resident FTE count from its "most recently filed" or "most recently completed" MCR period until three (3) MCR periods have been completed.

The rolling average resident FTE count includes all residents except those that qualify for an adjustment after the averaging rules are applied in accordance with 42 CFR 413.77.

The resident FTE count for any MCR period is based upon the number of:

1. allopathic and osteopathic residents following application of the "cap", where applicable; and
2. dental and podiatric residents.

Effective "for portions of cost reporting periods occurring on or after July 1, 2005", the CHGME Payment Program will not include resident FTEs counted against the §422 cap increase in the 3-year rolling average calculation for purposes of DME and IME payments. A*dditional information regarding the CHGME Payment Program's implementation of §422 of the MMA of 2003 is included in Sections VII and VIII of this application package.*

Effective "for portions of cost reporting periods ending on or after July 1, 2011", the CHGME Payment Program will include resident FTEs counted against the §5503 cap increase in the 3-year rolling average calculation for purposes of DME and IME payments. A*dditional information regarding the CHGME Payment Program's implementation of §5503 of the ACA of 2010 is included in Sections VII and VIII of this application package.*

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.77*
- *CMS, Federal Register Notice, August 11, 2004 (69 FR 48916)*

- *CMS, Federal Register Notice, November 24, 2010 (75 FR 72194)*
- *CHGME Payment Program , Federal Register Notice, June 19, 2000 (65 FR 37985)*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*
- *CHGME Payment Program , Federal Register Notice, July 20, 2001 (66 FR 37980)*
- *CHGME Payment Program , Federal Register Notice, October 22, 2003 (68 FR 60396)*

Applicable to the following application forms: *HRSA-99-1, HRSA-99-2, and HRSA-99-4*

Section VI

Hospital Data Needed to Complete the CHGME Payment Program Application

Data Sources for Children's Hospitals that File Full MCRs

To complete a CHGME Payment Program application, hospitals that file full MCRs (i.e., report residents to Medicare on CMS 2552-10, Worksheet E-4 (formerly named CMS 2552-96, Worksheet E-3, Part IV)) must use the data as reflected in their:

1. most recently filed MCR for the period ending on or before December 31, 1996 (the "cap year");
2. most recently filed MCR; and the
3. prior two years.

In addition, hospitals who received adjustments to their cap (increases or decreases) as a result of §422 of the MMA of 2003 must use data included in and provide a copy of their written notification from CMS regarding these adjustments on CMS 2552-10, Worksheet E-4 (formerly named CMS 2552-96, Worksheet E-3, Part VI). A*dditional information regarding the CHGME Payment Program's implementation of §422 of the MMA of 2003 is included in Sections VII and VIII of this application package.*

Also, hospitals who received adjustments to their cap (increases or decreases) as a result of §5503 of the ACA of 2010 must use data included in and provide a copy of their written notification from CMS regarding these adjustments on CMS 2552-10, Worksheet E-4 (formerly named CMS 2552-96, Worksheet E-3, Part IV). A*dditional information regarding the CHGME Payment Program's implementation of §5503 of the ACA of 2010 is included in Sections VII and VIII of this application package.*

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.77*
- *CMS, Federal Register Notice, August 11, 2004 (69 FR 48916)*
- *CMS, Federal Register Notice, November 24, 2010 (75 FR 72192)*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*

Applicable to the following application forms: *HRSA-99-1, HRSA-99-2, and HRSA-99-4*

Data Sources for Children's Hospitals that File Low- or No-Utilization MCRs

To complete a CHGME Payment Program application, hospitals that file low- or no-utilization MCRs (i.e., do not report residents to Medicare on CMS 2552-10, Worksheet E-4 (formerly named CMS 2552-96, Worksheet E-3, Part IV)) must use the data as reflected in their hospital records for the:

1. most recently completed MCR period for the period ending on or before December 31, 1996 (the "cap year");
2. most recently completed MCR period; and the

3. completed MCR periods for the prior two years.

In addition, hospitals who received adjustments to their cap (increases or decreases) as a result of §422 of the MMA of 2003 must use data included in and provide a copy of their written notification from CMS regarding these adjustments. A*dditional information regarding the CHGME Payment Program's implementation of §422 of the MMA of 2003 is included in Sections VII and VIII of this application package.*

Also, hospitals who received adjustments to their cap (increases or decreases) as a result of §5503 of the ACA of 2010 must use data included in and provide a copy of their written notification from CMS regarding these adjustments. A*dditional information regarding the CHGME Payment Program's implementation of §5503 of the ACA of 2010 is included in Sections VII and VIII of this application package.*

Hospitals whose most recently completed MCR period ends **less than** five (5) months prior to the stated CHGME Payment Program initial application deadline may report as their most recently completed MCR period resident FTE counts from their most recently completed or the previously completed MCR period.

> **Example:**
> Charlie's Angels Children's Center (CACC) will file a low-utilization MCR for its 06/30/08 year-end. The CHGME Payment Program application deadline for FY 2009 is August 1, 2008 (approximately 1 month after CACC's year-end). CACC has the option of reporting as its "most recently completed MCR period" data from its 6/30/07 or 6/30/08 year-end. Since CACC needs time to close-out its resident FTE counts and financial records for its 6/30/08 year-end, it decides to use the resident FTE count data from its 6/30/07 cost reporting period to complete Section 4 of HRSA-99-1. Consequently, CACC must use data from its 6/30/06 and 6/30/05 MCR periods to complete Sections 5 and 6 of the HRSA-99-1, respectively. CACC must also use its hospital data from its 6/30/07 cost reporting period to complete all subsequent application forms (i.e., HRSA-99-2, HRSA-99-4, etc.). CACC cannot use the resident FTE count data from its 6/30/08 MCR period until the next CHGME Payment Program initial application cycle (FY 2010).

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.77*
- *CMS, Federal Register Notice, August 11, 2004 (69 FR 48916)*
- *CMS, Federal Register Notice, November 24, 2010 (75 FR 72152)*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*

Applicable to the following application forms: *HRSA-99-1, HRSA-99-2, and HRSA-99-4*

Data Sources for Children's Hospitals that Have Not Completed Three (3) MCR Periods

If a hospital has completed at least one (1), but not more than two (2) MCR periods, CHGME Payment Program funding to the children's hospital will be based upon data from the hospital's "most recently filed" or "most recently completed" MCR period until three (3) MCR periods have been completed. Hence, the hospital will not complete sections 5 and 6 of HRSA-99-1 and its DME and IME payments will not be based upon a three-year rolling average resident FTE count.

Upon completion of three (3) MCR periods, the hospital will complete sections 5 and 6 of HRSA-99-1

and will receive DME and IME payments based upon a three-year rolling average resident FTE count.

In addition, hospitals who received adjustments to their cap (increases or decreases) as a result of §422 of the MMA of 2003 must use data included in and provide a copy of their written notification from CMS regarding these adjustments. A*dditional information regarding the CHGME Payment Program's implementation of §422 of the MMA of 2003 is included in Sections VII and VIII of this application package.*

Also, hospitals who received adjustments to their cap (increases or decreases) as a result of §5503 of the ACA of 2010 must use data included in and provide a copy of their written notification from CMS regarding these adjustments. A*dditional information regarding the CHGME Payment Program's implementation of §5503 of the ACA of 2010 is included in Sections VII and VIII of this application package.*

Additional references:

- *CHGME Payment Program , Federal Register Notice, July 20, 2001 (66 FR 37980)*
- *CMS, Federal Register Notice, August 11, 2004 (69 FR 48916)*
- *CMS, Federal Register Notice, November 24, 2010 (75 FR 72152)*

Applicable to the following application forms: *HRSA-99-1, HRSA-99-2, and HRSA-99-4*

Data Sources for Children's Hospitals that Have Not Completed One (1) MCR Period

New children's teaching hospitals (new to the CHGME Payment Program) training residents who were originally trained in a program that received and will continue to receive funding under the CHGME Payment Program are required to wait until they have completed a MCR period before applying for CHGME Payment Program funding. These hospitals must also apply the 3-year rolling average (to their resident FTE counts) in accordance with Medicare regulations. Over a 3-year period, the "new children's teaching hospital" will gradually increase its number of resident FTEs that can be claimed in the CHGME Payment Program as the children's hospital that originally trained those resident FTEs gradually decreases its resident FTE count for determining payments from the CHGME Payment Program.

New children's teaching hospitals (new to the CHGME Payment Program) training residents previously trained at a hospital that never received (or is no longer receiving) funding under the CHGME Payment Program are eligible for CHGME Payment Program funding without having completed a MCR period. In addition, a hospital that becomes newly eligible for the CHGME Payment Program by starting its own "new medical residency training program" according to Medicare regulation 42 CFR 413.79(e)(1) will also be eligible for CHGME Payment Program funding without having completed a MCR period.

Hospitals that are eligible to receive CHGME Payment Program funding without having completed a MCR period must follow the guidance provided in Section X of this application package which provides special calculation instructions for hospitals that have not completed a MCR report.

Additional references:

- *CHGME Payment Program , Federal Register Notice, July 20, 2001 (66 FR 37980)*

Applicable to the following application forms: *HRSA-99-1, HRSA-99-2, and HRSA-99-4*

Section VII

Determining the Total Number of Resident Full-Time Equivalents

Cap and Cap Year

Section 1886(d)(5)(B)(v) of the Social Security Act established "caps" on the number of allopathic and osteopathic residents that a hospital operating an approved GME program may count when requesting payment for DME and IME costs. A hospital's "**cap**" (hereinafter the "**1996 Base Year Cap**") is currently defined as the "number of un-weighted resident FTEs enrolled in a hospital's allopathic and osteopathic residency programs during the most recent cost reporting period ending on or before December 31, 1996 (the "cap year")." The cap (i.e., limit) on the number of allopathic and osteopathic residents is effective for all cost reporting periods beginning on or after October 1, 1997. Dental and podiatric residents are **exempt** from the cap, but are included in the resident FTE counts for all relevant years to calculate the three-year rolling average.

The "**cap year**" is defined as a hospital's most recent cost reporting period ending on or before December 31, 1996.

> **Example:**
> CACC had 75 resident FTEs enrolled in its allopathic programs, 25 resident FTEs enrolled in its osteopathic programs and 7 resident FTEs enrolled in its dental and podiatric programs for its 6/30/96 MCR period (its most recent MCR period ending on or before December 31, 1996). Hence, CACC's cap for Medicare and CHGME Payment Program purposes is 100 (75+25=100). Note: Dental residents do not count towards the cap amount.

Hospitals that are eligible to receive CHGME funds as "newly qualified hospitals" under the Children's Hospital GME Support Reauthorization Act of 2013, and that do not already have a CMS cap established and are not able to apply for a CMS cap as a new residency training program, will have a "CHGME cap" established using the number of FTEs trained during the most recent Medicare cost report period completed on or before April 7, 2014, the date of enactment of the Children's Hospital GME Support Reauthorization Act of 2013, as verified by the CHGME auditors during the Resident FTE Assessment Program.

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.79*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*
- *CHGME Payment Program , Federal Register Notice, July 20, 2001 (66 FR 37980)*

Applicable to the following application forms: *HRSA-99-1 and HRSA-99-2*

Adjustments to a Hospital's Cap

As noted above, Section 1886(d)(5)(B)(v) of the Social Security Act established caps on the number of allopathic and osteopathic residents that a hospital operating an approved GME program may count when requesting payment for DME and IME costs. While Medicare and the CHGME Payment Program only

make DME and IME payments for the number of allopathic and osteopathic resident FTEs up to a hospital's "1996 Base Year Cap", some hospitals have trained allopathic and osteopathic residents in excess of their 1996 Base Year Cap. There are also a number of hospitals that have reduced their resident positions to a level below their 1996 Base Year Cap.

Subsequent legislative actions and related Federal Register notices provisions have been published addressing these issues allowing a hospital's cap to be permanently changed (increased or decreased) by CMS or temporarily adjusted at the request of the hospital and approved by CMS. These provisions are detailed below.

§422 of the Medicare Modernization Act of 2003

In December 2003, the President signed the MMA of 2003 (also known as the Medicare Prescription Drug and Improvement Act of 2003), Public Law 108-173. §422 of the MMA, added Section 1886(h)(7) to the SSA. This provision reduced the 1996 Base Year Cap for certain hospitals and redistributed those positions to other hospitals that applied for and received an increase to their 1996 Base Year Cap under §422. Hereinafter, any decreases to a hospital's 1996 Base Year Cap as a result of §422 will be referred to as the "**§422 Cap Reduction**" and any increases to the 1996 Base Year Cap as a result of §422 will be referred to as the **"§422 Cap Increase**." Authority for implementing §422 of the MMA was delegated to the CMS. Determinations made and implemented by CMS in response to §422 are final and not subject to appeal, and binding on the CHGME Payment Program.

Under the CHGME Payment Program statute, by incorporation of the SSA provisions, the HRSA must implement the counting law and rules of Medicare, which include those related to the implementation of §422 of the MMA. Additional information regarding the CHGME Payment Program's implementation of §422 of the MMA can be found in Section VIII of this application package.

§5503 of the Affordable Care Act of 2010

In March 2010, the President signed the ACA of 2010 (also known as the Affordable Care Act of 2010), Public Law 111-148. §5503 of the ACA added Section 1886(h)(8)(F) to the SSA. This provision reduced the 1996 Base Year Cap for certain hospitals and redistributed those positions to other hospitals that applied for and received an increase to their 1996 Base Year Cap under §5503. Hereinafter, any decreases to a hospital's 1996 Base Year Cap as a result of §5503 will be referred to as the "**§5503 Cap Reduction**" and any increases to the 1996 Base Year Cap as a result of §5503 will be referred to as the **"§5503 Cap Increase**." Authority for implementing §5503 of the ACA was delegated to the CMS. Determinations made and implemented by CMS in response to §5503 are final and not subject to appeal, and binding on the CHGME Payment Program.

Under the CHGME Payment Program statute, by incorporation of the SSA provisions, the HRSA must implement the counting law and rules of Medicare, which include those related to the implementation of §5503 of the ACA. Additional information regarding the CHGME Payment Program's implementation of §5503 of the ACA can be found in Section VIII of this application package.

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.79(c)(2)*

Medicare GME Affiliation Agreements and Other Regulations Allowing the Establishment or Adjustment of a Hospital Cap

Hospitals that meet criteria as currently eligible hospitals (Section IV) that were not in existence for the most recent cost reporting period ending on or before December 31, 1996 do not have a "1996 Base Year Cap" and are, therefore, "capped" to a resident FTE count of zero "0". Hence, eligible hospitals must obtain (or adjust) their 1996 Base Year Cap (or lack thereof) in order to receive CHGME Payment Program funding.

To provide an adjustment to a cap, the CHGME Payment Program will allow hospitals to add resident FTEs to their "1996 Base Year Cap" based on the following Medicare and CHGME Payment Program regulations:

1. the formation of a new medical residency program as described in 42 CFR 413.79(e)(1); or
2. the redistribution of FTE resident positions from a closed hospital as described in §5506 of the ACA (75 FR 72212, November 24, 2010), with the following exceptions:
    i. In the first cost reporting period in which the hospital takes displaced residents and the hospital closure occurs, the applying hospital would receive a temporary cap adjustment, and the displaced residents FTEs would be exempt from the three-year rolling average and the IRB ratio cap.
    ii. In the cost reporting period following the one in which the hospital closure occurred, the applying hospital's permanent cap increase would take effect, and the displaced resident FTEs would no longer be exempt from the three-year rolling average and the IRB ratio cap.
3. the execution of a Medicare GME Affiliation Agreement for an aggregate cap, as set forth in 42 CFR 413.79(f) and 63 FR 26338 as published in the Federal Register on May 12, 1998, with the following exceptions:
    i. A "new children's teaching hospital" participating in the CHGME Payment Program for the first year must establish an effective date of the agreement for purposes of the CHGME Payment Program . For the first year, unless otherwise specified, the Department will use as the effective date of the Medicare GME Affiliation Agreement for an aggregate cap the date that the hospital becomes eligible for CHGME Payment Program funding. This effective date will only apply to the CHGME Payment Program. A hospital must also have an effective date of July 1st for the Medicare Program. Subsequent to the first year of the Medicare GME Affiliation Agreement, the effective date must comply with the above-cited Federal Register final rule, which specifies an effective date of July 1st for all affiliation agreements.

The CHGME Payment Program allows this exception because hospitals must meet eligibility criteria and have their caps determined prior to the CHGME Payment Program application

deadline. If the CHGME Payment Program application deadline occurs before July 1st, some hospitals would have a cap of zero and thus be excluded from receiving funds. By deviating from the prescribed Medicare final rule, the CHGME Payment Program will not place some hospitals in this position.

Unlike the Medicare Program, for the first year that a hospital is eligible to participate in the CHGME Payment Program, the CHGME Payment Program will not prorate the cap based on the effective date of the cap.

Instead, the full value of the cap as determined by the Medicare GME Affiliation Agreement will be used. For purposes of the CHGME Payment Program and its application forms, a hospital that is now starting to train residents previously trained at a hospital that never received or is no longer receiving funds from the CHGME Payment Program will be allowed to use the cap agreed upon in the Medicare GME Affiliation Agreement until the full value of the cap is reflected in the MCR. Afterwards, the hospital will use the resident FTE count and cap from its filed MCR as indicated in Section VI of this application package.

Example:

CACC opened as a freestanding children's hospital on January 1, 2008 and would like to apply for FY 2009 CHGME Payment Program funding. The CHGME Payment Program FY2009 application deadline is August 1, 2008. Since CACC did not train residents in 1996, it has a cap of zero, but was able to arrange a Medicare GME Affiliation Agreement for an aggregate cap with Shirley Temple Medical Center in which CACC's current residents had previously trained.

CACC did the following in order to apply for CHGME Payment Program funding:

1. Established a cap by forming a Medicare GME Affiliation Agreement with Shirley Temple Medical Center for an aggregate cap.
2. The agreement had an effective date of January 1, 2008 (for CHGME Payment Program purposes only) and an effective date of July 1, 2008 and expiration date of June 30, 2009 for and in accordance with Medicare rules and regulations.
3. CACC and Shirley Temple Medical Center filed the agreement with their Medicare FIs (the hospitals have different Medicare FIs) before June 30, 2008 (in accordance with Medicare rules and regulations) and provided a signed copy to the CHGME Payment Program following acceptance by the FIs.

Hospitals that report residents to Medicare and are part of an affiliated group may elect to apply the resident FTE limit on an aggregate basis under Medicare rules and regulations. If the combined resident FTE counts for the individual members of the group exceed the aggregate limit, each hospital's resident FTE cap will be adjusted per the agreement between the members of the affiliated group. These adjustments must be reflected in the filed MCR in order to be considered for the CHGME Payment Program.

Hospitals that receive an increase to their 1996 Base Year Cap from CMS under §422 of the MMA of 2003 and participate in a Medicare GME Affiliation Agreement under 42 CFR 413.79(f) on or after July 1, 2005, may only affiliate for the purpose of adjusting their (original) 1996 Base Year Cap. The additional slots that a hospital receives under §422 may not be aggregated and applied (through Medicare GME Affiliation Agreements) to the cap of any other hospitals.

The additional slots that a hospital receives under §5503 may not be aggregated and applied

(through Medicare GME Affiliation Agreements) to the cap of any other hospitals for the 5-year period probationary period. Hospitals that receive an increase to their 1996 Base Year Cap from CMS under §5503 of the ACA of 2010 and participate in a Medicare GME Affiliation Agreement under 42 CFR 413.79(f) for cost reporting periods ending on or after July 1, 2011, may only affiliate for the purpose of adjusting their (original) 1996 Base Year Cap.

After the 5-year probationary period, hospitals that receive an increase to their 1996 Base Year Cap from CMS under §5503 of the ACA of 2010 and participate in a Medicare GME Affiliation Agreement under 42 CFR 413.79(f) for cost reporting periods ending on or after July 1, 2011, may affiliate for the purpose of adjusting their (original) 1996 Base Year Cap and their §5503 Cap Increase. The additional slots that a hospital receives under §5503 may be aggregated and applied (through Medicare GME Affiliation Agreements) to the cap of any other hospitals following the 5-year probationary period beginning July 1, 2016.

Hospitals should refer to 42 CFR 413.79(f) for additional information on adjustments to the cap.

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.79(f)*
- *CMS, Federal Register Notice, November 24, 2010 (75 FR 72195)*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*
- *CHGME Payment Program , Federal Register Notice, July 20, 2001 (66 FR 37980)*

Applicable to the following application forms: *HRSA-99-1, HRSA-99-2, and HRSA-99-4*

Exceeding the Cap

For DME payment calculations if a hospital's un-weighted resident FTE count for allopathic and osteopathic residents exceeds its FTE limit ("cap"), the weighted count is reduced by the ratio of the resident FTE limit to the actual un-weighted resident FTE count for the subject cost reporting period. A*dditional information regarding the CHGME Payment Program's implementation of §422 of the MMA of 2003 and §5503 of the ACA of 2010 is provided below.*

Example:
CACC, per its Medicare GME Affiliation Agreement, has a cap of 100. For its 6/30/08 MCR, CACC reported an un-weighted resident FTE count of 150 and a weighted count of 105 for its allopathic and osteopathic programs.

For DME payment purposes, CACC would determine its weighted allopathic and osteopathic resident FTE count by taking its cap divided by its total un-weighted resident FTE count and multiplying that product by the total weighted resident FTE for allopathic and osteopathic residents [(100/150) x 105 = 70.00]. *The weighted count of any dental and podiatric residents trained during this MCR period would be added to the 70.00 as dental and podiatric residents are exempt from (i.e., not subject to) the cap.*

For IME payment calculations if a hospital's un-weighted resident FTE count for allopathic and osteopathic residents exceeds its FTE limit ("cap"), the hospital must report the lesser of the un-weighted resident FTE count or the cap for the subject cost reporting period. A*dditional information regarding the CHGME Payment Program's implementation of §422 of the MMA of 2003 and §5503 of the ACA of 2010 is provided below.*

Example:
CACC, per its Medicare GME Affiliation Agreement, has a cap of 100. For its 6/30/08 MCR, CACC reported an un-weighted resident FTE count of 150 and a weighted count of 105 for its allopathic and osteopathic programs.

For IME payment purposes, CACC would report 100.00 [the lesser of the un-weighted allopathic and osteopathic resident FTE count (150) or the cap (100)]. *The un-weighted count of any dental and podiatric residents trained during this MCR period would be added to the 100.00 as dental and podiatric residents are exempt from (i.e., not subject to) the cap.*

Impact of §422 of the MMA When a Hospital Exceeds Its Cap

§422 of the MMA will affect the determination of DME and IME payments for each of the children's hospitals participating in the CHGME Payment Program. The CHGME Payment Program will begin accounting for the redistribution of the 1996 caps under §422 of the MMA in determining DME and IME payments starting with "portions of a hospital's cost reporting periods occurring on or after July 1, 2005."

Children's hospitals whose cap has been reduced under §422 of the MMA will report and be paid based on the §422 Cap Reduction effective "for portions of cost reporting periods occurring on or after July 1, 2005." The 1996 Base Year Cap will be used for MCR periods prior to the effective date. Children's hospitals will be asked to submit a copy of the letter they received from CMS informing them of the reduction in their cap that includes the actual reduction. The full effect of the reduction for a given hospital will take about three years following implementation of §422 when all three MCR periods reflected in the hospital's application for CHGME Payment Program funding are affected by the §422 Cap Reduction.

For children's hospitals who received an increase to their 1996 Base Year Cap under §422 of the MMA, the CHGME Payment Program will not include resident FTEs counted against the §422 Cap Increase in the 3-year rolling average calculation for purposes of DME and IME payments effective for portions of cost reporting periods and discharges occurring on or after July 1, 2005. In addition, effective for discharges occurring on or after July 1, 2005, the CHGME Payment Program will not apply the intern/resident to bed (IRB) ratio cap to the residents claimed against a hospital's §422 Cap Increase. However, residents claimed against the 1996 Base Year Cap will be subject to the 3-year rolling average and will be subject to the IRB ratio cap.

Impact of §5503 of the ACA When a Hospital Exceeds Its Cap

§5503 of the ACA will affect the determination of DME and IME payments for each of the children's hospitals participating in the CHGME Payment Program. The CHGME Payment Program will begin accounting for the redistribution of the 1996 caps under §5503 of the ACA in determining DME and IME payments starting with "portions of a hospital's cost reporting periods ending on or after July 1, 2011."

Children's hospitals whose cap has been reduced under §5503 of the ACA will report and be paid based on the §5503 Cap Reduction effective "for portions of cost reporting periods ending on or after July 1, 2011." The 1996 Base Year Cap and §422 of the MMA (if applicable) will be used for MCR periods prior to the effective date. Children's hospitals will be asked to submit a copy of

the letter they received from CMS informing them of the reduction in their cap that includes the actual reduction. The full effect of the reduction for a given hospital will immediately take effect following implementation of §5503 when the current MCR period reflected in the hospital's application for CHGME Payment Program funding is affected by the §5503 Cap Reduction.

For children's hospitals who received an increase to their 1996 Base Year Cap under §5503 of the ACA, the CHGME Payment Program will include resident FTEs counted against the §5503 Cap Increase in the 3-year rolling average calculation for purposes of DME and IME payments effective for portions of cost reporting periods ending on or after July 1, 2011. In addition, effective for portions of cost reporting periods ending on or after July 1, 2011, the CHGME Payment Program will apply the intern/resident to bed (IRB) ratio cap to the residents claimed against a hospital's §5503 Cap Increase.

Additional references:

- *CMS, 42 CFR 413.79*
- *CMS, Federal Register Notice, November 24, 2010 (75 FR 72194)*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*

Applicable to the following application forms: *HRSA 99-1and HRSA 99-2*

Eligible Residency Programs (Approved Training Programs)

Residents may be included in a hospital's resident FTE count for CHGME Payment Program purposes if the residency program (in which the resident is enrolled) meets **one** of the following criteria:

- The program must be approved by one of the following accrediting bodies:

    1. Accreditation Council for Graduate Medical Education (ACGME);
    2. Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association;
    3. Commission on Dental Accreditation of the American Dental Association; or
    4. Council of Podiatric Medicine Education of the American Podiatric Medical Association.
- The program may count towards certification of the participant in a specialty or subspecialty listed in the **current** edition of the Directory of Graduate Medical Education Programs (published by the American Medical Association) or the Annual Report and Reference Handbook (published by the American Board of Medical Specialties).

- The program is approved by the ACGME as a fellowship program in geriatric medicine; or

- The program would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.75(b)*

Applicable to the following application forms: *HRSA-99-1, HRSA-99-2, and HRSA-99-4*

Eligible Residents

In order to be counted in CHGME payment calculations, a resident must be:

- in an approved residency training program *(see Eligible Residency Program above)*;

and either

- a graduate of an accredited medical school in the U.S. or Canada; **or**
- have passed the United States Medical Licensing Examination (USMLE) Parts I & II (international or foreign medical graduates)

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.75(b)*
- *CMS, 42 CFR 413.80*

Applicable to the following application forms: *HRSA-99-1, HRSA-99-2, and HRSA-99-4*

International Medical Graduates (IMGs)

An IMG [(formerly known as a foreign medical graduate (FMG)] is a resident who is not a graduate of a medical, osteopathy, dental, or podiatry school, respectively, accredited or approved as meeting the standards necessary for accreditation by the:

1. Liaison Committee on Medical Education of the American Medical Association;
2. American Osteopathic Association;
3. Commission on Dental Accreditation; or the
4. Council on Podiatric Medical Education.

In order for an IMG to be included in a hospital's resident FTE count, s/he must have passed Parts I and II of the USMLE and be enrolled in an eligible residency program.

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.75(b)*
- *CMS, 42 CFR 413.80*

Applicable to the following application forms: *HRSA-99-1, HRSA-99-2, and HRSA-99-4*

Resident Full-Time Equivalent (FTE) Counts

Resident FTE counts are based on the number of residents training at the hospital complex and certain non-hospital/non-provider settings/sites throughout the hospital's fiscal year. Residents are counted as FTEs based on the total time necessary to fill a full-time residency slot for the year.

For purposes of clarification, a resident FTE is measured in terms of time worked during a residency training year. It is not a measure of the number of individual residents who are working.

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.78*

Applicable to the following application forms: *HRSA-99-1, HRSA-99-2, and HRSA-99-4*

Initial Residency Period (IRP)

Residents are divided into two categories, those in their:

1. initial residency period (IRP);
   i. Effective July 1, 1995, an IRP is defined as the minimum number of years required for board eligibility.
   ii. For osteopathic, dentistry, and podiatric programs, the IRP is the minimum number of years of formal training necessary to satisfy the requirements of the approving body for those programs.
   iii. Prior to July 1, 1995, an IRP is defined as the minimum number of years required for board eligibility in a specialty or subspecialty plus 1 year (not to exceed 5 years with some exceptions).

2. and those beyond their IRP.

Example:

The IRP for pediatrics is 3 years. Therefore, the initial residency period for all pediatric subspecialties (e.g., pediatric cardiology) is three years.

The IRP for general surgery is 5 years. Therefore, the initial residency period of all surgical subspecialties (e.g., pediatric surgery) is 5 years even if the training program requires a longer period of training.

A Pediatric Surgery (subspecialty) resident (or fellow) who previously completed a 5-year general surgery residency program and is now in his first year of subspecialty training (in Pediatric Surgery) is beyond his IRP. His IRP was 5 years (general surgery).

Exceptions apply to the IRP for residents enrolled in preventive medicine, geriatric medicine, transitional year and combined residency programs. Refer to 42 CFR 413.79(a) for additional information on the IRP and exceptions.

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.79(a)*

Applicable to the following application forms: *HRSA-99-1*

Weighting of Resident FTE Counts

The CHGME Payment Program, like Medicare, assigns a 0.5 (or ½) weighting factor to residents who are beyond their IRP. Hence a resident who is beyond his or her initial residency period is factored by 0.5 regardless of the number of years or length of the training program in which s/he is currently enrolled.

> **Example:**
> John Doe completed a 3-year pediatric residency program on June 30, 2007 at CACC. Following completion of his residency program, John continued his training in a pediatric cardiology fellowship program also at CACC. During the first year of his fellowship program (July 1, 2007 to June 30, 2008), John spent 40% of the academic year at CACC and 60% of the academic year rotating to other teaching hospitals.
>
> CACC's MCR period is the same as the academic year (July 1 to June 30). Hence, CACC would report John as 0.20 for the MCR period ending June 30, 2000 [(40/100) x 0.5 = .20]. CACC must weight John's resident FTE count because the IRP for pediatrics is 3 years and John is in his 4th year of training (3 years of residency training and 1 year of fellowship training).

For CHGME Payment Program purposes, the weighting of resident FTE counts is also applicable to the increase in resident FTEs based on §422 of the MMA and §5503 of the ACA et al.

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.79(b)*

Applicable to the following application forms: *HRSA-99-1*

Where Residents Are Counted

The time a resident spends anywhere within the hospital complex (see "Hospital Complex" below) may be included in the resident FTE count for CHGME Payment Program purposes. In addition, the time spent by residents in certain non-hospital/non-provider settings/sites is counted if the criteria identified below (under "Non-Provider/Non-Hospital Settings and Written Agreements") are met.

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.78*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*

Applicable to the following application forms: *HRSA-99-1, HRSA-99-2, and HRSA-99-4*

Hospital Complex

The time a resident spends anywhere within the hospital complex (as defined in 42 CFR 413.65) may be included in the resident FTE count for CHGME Payment Program purposes.

The CMS final rule implementing the per resident amount (PRA) methodology for payment of the direct GME costs of approved GME activities defines a hospital complex as "hospitals and hospital-based providers and sub providers" (54 FR 40286, September 29, 1989). The term "hospital" is defined in Section 1861(e) of the Social Security Act as, in part, an institution which is primarily engaged in providing, by or under the supervision of physicians, diagnostic and therapeutic services to inpatients. The term "provider of services" is defined in Section 1861(u) of the Social Security Act as a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of Section 1814(g) and Section 1835(c), a fund. The term "sub provider" is defined in the Provider Reimbursement Manual (PRM) Part II, Section 2405(b) as "a portion of a general hospital which has been issued a sub provider identification number because it offers a clearly different type of service from the remainder of the hospital, such as long-term psychiatric."

The CHGME Payment Program, however, does not differentiate between PPS and non-PPS locations within a hospital complex.

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.65*
- *CMS, 42 CFR 413.78(a)*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*

Applicable to the following application forms: *HRSA-99-1, HRSA-99-2, and HRSA-99-4*

Non-Provider/Non-Hospital Settings and Written Agreements

The time a resident spends in a non-provider (or non-hospital) setting such as a physician's office or a freestanding community health center in connection with an approved program may be included in the resident FTE count if the criteria in Federal regulation 42 CFR 413.78 and §5504 of the ACA (75 FR 72141, November 24, 2010) are met. For CHGME Payment Program purposes, 42 CFR 413.78 and §5504 of the ACA (75 FR 72141, November 24, 2010) applies to both DME and IME funding received under the CHGME Payment Program.

Written agreements covering residents' time spent in non-provider/non-hospital settings shall cover a period of one year and must commence on the start of the cost reporting period and must be between the hospital and the non-hospital setting, not between the related School of Medicine (SOM), School of Podiatric Medicine (SOPM), or School of Dentistry (SOD). Refer to 42 CFR 413.78 and §5504 of the ACA (75 FR 72134, November 24, 2010) for additional information on written agreements.

Additional references and application forms:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.78*
- *CMS, Federal Register Notice, November 24, 2010 (75 FR 72134)*

- *CMS, Federal Register Notice, November 24, 2010 (75 FR 72141)*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*

Applicable to the following application forms: *HRSA-99-1, HRSA-99-2, and HRSA-99-4*

Partial Resident Full-Time Equivalents (FTEs)

A partial resident FTE is a resident who does not spend all time that is part of the approved training program in the hospital complex or qualified non-hospital setting. A resident will count as a partial resident FTE based on the proportion of allowable time worked at the children's hospital and qualified non-hospital (provider) settings compared to the total time necessary to fill a full-time residency slot. Instances where a resident would be counted as a partial resident FTE include, if the resident:

1. is part-time;
2. rotates to other hospitals as part of the approved training program sponsored by the children's hospital;
3. is in a program sponsored by another hospital and spends one or more rotations at the children's hospital;
4. is on maternity leave;
5. joins or leaves a program mid-year; or
6. passes the USMLE mid-year.

Hospitals should consult with their FIs regarding additional exceptions.

The sum of partial FTE resident counts at all institutions where an individual resident works as part of his/her approved residency program may not exceed 1.0 FTE. Also, time spent by residents moonlighting ***may not*** be counted.

> **Example:**
> During the course of the year, a full-time resident in orthopedic surgery spends 90 days at the children's hospital and 275 days at the hospital sponsoring the residency program. The resident would count as a 0.25 FTE at the children's hospital [90/365 = 0.2465 (rounded to 0.25)].
>
> A part-time third year resident in pediatrics works 4 days week. The normal workweek for a full time third year pediatric residents is 6 days per week. The resident would count as 0.67 FTE [4/6 = .6666 (rounded to 0.67)]
>
> During the course of the year, a full-time resident (who is also a foreign medical graduate) is enrolled in his second year of a three-year family practice residency program at CACC. The resident spends the entire academic year (2007-2008) at CACC and does not rotate to any other sites. The resident took and passed Part I of the USMLE in September 2007. On May 1, 2008, the resident sat for Part II of the USMLE and is awaiting the examination results. In June 2008 the resident learns that he passed Part II of the USMLE. Since CACC's year-end is June 30, CACC may count and include the resident in their resident FTE counts (as a partial FTE) for the period May 1, 2008 (the date he took the examination) to June 30, 2008 (CACC's year end). The resident would count as 0.17 FTE [61 days (31 days in May + 30 days in June)/ 365 days = 0.1671 (rounded to 0.17)].

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.78(b)*

Applicable to the following application forms: *HRSA-99-1, HRSA-99-2, and HRSA-99-4*

Research Time

Research may be included in a hospital's resident FTE count if the research is part of the residency program and the resident carries out the research in:

1. the children's hospital complex (clinical or bench research); or
2. in a non-provider setting where the research involves patient care and the compensation for both the residents, the faculty and other teaching costs are paid by the children's hospital (requirements listed at 42 CFR 413.78 (66 FR 39896, Aug. 1, 2001) and §5505 of the ACA (75 FR 72144, Nov. 24, 2010) must be met.

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.75*
- *CMS, 42 CFR 413.78*
- *CMS, Federal Register Notice, November 24, 2010 (75 FR 72144)*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*

Applicable to the following application forms: *HRSA-99-1, HRSA 99-2, and HRSA 99-4*

Resident FTE Count Accuracy and Documentation

Children's hospitals are responsible for the accuracy of the resident FTE counts submitted to HRSA and are subject to audit. More specifically, the Secretary, by statute, must "determine any changes to the number of residents reported by a hospital in the *(initial)* application of the hospital for the current FY for both direct and indirect expense amounts." This mandate is accomplished through the Resident FTE Assessment Program carried out by the CHGME Payment Program (see "Application Cycle and Deadlines"). Children's hospitals are not required to submit with their completed initial applications for CHGME Payment Program funding, documentation in support of the resident FTE data reported in their applications. However, at the time children's hospitals certify their applications, the hospital should possess documentation in accordance with 413.75(d) and other applicable Medicare record-keeping regulations. Hospitals that do not report resident FTE counts to Medicare are **not exempt** from this policy.

The CHGME Payment Program has developed a Documentation Guidance (document) and an accompanying sample documentation binder to assist participating hospitals in collecting and providing the documentation necessary to support resident FTEs reported by a children's hospital in its initial application for CHGME Payment Program funding. Participating children's hospitals can use this document and the accompanying sample binder for compiling and organizing the information/data to be provided to the CHGME FI during the Resident FTE Assessment process. The Documentation Guidance (document) is available at http://bhpr.hrsa.gov/childrenshospitalgme/apply.htm.

Additional references:

- *CMS, 42 CFR 413.20*
- *CMS, 42 CFR 413.24*
- *CMS, 42 CFR 413.75(d)*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*

Applicable to the following application forms: *HRSA-99-1, HRSA 99-2, and HRSA 99-4*

Section VIII

Special Instructions for Calculating Reductions and Increases to a Hospital's 1996 Base Year Cap as a Result of §422 of the Medicare Modernization Act of 2003

Hospitals that received an increase or reduction to their 1996 Base Year Cap as a result of §422 of the MMA must use the following methodology for calculating and claiming resident FTE counts against their caps.

Decrease to a Hospital's 1996 Base Year Cap (§422 Cap Reduction)

Children's hospitals who received a decrease to their 1996 Base Year Cap as a result of §422 of the MMA will report and be paid based on the §422 Cap Reduction effective "for portions of cost reporting periods occurring on or after July 1, 2005." The 1996 Base Year Cap will be used for MCR periods prior to the effective date. Children's hospitals will be asked to submit a copy of the letter they received from CMS informing them of the reduction in their cap that includes the actual reduction amount. The full effect of the reduction for a given hospital will take about three years following the implementation of §422 when all three MCR periods reflected in the hospital's application for CHGME Payment Program funding are subject to the §422 Cap Reduction.

> **Example:**
> CACC had 75 resident FTEs enrolled in its allopathic programs, 25 resident FTEs enrolled in its osteopathic programs and 7 resident FTEs enrolled in its dental and podiatric programs for its 6/30/96 MCR period (its most recent MCR period ending on or before December 31, 1996). Hence, CACC's 1996 Base Year Cap for Medicare and CHGME Payment Program purposes is 100 (75+25=100). However, in December 2004 CACC received a letter from CMS indicating that their 1996 Base Year Cap would be reduced by 7.50 resident FTEs under §422 of the MMA. CACC's new, revised cap is now 92.50 (1996 Base Year Cap - §422 Cap Reduction). Any *dental and podiatric residents trained during this MCR period would not be included in the 1996 Base Year Cap or the "new, revised" cap as dental and podiatric residents are exempt from (i.e., not subject to) the cap.*

Increase to a Hospital's 1996 Base Year Cap (§422 Cap Increase)

Children's hospitals who received an increase to their 1996 Base Year Cap as a result of §422 of the MMA will report and be paid based on the §422 Cap Increase effective "for portions of cost reporting periods occurring on or after July 1, 2005." The 1996 Base Year Cap will be used for MCR periods prior to the effective date. Children's hospitals will be asked to submit a copy of the letter they received from CMS informing them of the adjustment to their cap that includes the actual increase amount. It is important to note that a §422 Cap Increase is not automatically added to a hospital's 1996 Base Year Cap. A hospital's ability to utilize their §422 Cap Increase is contingent upon whether the hospital is training above or below their total adjusted cap (including the 1996 Base Year Cap and the §5503 Cap (if applicable)). Examples are provided below.

CACC had 75 resident FTEs enrolled in its allopathic programs, 25 resident FTEs enrolled in its osteopathic programs and 7 resident FTEs enrolled in its dental and podiatric programs for its 6/30/96 MCR period (its most recent MCR period ending on or before December 31, 1996). Hence, CACC's 1996 Base Year Cap for Medicare and CHGME Payment Program purposes is 100 (75+25=100). However, in December 2004 CACC received a letter from CMS indicating that their 1996 Base Year Cap would be increased by 20 resident FTEs under §422 of the MMA. CACC now has a 1996 Base Year Cap of 100 and a §422 Cap Increase of 20.

Examples (for Hospitals Training "Above" Their 1996 Base Year Cap):

Example #1: During CACC's most recent MCR period, CACC claimed 110 allopathic and osteopathic resident FTEs and 7 dental and podiatric resident FTEs. Based on CACC's 1996 Base Year Cap of 100 and §422 Cap Increase of 20, CACC would claim 100 resident FTEs against its 1996 Base Year Cap and the remaining 10 resident FTEs would be claimed against its §422 Cap Increase. A*ny dental and podiatric residents trained during this MCR period would be added to the total (un)weighted allopathic and osteopathic resident FTEs following application of the caps as dental and podiatric residents are exempt from (i.e., not subject to) the cap.*

Example #2: During CACC's most recent MCR period, CACC claimed 140 allopathic and osteopathic resident FTEs and 7 dental and podiatric resident FTEs. Based on CACC's 1996 Base Year Cap of 100 and §422 Cap Increase of 20, CACC would claim 100 resident FTEs against its 1996 Base Year Cap and the remaining 40 resident FTEs would be claimed against its §422 Cap Increase. As CACC's number of resident FTEs claimed exceeds both its 1996 Base Year Cap and its §422 Cap Increase, the DME and IME payment calculation methodology described in Section VII of this application package ("Exceeding the Cap") would be followed. A*ny dental and podiatric residents trained during this MCR period would be added to the total (un)weighted allopathic and osteopathic resident FTEs following application of the caps as dental and podiatric residents are exempt from (i.e., not subject to) the cap.*

Examples (for Hospitals Training "Below" Their 1996 Base Year Cap):

Example #1: During CACC's most recent MCR period, CACC claimed 95 allopathic and osteopathic resident FTEs and 7 dental and podiatric resident FTEs. Based on CACC's 1996 Base Year Cap of 100 and a §422 Cap Increase of 20, CACC would claim 95 resident FTEs against its 1996 Base Year Cap and zero "0" residents against its §422 Cap Increase. Any dental and podiatric residents trained during *this MCR period would be added to the total (un)weighted allopathic and osteopathic resident FTEs following application of the caps as dental and podiatric residents are exempt from (i.e., not subject to) the cap*

Example #2: During CACC's most recent MCR period, CACC claimed 105 allopathic and osteopathic resident FTEs and 7 dental and podiatric resident FTEs. In August 2011 CACC received a letter from CMS indicating that their 1996 Base Year Cap would be increased by 10 resident FTEs under §5503 of the ACA. Based on CACC's 1996 Base Year Cap of 100, a §5503 Cap Increase of 10, and a §422 Cap Increase of 20, CACC would claim 100 resident FTEs against its 1996 Base Year Cap, five "5" resident FTE against its §5503 Cap Increase and zero "0" residents against its §422 Cap Increase. *Any dental and podiatric residents trained during this MCR period would be added to the total (un)weighted allopathic and osteopathic resident FTEs following application of the caps as dental and podiatric residents are exempt from (i.e., not subject to) the cap*

Additional references:

- *Social Security Act, Section 1886(h)(7)*
- *CMS, Federal Register Notice, November 24, 2010 (75 FR 72193)*
- *CMS, 42 CFR 413.79(b)*

Applicable to the following application forms: *HRSA-99-1*

Section IX

Special Instructions for Calculating Reductions and Increases to a Hospital's 1996 Base Year Cap as a Result of §5503 of the Affordable Care Act of 2010

Hospitals that received an increase or reduction to their 1996 Base Year Cap as a result of §5503 of the ACA must use the following methodology for calculating and claiming resident FTE counts against their caps. It is important to note that 75% of the §5503 Cap Increase must be used to train residents in primary care (defined in 42 CFR 413.75(b)) as an approved program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice) and general surgery programs. A*dditional information regarding §5503 Cap Increase and its resident FTE requirements is specified in §1886(h)(8)(B)(ii) of the SSA.*

Decrease to a Hospital's 1996 Base Year Cap (§5503 Cap Reduction)

Children's hospitals who received a decrease to their 1996 Base Year Cap as a result of §5503 of the ACA will report and be paid based on the §5503 Cap Reduction effective "for portions of cost reporting periods ending on or after July 1, 2011." The 1996 Base Year Cap and the §422 Cap Reduction (if applicable) will be used for MCR periods prior to the effective date. Children's hospitals will be asked to submit a copy of the letter they received from CMS informing them of the reduction in their cap that includes the actual reduction amount. The full effect of the reduction for a given hospital will immediately take effect following implementation of §5503 when the current MCR period reflected in the hospital's application for CHGME Payment Program funding is affected by the §5503 Cap Reduction.

Example:
CACC had 75 resident FTEs enrolled in its allopathic programs, 25 resident FTEs enrolled in its osteopathic programs and 7 resident FTEs enrolled in its dental and podiatric programs for its 6/30/96 MCR period (its most recent MCR period ending on or before December 31, 1996). Hence, CACC's 1996 Base Year Cap for Medicare and CHGME Payment Program purposes is 100 (75+25=100). However, in August 2011 CACC received a letter from CMS indicating that their 1996 Base Year Cap would be reduced by 7.50 resident FTEs under §5503 of the ACA. CACC's new, revised cap is now 92.50 (1996 Base Year Cap - §5503 Cap Reduction). Any *dental and podiatric residents trained during this MCR period would not be included in the 1996 Base Year Cap or the "new, revised" cap as dental and podiatric residents are exempt from (i.e., not subject to) the cap.*

Increase to a Hospital's 1996 Base Year Cap (§5503 Cap Increase)

Children's hospitals who received an increase to their 1996 Base Year Cap as a result of §5503 of the MMA will report and be paid based on the §5503 Cap Increase effective "for portions of cost reporting periods ending on or after July 1, 2011." The 1996 Base Year Cap and the §422 Cap Increase (if applicable) will be used for MCR periods prior to the effective date. Children's hospitals will be asked to submit a copy of the letter they received from CMS informing them of the adjustment to their cap that includes the actual increase amount. It is important to note that a §5503 Cap Increase is not automatically added to a hospital's 1996 Base Year Cap. A hospital's ability to utilize their §5503 Cap Increase is

contingent upon whether the hospital is training above or below their 1996 Base Year Cap. Examples are provided below.

CACC had 75 resident FTEs enrolled in its allopathic programs, 25 resident FTEs enrolled in its osteopathic programs and 7 resident FTEs enrolled in its dental and podiatric programs for its 6/30/96 MCR period (its most recent MCR period ending on or before December 31, 1996). Hence, CACC's 1996 Base Year Cap for Medicare and CHGME Payment Program purposes is 100 (75+25=100). However, in August 2011 CACC received a letter from CMS indicating that their 1996 Base Year Cap would be increased by 20 resident FTEs under §5503 of the ACA. CACC now has a 1996 Base Year Cap of 100 and a §5503 Cap Increase of 20.

Examples (for Hospitals Training "Above" Their 1996 Base Year Cap):

Example #1: During CACC's most recent MCR period, CACC claimed 110 allopathic and osteopathic resident FTEs and 7 dental and podiatric resident FTEs. Based on CACC's 1996 Base Year Cap of 100 and §5503 Cap Increase of 20, CACC would claim 100 resident FTEs against its 1996 Base Year Cap and the remaining 10 resident FTEs would be claimed against its §5503 Cap Increase. Please note 75% (in this case 7.5) of the resident FTEs claimed against the §5503 Cap Increase would need to be residents training in primary care and general surgery programs. A*ny dental and podiatric residents trained during this MCR period would be added to the total (un)weighted allopathic and osteopathic resident FTEs following application of the caps as dental and podiatric residents are exempt from (i.e., not subject to) the cap.*

Example #2: During CACC's most recent MCR period, CACC claimed 140 allopathic and osteopathic resident FTEs and 7 dental and podiatric resident FTEs. Based on CACC's 1996 Base Year Cap of 100 and §5503 Cap Increase of 20, CACC would claim 100 resident FTEs against its 1996 Base Year Cap and the remaining 40 resident FTEs would be claimed against its §5503 Cap Increase. As CACC's number of resident FTEs claimed exceeds both its 1996 Base Year Cap and its §5503 Cap Increase, the DME and IME payment calculation methodology described in Section VII of this application package ("Exceeding the Cap") would be followed. Please note 75% (in this case 15) of the resident FTEs claimed against the §5503 Cap Increase would need to be residents training in primary care and general surgery programs. A*ny dental and podiatric residents trained during this MCR period would be added to the total (un)weighted allopathic and osteopathic resident FTEs following application of the caps as dental and podiatric residents are exempt from (i.e., not subject to) the cap.*

Examples (for Hospitals Training "Below" Their 1996 Base Year Cap):

Example #1: During CACC's most recent MCR period, CACC claimed 95 allopathic and osteopathic resident FTEs and 7 dental and podiatric resident FTEs. Based on CACC's 1996 Base Year Cap of 100 and a §5503 Cap Increase of 20, CACC would claim 95 resident FTEs against its 1996 Base Year Cap and zero "0" residents against its §5503 Cap Increase. *Any dental and podiatric residents trained during this MCR period would be added to the total (un)weighted allopathic and osteopathic resident FTEs following application of the caps as dental and podiatric residents are exempt from (i.e., not subject to) the cap.*

Additional references:

- *Social Security Act, Section 1886(h)(8)(F)*
- *CMS, Federal Register Notice, November 24, 2010 (75 FR 72147)*
- *CMS, 42 CFR 413.79(b)*

Applicable to the following application forms: *HRSA-99-1*

Section X

Special Instructions for Calculating Indirect Medical Education Payment Variables

Hospitals applying for IME payments should follow the instructions provided below when calculating inpatient discharges, CMI, available beds, and the intern/resident to bed ratio. Additional information and "calculation" instructions are provided in Section X of this application package for hospitals that are eligible to begin receiving CHGME Payment Program funding without having completed a MCR period.

Number of Inpatient Discharges

The number of inpatient discharges is a measure of a hospital's inpatient care. This measure is defined as the sum of all daily inpatient discharges for the hospital's most recently filed (or most recently completed) MCR period from all parts of the hospital complex including healthy newborns from the healthy newborn nursery. *Public Law 108-490 does not exclude inpatient discharges associated with healthy newborns inpatient stays in the "well baby" nursery.*

Additional references:

- *Social Security Act, Section 1886*
- *Public Law 108-490, December 23, 2004*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*
- *CHGME Payment Program , Federal Register Notice, July 20, 2001 (66 FR 37986)*

Applicable to the following application forms: *HRSA-99-2*

Case Mix Index (CMI)

The CMI is the sum of the diagnosis-related group (DRG) weights for all inpatient discharges *excluding healthy newborns* from the most recently filed (or most recently completed) MCR period divided by the number of inpatient discharges for the same period. All hospitals applying for IME payments must submit a CMI on all inpatients discharges using the appropriate CMS DRG version, excluding healthy newborns. This value must be reported to four decimal points. The CMS DRG version to be used for CHGME Payment Program purposes is published, through the CHGME Payment Program alert system each spring, prior to the beginning of the FY for which payments will be made. The principles in determining the version of the CMS grouper is delineated is the July 20, 2001 CHGME Payment Program Federal Register Notice.

Additional references:

- *Social Security Act, Section 1886*
- *Public Law 108-490, December 23, 2004*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*

Applicable to the following application forms: *HRSA-99-2*

Number of Available Beds

An available bed is defined as an adult or pediatric bed, including beds or bassinets available for lodging inpatients including beds in intensive care units, coronary care units, neonatal intensive care units, short stay units, and other special care inpatient hospital units. Beds in the following location are excluded: healthy newborn nursery, labor rooms, post-anesthesia or post-operative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residence, and other areas as are regularly maintained and utilized for purposes other than lodging inpatients. To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patient rooms or wards (i.e. not in corridors or temporary beds). CMS in its August 11, 2004, final inpatient PPS Federal Register Notice, revised its regulations at 42 CFR 412.105(b) and 412.106(a)(1)(ii) to specify that bed days in a unit that was occupied to inpatient care for at least one day during the preceding 3 months are included in the available bed day count for a month. In addition, bed days for any beds 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. This clarified policy is effective for discharges occurring on or after October 1, 2004.

The available bed count for the current or prior MCR period is the sum of all available beds per day in the cost reporting period, *excluding* beds and bassinets in the healthy newborn nursery, divided by the number of days in that period.

Additional references:

- *Social Security Act, Section 1886*
- *Public Law 108-490, December 23, 2004*
- *CMS, 42CFR412.105(b)*
- *CMS, 42 CFR 412.106(a)(1)(ii)*
- *CMS, Federal Register Notice, August 11, 2004 (*69 FR 48916)
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*
- *CHGME Payment Program , Federal Register Notice, July 20, 2001* (66 FR 37980, 37986)

Applicable to the following application forms: *HRSA-99-2*

Intern/Resident to Bed (IRB) Ratio

The IRB ratio for the most recently filed (or most recently completed) MCR period is equal to the 3-year un-weighted rolling average divided by the number of available beds for the same period. The IRB ratio for the previous MCR period is equal to the un-weighted resident FTE count for the previous MCR period divided by the number of available beds for the same period. To comply as closely as possible with Medicare rules and regulations, the Department applies a cap on the IRB ratio pursuant to regulations at 42 CFR 412.105(a)(1), whereby the ratio from the most recently filed (or most recently completed) MCR period may not exceed the ratio for the hospital's prior cost reporting period as defined above. Hospitals that meet the criteria for an exception or adjustment to their 1996 Base Year Cap (e.g. through a Medicare GME Affiliation Agreement) should refer to the CMS August 1, 2001 Federal Register Notice which provides additional information and guidance in determining the IRB ratio subject to these exceptions.

Effective for portions of cost reporting periods and discharges occurring on or after July 1, 2005, the CHGME Payment Program will not include resident FTEs counted against the §422 cap in the 3-year rolling average calculation and the CHGME Payment Program will not apply an IRB ratio cap to the resident FTEs counted against a hospital's §422 Cap Increase for purposes of determining IME payments. A §422 IRB calculation will be implemented as guided by CMS rules and regulations. Effective for portions of cost reporting periods ending on or after July 1, 2011, the CHGME Payment Program will include resident FTEs counted against the §5503 cap in the 3-year rolling average calculation and the CHGME Payment Program will apply an IRB ratio cap to the resident FTEs counted against a hospital's §5503 Cap Increase for purposes of determining IME payments.

Additional references:

- *Social Security Act, Section 1886*
- *CMS, 42 CFR 413.77*
- *CMS, Federal Register Notice, August 1, 2001 (66 FR 39878)*
- *CMS, Federal Register Notice, August 11, 2004 (69 FR 48916)*
- *CHGME Payment Program , Federal Register Notice, June 19, 2000 (65 FR 37985)*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*
- *CHGME Payment Program , Federal Register Notice, July 20, 2001 (66 FR 37980)*
- *CHGME Payment Program , Federal Register Notice, October 22, 2003 (68 FR 60396)*

Applicable to the following application forms: *HRSA-99-2*

Section XI

Special Calculation Instructions for Hospitals that Have Not Completed a Medicare Cost Reporting Period

Hospitals eligible to begin receiving CHGME Payment Program funding without having completed a MCR period, must use the following methodology to convert a partial MCR period to a full one. To calculate the variables that follow below, the participating children's hospitals must first determine the number of days in which the hospital has been eligible to receive CHGME Payment Program funding (its period of eligibility for CHGME Payment Program funding).

Determining the Period of Eligibility

For the initial application process, the period of eligibility is equal to the number of days from the date the hospital became eligible to participate in the CHGME Payment Program to the CHGME Payment Program initial application deadline date. The start date for hospitals that are training residents from an existent program is the effective date of the affiliation agreement for the aggregate cap, established for purposes of the CHGME Payment Program. For new hospitals starting a new residency program, the start date is the date on which the hospital first trains residents.

For the reconciliation application process, the hospital will report the actual resident FTE count from the most recently filed (or most recently completed) MCR. If the hospital has not filed (or completed) an MCR period by the CHGME Payment Program reconciliation application deadline, the period of eligibility is equal to the number of days from the beginning of the FY for which payments are being made (October 1) to the CHGME Payment Program reconciliation application deadline date.

Example:

CACC became a freestanding children's hospital when it received its own Medicare provider number (55-3300) on January 1, 2008. CACC has a June 30th MCR year-end. On July 1, 2008 CACC began training residents previously trained at a hospital that has never received funding from the CHGME Payment Program. The FY 2009 CHGME Payment Program application deadline is August 1, 2008. CACC's period of eligibility for the initial application is July 1, 2008 to July 30, 2008. Hence, the resident FTE counts and all other data reported in CACC's CHGME Payment Program initial application will be based on this period (7/1/08 through 7/30/08). CACC will follow the instructions provided herein to calculate its resident FTE counts, CMI, etc. for an incomplete cost reporting period. CACC's CHGME Payment Program funding will not be based upon a rolling-average until three (3) MCR periods have been completed.

The reconciliation application deadline is May 1, 2009. CACC will not complete its first MCR period until June 30, 2009. Consequently, CACC's period of eligibility for the reconciliation application will be October 1, 2008 through May 1, 2009.

The following methodology should be used to convert relevant data from a partial MCR period to a full MCR period.

Calculating the Resident FTE Count for an Incomplete Cost Reporting Period

To convert the resident FTE count from a partial MCR period to a full MCR period:

1. Determine the hospital's period of eligibility.
2. Count the actual ("raw") number of un-weighted allopathic and osteopathic resident FTEs during the hospital's period of eligibility.
3. Divide the un-weighted resident FTE count for allopathic and osteopathic residents (number 2 above) by the number of days in during the hospital's period of eligibility (number 1 above). This number is the average number of un-weighted resident FTEs per day.
4. Multiply the average number of un-weighted resident FTEs (number 3 above) by the number of days that your hospital will be training residents during the FY in which payments are being made. This number is the estimated number of un-weighted allopathic and osteopathic resident FTEs trained per year.
5. Use the same methodology (steps 1-4 above) to determine the weighted resident FTE count of allopathic and osteopathic residents. The example below includes the calculation of the weighted resident FTE count.
6. Use the same methodology (steps 1-4 above) to determine the un-weighted and weighted resident FTE count for dental and podiatric residents.

The concept of converting a partial MCR period into a full MCR period is consistent with Medicare regulations. Since the CHGME Payment Program is paying hospitals for training residents during the FY for which payments are being made, the Program will convert a partial training period to reflect the amount of time the hospital will training residents during the FY for which payments are being made. Although this methodology delineates the method by which partial year residents are counted, it is important to note that all counts are subjected to the cap set by the affiliation agreement.

Example:

CACC received its unique Medicare provider number (in the 3300 series) classifying it as a children's hospital on January 1, 2008. CACC did not begin training residents until Shirley Temple Medical Center transferred its pediatric residents to CACC on July 1, 2008 at which time it met all CHGME Payment Program hospital eligibility criteria. CACC has an affiliation agreement with Shirley Temple Medical Center giving it an aggregate cap of 100 FTEs. Based upon its eligibility, CACC will apply for FY 2009 CHGME Payment Program funding.

1. The number of days in which CACC was eligible to participate in the CHGME Payment Program is 30 days (the number of days from July 1, 2008 to July 30, 2008). *CACC chose to use July 30 as its "end date" to allow time for completing and validating its CHGME Payment Program application and to ensure that the application was postmarked by the CHGME Payment Program application deadline. CACC was not eligible to receive CHGME Payment Program funding prior to July 1, 2008 because it was not training residents.*
2. From July 1st to July 30th CACC trained a total of 10 un-weighted resident FTEs and 8.5 weighted resident FTEs. This resident FTE count reflects the actual "raw" number of resident FTEs that CACC trained during July. [e.g., The normal workweek for a pediatric resident is 6 days. During the week of July 1 through July 7 CACC had one full-time resident in his IRP that worked 6/6 days (6/6 = 1 FTE) and one part-time FTE in her IRP that worked 4/6 days (4/6 = 0.67 FTE). Hence, the actual "raw" number of weighted and un-weighted residents that CACC trained during the first week of July is 1.67 (1 + .67 = 1.67).]
3. The average un-weighted resident FTE count per day is 0.3333 (10 resident FTEs/30 days = 0.3333) and the average weighted resident FTE count per day is 0.2833 (8.5 FTE residents/30 days = 0.2833).
4. Since CACC will be eligible for the CHGME Payment Program and training residents every day of FY

2004 for which it is applying for CHGME Payment Program funding (October 1, 2008 to September 30, 2009), CACC will report an "estimated annualized" un-weighted FTE resident count of 121.65 [365 x 0.3333 = 121.65 (rounded from 121.6545)] and an "estimated annualized" weighted FTE count of 103.40 [365 x 0.2833= 103.40 (rounded from 103.4045]. Since CACC's un-weighted FTE count is more than its FTE cap (of 100), CACC will have to reduce its FTE count using the methodology described under "Exceeding the Cap".

Additional references:

- *CMS, 42 CFR 413.77*
- *CHGME Payment Program , Federal Register Notice, March 1, 2001 (66 FR 12940)*

Applicable to the following application forms: *HRSA-99-1, HRSA-99-2, and HRSA-99-4*

Calculating the Case Mix Index (CMI) for an Incomplete Cost Reporting Period

Hospitals that have not completed a MCR period will report a CMI to the CHGME Payment Program based upon the discharges during the hospital's period of eligibility.

Example:

CACC received its unique Medicare provider (3300 series) number on January 1, 2008. CACC did not begin training residents until Shirley Temple Medical Center transferred its pediatric residents to CACC on July 1, 2008 at which time it met all CHGME Payment Program hospital eligibility criteria. The number of days in which CACC was eligible to participate in the CHGME Payment Program is 30 days (the number of days from July 1, 2008 to July 30, 2008). *CACC chose to use July 30 as its "end date" to allow time for completing and validating its CHGME Payment Program application and to ensure that the application was postmarked by the CHGME Payment Program application deadline. CACC was not eligible to receive CHGME Payment Program funding prior to July 1, 2008 because it was not training residents.* Hence, CACC's CMI will be based upon all discharges from July 1 to July 30 using the CMS DRG-version specified by the CHGME Payment Program.

Additional references:

- *CMS, 42 CFR 413.77*
- *CHGME Payment Program , Federal Register Notice, July 20, 2001 (66 FR 37980)*

Applicable to the following application forms: *HRSA 99-2*

Calculating Discharges for an Incomplete Cost Reporting Period

Hospitals that have not completed a MCR period will report discharge data to the CHGME Payment Program based upon discharges during the hospital's period of eligibility using the following methodology:

1. Calculate the number of discharges during the hospital's period of eligibility. This number represents the total number of discharges during the hospital's period of eligibility.
2. Divide the total number of discharges by the number of days in during the hospital's period of eligibility. This represents the average number of discharges per day.
3. Multiply the average number of discharges per day by the number of days in which the hospital is eligible to receive CHGME Payment Program funding during the FY for which it is applying for funding.

Example:
The number of days in which CACC was eligible to participate in the CHGME Payment Program is 30 days (the number of days from July 1, 2008 to July 30, 2008). *CACC chose to use July 30 as its "end date" to allow time for completing and validating its CHGME Payment Program application and to ensure that the application was postmarked by the CHGME Payment Program application deadline. CACC was not eligible to receive CHGME Payment Program funding prior to July 1, 2008 because it was not training residents.*

1. CACC had 752 discharges from July 1 to July 30.
2. CACC's average number of discharges per day is 25.07 (752 discharges/30 days = 25.0666).
3. Since CACC will be caring for patients as a freestanding children's teaching hospital during the entire FY 2004 (October 1, 2008 – September 30, 2009) for which it is applying for CHGME Payment Program funding, CACC will report 9,150 discharges on HRSA-99-2 [365 days x 25.07 discharges per day = 9,150.55 discharges (whole numbers only)].

Additional references:
- *CMS, 42 CFR 413.77(e)(2)*
- *CHGME Payment Program , Federal Register Notice, July 20, 2001 (66 FR 37980)*

Applicable to the following application forms: *HRSA 99-2*

Calculating the Number of Available Beds for an Incomplete Cost Reporting Period

Hospitals that have not completed a MCR period will calculate their bed count by summing the total available bed count during the hospital's period of eligibility.

Example:
The number of days in which CACC was eligible to participate in the CHGME Payment Program is 30 days (the number of days from July 1, 2008 to July 30, 2008). *CACC chose to use July 30 as its "end date" to allow time for completing and validating its CHGME Payment Program application and to ensure that the application was postmarked by the CHGME Payment Program application deadline. CACC was not eligible to receive CHGME Payment Program funding prior to July 1, 2008 because it was not training residents.*

During the period July 1 to July 30, 2008 CACC had 2,730 beds available to house pediatric inpatients and 910 bassinets available for healthy newborn babies. Therefore, the bed count is 91 beds per day (2,730 beds/30 days=91) as healthy newborn babies should be excluded from the reported available bed count.

Additional references:
- *CMS, 42 CFR 413.77(e)(2)*
- *CHGME Payment Program , Federal Register Notice, July 20, 2001 (66 FR 37980)*

Applicable to the following application forms: *HRSA 99-2*

Calculating Inpatient Days for an Incomplete Cost Reporting Period

Hospitals that have not completed a MCR period will calculate their inpatient days by summing the daily midnight census during the hospital's period of eligibility.
Then the hospital divides that sum by the number of days in that period, resulting in the average midnight census. The hospital should then multiply the average midnight census with the number of days that the hospital is eligible for the CHGME Payment Program during the FY in which payments are to be made.

Example:

The number of days in which CACC was eligible to participate in the CHGME Payment Program is 30 days (the number of days from July 1, 2008 to July 30, 2008). *CACC chose to use July 30 as its "end date" to allow time for completing and validating its CHGME Payment Program application and to ensure that the application was postmarked by the CHGME Payment Program application deadline. CACC was not eligible to receive CHGME Payment Program funding prior to July 1, 2008 because it was not training residents.*

From July 1 to July 30, the CACC had a total of 1,911 inpatient days, resulting in an average of 63.70 inpatients per day (1,911 inpatient days/30 days). Their inpatient day total for the FY would be 365 days x 64 inpatients per day = 23,360 inpatient days (must also use whole numbers).

Additional references:

- *CMS, 42 CFR 413.77*
- *CHGME Payment Program , Federal Register Notice, July 20, 2001 (66 FR 37980)*

Applicable to the following application forms: *HRSA 99-2*

Calculating Outpatient Services for an Incomplete Cost Reporting Period

Hospitals will not complete this section until a MCR period has been completed.

Additional references:

- *CHGME Payment Program , Federal Register Notice, July 20, 2001 (66 FR 37980)*

Section XII

Special Calculation Instructions for Establishing a CHGME cap for Newly Qualified Hospitals

Hospitals that are newly qualified to receive CHGME funds as "newly qualified hospitals" under the Children's Hospital GME Support Reauthorization Act of 2013, and that do not already have a CMS cap established and are not able to apply for a CMS cap as a new residency training program, will have a "CHGME cap" established. The "CHGME cap" will be established using the number of FTEs trained during the most recent Medicare cost reporting period completed on or before April 7, 2014, the date of enactment of the Children's Hospital GME Support Reauthorization Act of 2013, as verified by the CHGME auditors during the Resident FTE Assessment Program. The "CHGME cap" will be entered in Sections 4, 5, and 6 of the HRSA 99-1, on lines 4.06, 5.06, and 6.06 respectively.

Section XIII

CHGME Payment Program Application Form Instructions

Instructions for Completing HRSA 99

Hospital Demographic and Contact Information

The HRSA 99 must be completed in its entirety. All sections of this form must be completed unless otherwise specified. Specific line item instructions are provided below.

Section	Instructions
1	Provide the official name, physical address, tax identification number, county where the hospital is physically located, Medicare provider number, D&B D-U-N-S number, and website of the applicant children's hospital. Information regarding D&B D-U-N-S numbers can be obtained at 1-800-234-3867 or www.dnb.com.
2	Provide the complete name, title, mailing address, telephone number and email address of the person to be notified if the application is funded. **All future correspondence will be mailed to this individual only** (e.g., notice of award letters).
3	Provide the complete name, title, mailing address, telephone number, and email address of the person authorized to submit the application for the applicant hospital.
4	Provide the complete name, title, mailing address, telephone number, and email address of the hospital's Director of Graduate Medical Education. If the hospital does not have a Director of GME, the individual who has oversight responsibility for residents participating in GME programs at the hospital should be identified.
5	Provide the complete name, title, mailing address, telephone number and email address of the person who can provide documentation in support of the information reported in the CHGME Payment Program application for funding. Like all Federal programs, information submitted is subject to audit. **All Resident FTE Assessment inquiries and related communications will be directed to this individual.**
6	Provide the complete name, title, mailing address, telephone number, and email address of the person who prepared and/or completed this application package for the applicant hospital. This individual will be the person contacted if there are questions or issues related to the information submitted in the CHGME Payment Program application for funding.

Instructions for Completing HRSA 99-1

Determination of Weighted and Unweighted Resident FTE Counts

<u>All values</u> entered on HRSA 99-1 must be taken to the hundredth place [two decimal points (e.g. 38.00 or 12.43)] and the standard rounding rules applied [if the number is .5 or greater then round up to the next number (e.g., 38.189 would be rounded to 38.19)].

Instructions for the Initial Application Cycle

GUIDE TO INSTRUCTIONS		
The Section and Line Number that the instruct-ions apply to are identified in this area in the following table.	**Hospitals that filed a full MCR** for the subject cost reporting period must follow the instructions provided in this (left) column for each section. Where specified, hospitals must report the data as stated in the hospital's CMS 2552-10, Worksheet E-4 (formerly named CMS 2552-96 Worksheets E-3, Part IV and E-3, Part VI) from the subject cost reporting period. Deviation from what is stated on Worksheets E-3, Part IV and E-3, Part VI must be supported and attested to by the FI prior to submission of this application in order to be accepted by the CHGME Payment Program. In some instances, the instructions are the same for all hospitals irrespective of the type of MCR the hospital filed for the subject cost reporting period. In those cases, only one set (i.e., one column) of instructions is provided.	**Hospitals that filed a Low or No-Utilization MCR** for the subject recent cost reporting period must follow the instructions provided in this (right) column for each section. In some instances, the instructions are the same for all hospitals irrespective of the type of MCR the hospital filed for the subject cost reporting period. In those cases, only one set (i.e., one column) of instructions is provided.
	Hospitals that have not completed at least three (3) MCR periods must follow the instructions provided in italics, where provided below.	

Section 1	**DETERMINATION OF RESIDENT FTE CAP FOR THE HOSPITAL'S MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE DECEMBER 31, 1996**	
	Hospitals that did not train residents during the most recent cost reporting period ending on or before December 31, 1996 should enter "N/A" on lines 1.01 through 1.03.	
1.01	Enter the inclusive dates of the subject cost reporting period. The following format must be used: (From:) **mm/dd/yyyy** (To:) **mm/dd/yyyy.**	
1.02	Enter the status of the subject MCR using the codes below:	Enter the status of the subject MCR using the codes below:

Code	Definition	Code	Definition
S	<u>Settled.</u> This status refers to cost reports that have been settled [a notice of program reimbursement (NPR) issued] by the Medicare FI.	L	<u>Low-utilization MCR.</u> This status refers to resident FTE counts submitted by the hospital in their initial application that have not been assessed by the CHGME FI.
S/R/P	<u>Settled/Reopened/Preliminary FI.</u> This status refers to cost reports that have been settled (an NPR issued by the Medicare FI), then re-opened by the Medicare FI and any changes (to the resident FTE counts during the reopening) have been assessed by the CHGME (or Medicare) FI.	N	<u>No-utilization MCR.</u> This status refers to resident FTE counts submitted by the hospital in their initial application that have not been assessed by the CHGME FI.
S/R/RS	<u>Settled/Reopened/Resettled.</u> This status refers to cost reports that have been settled (an NPR issued by the Medicare FI), re-opened by the Medicare FI, and then re-settled	C	<u>Complete.</u> This status refers to resident FTE counts that have been assessed by the CHGME FI and reported to the hospital and the CHGME

		by the Medicare FI.		Payment Program in the CHGME FI's final assessment report.
			R	Re-issue. This status refers to resident FTE counts reported in a CHGME FI's final assessment report that have been re-assessed based on a request from the children's hospital or the CHGME FI and the results of the reassessment reported to the hospital and the CHGME Payment Program in the CHGME FI's final re-assessment report.
1.03	Enter the un-weighted resident FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996. Worksheet E-4 (formerly named Worksheet E-3, Part IV) Line 3.01 on the hospital's MCR beginning on or after October 1, 1997.)		Enter the un-weighted resident FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996.	

Hospitals must complete Sections 4 through 6 of Form HRSA-99-1 prior to completing Sections 2 and 3.

Section 2	**AVERAGE UNWEIGHTED RESIDENT FTE COUNT**
2.01	Enter the amount from line 4.19 of the 1996 Cap Year column.
2.02	Enter the amount from line 5.19 of the 1996 Cap Year column. *Hospitals that have not completed three (3) MCR periods should enter "N/A".*
2.03	Enter the amount from line 6.19 of the 1996 Cap Year column. *Hospitals that have not completed three (3) MCR periods should enter "N/A".*
2.04	Enter the sum of lines 2.01, 2.02 and 2.03 from above divided by 3. *Hospitals that have not completed three (3) MCR periods should enter the amount from line 2.01 above.*
2.05	Enter the un-weighted number of resident FTEs in the initial years of all programs that meet the rolling average exception criteria in 42 CFR 413.79(d).
2.06	Enter the sum of lines 2.04 and 2.05 from above.
2.07	Enter the amount from line 4.19 of the **§**422 of the MMA column.
2.08	Enter the sum of lines 2.06 and 2.07 from above.

Section 3	**AVERAGE WEIGHTED RESIDENT FTE COUNT**	
3.01	Enter the amount from line 4.20 of the 1996 Cap Year column.	
3.02	Enter the amount from line 5.20 of the 1996 Cap Year column. *Hospitals that have not completed three (3) MCR periods should enter "N/A".*	
3.03	Enter the amount from line 6.20 of the 1996 Cap Year column. *Hospitals that have not completed three (3) MCR periods should enter "N/A".*	
3.04	*Hospitals that have not completed three (3) MCR periods should enter the amount from line 3.01 above.*	
	Enter the sum of lines 3.15 and 3.21 from CMS 2552-10, Worksheet E-4 (formerly named CMS 2552-96 Worksheet E-3, Part IV) from your most recently filed MCR which is equivalent to the sum of lines 3.01, 3.02 and 3.03 from above divided by 3. If the sum of lines 3.01 through 3.03 divided by 3 does not equal the sum of lines 3.15 and 3.21 from CMS 2552-10, Worksheet E-4 (formerly named CMS 2552-96) on your most recently filed MCR, please contact your regional manager immediately.	Enter the sum of lines 3.01, 3.02 and 3.03 from above divided by 3.

3.05	***Hospitals that have not completed three (3) MCR periods should enter the weighted number of resident FTEs in the initial years of all programs that meet the rolling average exception criteria in 42 CFR 413.79(d).***	
	Enter the weighted number of resident FTEs in the initial years of all programs that meet the rolling average exception criteria in 42 CFR 413.79(d) .	Enter the weighted number of resident FTEs in the initial years of all programs that meet the rolling average exception criteria in 42 CFR 413.79(d) .
3.06	*Hospitals that have not completed three (3) MCR should enter the sum of lines 3.04 and 3.05 from above. This is the weighted resident FTE count.*	
	Enter the sum of lines 3.04 and 3.05 from above.	
3.07	Enter the amount from line 4.20 of the **§**422 of the MMA column.	
3.08	Enter the sum of lines 3.06 and 3.07 from above.	
Section 4	**DETERMINATION OF RESIDENT FTE COUNT FOR THE HOSPITAL'S MOST RECENTLY COMPLETED COST REPORTING PERIOD**	
	Hospitals that have not completed a MCR period must use the methodology described in the application guidance section titled "Special Calculation Instructions for Hospitals that Have Not Completed a Medicare Cost Reporting Period" to determine their weighted and un-weighted resident FTE counts based upon an incomplete cost reporting period.	
4.01	Enter the inclusive dates of the subject cost reporting period. The following format must be used: (From:) **mm/dd/yyyy** (To:) **mm/dd/yyyy.**	
	Hospitals that have not completed a full MCR period must enter the date in which the hospital became eligible to participate (i.e. date that the hospital obtained a Medicare provider number and began training residents) and the CHGME Payment Program application deadline. This is the hospital's period of eligibility.	
4.02	Enter the status of the subject MCR using the codes below:	Enter the status of the subject MCR using the codes below:

Code	Definition	Code	Definition
AF	As Filed. This status refers to cost reports that have been submitted by the children's hospital to the Medicare FI, but have not yet been reviewed by the CHGME (or Medicare) FI.	L	Low-utilization MCR. This status refers to resident FTE counts submitted by the hospital in their initial application that have not been assessed by the CHGME FI.
AM	Amended. This status refers to cost reports that have been amended and submitted by the children's hospital to the Medicare FI, but have not yet been reviewed by the CHGME (or Medicare) FI.	N	No-utilization MCR. This status refers to resident FTE counts submitted by the hospital in their initial application that have not been assessed by the CHGME FI.
P	Preliminary. This status refers to resident FTE counts that have been assessed by the CHGME (or Medicare) FI where the cost report has not yet been settled (notice of program reimbursement has not been issued).	C	Complete. This status refers to resident FTE counts that have been assessed by the CHGME FI and reported to the hospital and the CHGME Payment Program in the CHGME FI's final assessment report.
S	Settled. This status refers to cost reports that have been settled [an NPR issued] by the Medicare FI.	R	Re-issue. This status refers to resident FTE counts reported in a CHGME FI's final assessment report that have been re-assessed based on a request from the children's hospital or the CHGME FI and the results of the reassessment reported to the hospital and the CHGME Payment Program in the CHGME FI's final re-assessment report.
S/R/P	Settled/Reopened/Preliminary FI. This status refers to cost reports that have been settled (an NPR issued by the Medicare FI), then re-opened by the Medicare FI and any changes (to the resident FTE counts during the reopening) have been assessed by the CHGME (or Medicare) FI.		
S/R/RS	Settled/Reopened/Resettled. This status refers to cost reports that have been settled (an NPR issued by the Medicare FI), re-opened by the Medicare FI, and then		

		re-settled by the Medicare FI.	
4.03	1996 cap year column: Enter the un-weighted resident FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996 which is equivalent to Line 3.01 Line 3.01 from CMS 2552-96 Worksheet E-3, Part IV or to Line 1.0 from CMS 2552-10 Worksheet E-4 from the subject cost reporting period. For hospitals whose MCR did not contain an entry on line 3.01, enter "0". If Line 3.01 from Worksheet E-3, Part IV does not equal line 1.03 from above, line 3.01 from CMS 2552-96 Worksheet E-3, part IV or to Line 1.0 from CMS 2552-10 Worksheet E-4 must be supported and attested to by the FI prior to submission of this application in order to be accepted by the CHGME Payment Program.	1996 cap year column: Enter the un-weighted resident FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996 which is equivalent to Line 1.03 from above.	
4.04	Enter addition for the un-weighted resident FTE count for allopathic and osteopathic programs which meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.79(e) [which is equivalent to Line 3.02 from CMS 2552-96 Worksheet E-3, Part IV or to Line 2 from CMS 2552-10 Worksheet E-4 from the subject MCR]	Enter the un-weighted resident FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) [which is equivalent to Line 3.02 from CMS 2552-96 Worksheet E-3, Part IV or to Line 2 from CMS 2552-10 Worksheet E-4 from the subject MCR	
4.04a	Enter the reduction for the un-weighted resident FTE count for allopathic or osteopathic programs due to §422 of the MMA [which is equivalent to Line 2.0 from CMS 2552-96 Worksheet E-3, Part VI or to Line 3.0 from CMS 2552-10 Worksheet E-4 from the subject cost reporting period].	Enter the reduction for the un-weighted resident FTE count for allopathic or osteopathic programs due to §422 of the MMA [which is equivalent to Line 2.0 from CMS 2552-96 Worksheet E-3, Part VI or to Line 3.0 from CMS 2552-10 Worksheet E-4 from the subject cost reporting period].	
4.04b	Enter the reduction for the un-weighted resident FTE count for allopathic or osteopathic programs in accordance with §5503 of the ACA in accordance with 42 CFR 413.79(m) [which is equivalent to Line 3.01 from CMS 2552-10 Worksheet E-4 from the subject cost reporting period].	Enter the reduction for the un-weighted resident FTE count for allopathic or osteopathic programs in accordance with §5503 of the ACA [which is equivalent to Line 3.01 from CMS 2552-10 Worksheet E-4 from the subject cost reporting period].	
4.05	Enter the adjustment (increase or decrease) for the un-weighted resident FTE count for allopathic or osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), and 63 FR 26336 of May 12, 1998 [which is equivalent to Line 3.03 from CMS 2552-96 Worksheet E-3, Part IV or to Line 4.0 from CMS 2552-10 Worksheet E-4 from the subject cost reporting period].	Enter the adjustment (increase or decrease) for the un-weighted resident FTE count for allopathic or osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), and 63 FR 26336 of May 12, 1998 [which is equivalent to Line 3.03 from CMS 2552-96 Worksheet E-3, Part IV or to Line 4.0 from CMS 2552-10 Worksheet E-4 from the subject cost reporting period].	
4.05a	Enter the addition for un-weighted FTE resident count allopathic and osteopathic programs in accordance witl §5503 of the ACA [which is equivalent to Line 4.01 fr CMS 2552-10 Worksheet E-4 from the subject cost reporting period].	Enter the addition for un-weighted FTE resident count for allopathic and osteopathic programs in accordance with §5503 of the ACA [which is equivalent to Line 4.01 from CMS 2552-10 Worksheet E-4 from the subject cost reporting period].	Enter the additi allopathic and o of the ACA [wh 10 Worksheet E
4.05b	Enter the addition for un-weighted FTE resident count for allopathic and osteopathic programs in accordance with §5506 of the ACA [which is equivalent to Line 4.02 from CMS 2552-10 Worksheet E-4 from the subject cost reporting period].	Enter the addition for un-weighted FTE resident count for allopathic and osteopathic programs in accordance with §5506 of the ACA [which is equivalent to Line 4.02 from CMS 2552-10 Worksheet E-4 from the subject cost reporting period].	
4.06	1996 cap year column: Enter the sum of lines 4.03 through 4.05a. This is the FTE adjusted cap which is equivalent to Line 3.04 from CMS 2552-96 Worksheet E-3, Part IV or to Line 5 from CMS 2552-10 Worksheet E-4 from the subject cost reporting period. If the hospital's 1996 Base Year Cap is reduced under 42 CFR 413.79(c)(3) due to unused resident slots, effective for cost reporting periods ending on or after	1996 cap year column: Enter the sum of lines 4.03 through 4.05a from above. This is the FTE adjusted cap. If the hospital's 1996 Base Year Cap is reduced under 42 CFR 413.79(c)(3) due to unused resident slots, effective for cost reporting periods ending on or after July 1, 2005, enter Line 3.04 from CMS 2552-96 Worksheet E-3, Part IV from the subject MCR which is equivalent to the sum of Line 3.03 from CMS 2552-96 Worksheet E-3, Part IV	

	July 1, 2005, Line 3.04 from CMS 2552-96 Worksheet E-3, Part IV is equivalent to the sum of Line 3.03 from CMS 2552-96 Worksheet E-3, Part IV and Line 4 from Worksheet E-3, Part VI from the subject cost reporting period. Line 5 from CMS 2552-10 Worksheet E-4 is equivalent to the sum of Line 3.03 from CMS 2552-10 Worksheet E-4 and Line 4.0 from Worksheet E-4 from the subject cost reporting period. For "newly qualified" hospitals which will have a CHGME "cap" established by the Secretary, enter the number of FTEs trained during the most recent Medicare Cost Report period completed on or before April 7, 2014.	and Line 4 from Worksheet E-3, Part VI from the subject MCR. If the hospital was not required to file CMS 2552-96 Worksheets E-3, Part IV or E-3, Part VI following the 1996 Base Year Cap reduction under 42 CFR 413.79(c)(3) for the subject cost reporting period contact your regional manager.
	§422 of the MMA column: Enter the number of un-weighted allopathic and osteopathic GME FTE resident cap slots the hospital received under 42 CFR 413.79(c)(4) [which is equivalent to Line 5 (or 5.01 for cost reporting periods that overlap July 1, 2005) from CMS 2552-96 Worksheet E-3, Part VI or Line 20.0 from CMS 2552-10 Worksheet E-4 from the subject cost reporting period. If the hospital received GME FTE resident cap slots under 42 CFR 413.79(c)(4), but was not required to file CMS 2552-96 Worksheets E-3, Part VI or to file CMS 2552-10 Worksheets E-4 for the subject cost reporting period contact your regional manager. If the hospital did not receive GME FTE resident cap slots under 42 CFR 413.79(c) enter "zero" on Lines 4.06 through 4.13, 4.19 and 4.20 of this column.	
4.07	1996 cap year column: Enter the un-weighted resident FTE count for allopathic or osteopathic programs for the current year from your records, other than those in the initial years of the program that meet the criteria for an exception to the rolling average rules (42 CFR 413.79(d) and/or (e)). This is equivalent to Line 3.05 from CMS 2552-96 Worksheet E-3, Part IV or enter line 6.0 from CMS 2552-10 Worksheet E-4 from the subject cost reporting period.	1996 cap year column: Enter the un-weighted resident FTE count for allopathic or osteopathic programs for the current year from your records, other than those in the initial years of the program that meet the criteria for an exception to the rolling average rules (42 CFR 413.79(d) and/or (e)).
	§422 of the MMA column: Enter the sum of Lines 4.07 minus 4.08 from the 1996 Cap Year Column.	
4.08	1996 cap year column: Enter line 3.06 from CMS 2552-96 Worksheet E-3, Part IV or enter line 7.0 from CMS 2552-10 Worksheet E-4 from the subject cost reporting period.	1996 cap year column: Enter the lesser of lines 4.06 or 4.07 from above (lesser of lines 5.06 or 5.07 for Section 5 and lines 6.06 or 6.07 for Section 6).
	§422 of the MMA column: enter the lesser of Lines 4.06 or 4.07 from above.	
4.09	1996 cap year column: Enter the un-weighted FTE resident count for allopathic and osteopathic residents in their initial residency period.	
	§422 of the MMA column: Enter the un-weighted FTE resident count for allopathic and osteopathic residents in their initial residency period.	
4.10	1996 cap year column: Enter the hospital's un-weighted FTE resident count for allopathic and osteopathic residents beyond their initial residency period. The sum of lines 4.09 and 4.10 should equal line 4.07 from above (the sum of lines 5.09 and 5.10 should equal line 5.07 for Section 5 and the sum of lines 6.09 and 6.10 should equal line 6.07 for Section 6).	
	§422 of the MMA column: Enter the hospital's un-weighted FTE resident count for allopathic and osteopathic residents beyond their initial residency period. The sum of lines 4.09 and 4.10 should equal line 4.07 from above.	
4.11	1996 cap year column: Multiply line 4.10 from above (line 5.10 for Section 5 and line 6.10 for Section 6) by 0.5 and enter the product. This is the weighted FTE resident count for allopathic and osteopathic residents beyond their initial residency period.	
	§422 of the MMA column: Multiply line 4.10 from above by 0.5 and enter the product. This is the weighted FTE resident count for allopathic and osteopathic residents beyond their initial residency period.	
4.12	1996 cap year column: Enter line 3.09 from CMS 2552-96 Worksheet E-3, Part IV or enter line 8.0 from CMS 2552-10 Worksheet E-4. This should equal the sum of lines 4.09 and 4.11 from above.	1996 cap year column: Enter the sum of lines 4.09 and 4.11 from above (sum of lines 5.09 and 5.11 for Section 5 and lines 6.09 and 6.11 for Section 6). This is the total weighted resident FTE count for allopathic and osteopathic programs.
	§422 of the MMA column: Enter the sum of lines 4.09 and 4.11 from above.	
4.13	1996 cap year column: Enter line 3.10 from CMS 2552-96 Worksheet E-3, Part IV or enter line 9.0 from	1996 cap year column: For Section 4: If line 4.07 is less than or equal to line 4.06 enter the amount from line 4.12

	CMS 2552-10 Worksheet E-4.	above. If line 4.07 is greater than line 4.06, multiply line 4.12 by (line 4.06 divided by line 4.07) and enter the product. For Section 5: If line 5.07 is less than or equal to line 5.06 enter the amount from line 5.12 above. If line 5.07 is greater than line 5.06, multiply line 5.12 by (line 5.06 divided by line 5.07) and enter the product. For Section 6: If line 6.07 is less than or equal to line 6.06 enter the amount from line 6.12 above. If line 6.07 is greater than line 6.06, multiply line 6.12 by (line 6.06 divided by line 6.07) and enter the product.
	§422 of the MMA column: If line 4.07 is less than or equal to line 4.06, enter the amount from line 4.12 above. If line 4.07 is greater than line 4.06, multiply line 4.12 by (line 4.06 divided by line 4.07) and enter the product.	
4.14	1996 cap year column: Enter the un-weighted resident FTE count for dental and podiatric programs.	
4.15	1996 cap year column: Enter the un-weighted resident FTE count for dental and podiatric residents in their initial residency period.	
4.16	1996 cap year column: Enter the un-weighted resident FTE count for dental and podiatric residents beyond their initial residency period.	
4.17	1996 cap year column: Multiply line 4.16 from above (line 5.16 for Section 5 and line 6.16 for Section 6) by 0.5 and enter the product.	
4.18	1996 cap year column: Enter line 3.11 from CMS 2552-96 Worksheet E-3, Part IV or enter line 10.0 from CMS 2552-10 Worksheet E-4. This should equal the sum of lines 4.15 and 4.17. For hospitals who's MCR did not contain an entry on line 3.11 on Worksheet E-3, Part IV enter the sum of lines 4.15 and 4.17 from above (the sum of lines 5.15 and 5.17 for Section 5 and lines 6.15 and 6.17 for Section 6). This is the total weighted resident FTE count for dental and podiatric programs.	1996 cap year column: Enter the sum of lines 4.15 and 4.17 from above (the sum of lines 5.15 and 5.17 for Section 5 and lines 6.15 and 6.17 for Section 6). This is the total weighted resident FTE count for dental and podiatric programs.
4.19	1996 cap year column: Enter the sum of lines 4.08, 4.15 and 4.16 from above (the sum of lines 5.08, 5.15 and 5.16 for Section 5 and the sum of lines 6.08, 6.15 and 6.16 for Section 6). This is the hospital's total un-weighted FTE resident count.	
	§422 of the MMA column: Enter line 4.08 from above.	
4.20	1996 cap year column: Enter the sum of lines 3.10 and 3.11 from CMS 2552-96 Worksheet E-3, Part IV or enter line 11.0 from CMS 2552-10 Worksheet E-4. This should equal the sum of lines 4.13 and 4.18 (sum of lines 5.13 and 5.18 for Section 5 and the sum of lines 6.13 and 6.18 for Section 6).	1996 cap year column: Enter the sum of lines 4.13 and 4.18 from above (sum of lines 5.13 and 5.18 for Section 5 and the sum of lines 6.13 and 6.18 for Section 6). This is the hospital's total weighted FTE resident count.
	§422 of the MMA column: Enter line 4.13 from above.	
Section 5	**DETERMINATION OF RESIDENT FTE COUNT FOR THE HOSPITAL'S PRIOR COST REPORTING PERIOD**	
	The direct GME FTE resident cap slots hospitals received under 42 CFR 413.79(c)(4) are not subject to the three year rolling average; therefore, Section 5 does not include a §422 of the MMA column and related guidance is not applicable this section.	
	Hospitals that have not completed three (3) MCR periods should enter "N/A" on lines 5.01 through 5.20.	
Section 6	**DETERMINATION OF FTE RESIDENT COUNT FOR THE HOSPITAL'S PENULTIMATE COST REPORTING PERIOD**	
	The direct GME FTE resident cap slots hospitals received under 42 CFR 413.79(c)(4) are not subject to the three year rolling average; therefore, Section 6 does not include a §422 of the MMA column and related guidance is not applicable this section.	
	Hospitals that have not completed three (3) MCR periods should enter "N/A" on lines 6.01 through 6.20.	

Instructions for the Reconciliation Application Cycle

All children's hospitals, regardless of their filing status, will use the resident FTE counts as reported by their CHGME FI in his/her final Resident FTE Assessment Report to complete their reconciliation application which includes an updated and revised, as needed, HRSA 99-1. For additional information regarding the Resident FTE Assessment Program see Section II.

Instructions for Completing HRSA 99-2

Determination of Indirect Medical Education Data Related to the Teaching of Residents

Inpatient Data for the Current Medicare Cost Report (MCR) Period

The "current" MCR period is defined as the hospital's most recently filed MCR for hospitals that file full MCRs (report residents to Medicare on CMS 2552-10, Worksheet E-4 (formerly named CMS 2552-96, Worksheet E-3, Part IV)) or the most recently completed MCR period for hospitals that file low or no-utilization MCRs.

Hospitals that have not completed a full MCR period must use the methodology described in the application guidance section titled "Special Calculation Instructions for Hospitals that Have Not Completed a Medicare Cost Reporting Period" to complete the below.

1.01	Inclusive dates of the current MCR period. Enter the inclusive dates of the MCR period reported on line 4.01 of HRSA 99-1.
1.02	Number of Inpatient Days. The sum of the entire midnight census counts including nursery days for the MCR period reported on line 1.01 above. **[Value must be taken to two decimal points (i.e., 38.00 or 12.43).]**
1.03	Number of Inpatient Discharges. The sum of all inpatient discharges including healthy newborns for the MCR period reported on line 1.01 above. **[Value must be taken to two decimal points (i.e., 38.00 or 12.43).]**
1.04	Case Mix Index (CMI). The CMI is the sum of the diagnosis-related group (DRG) weights for all discharges during the MCR period identified on line 1.01 above divided by the number of discharges. The CMI represents the average DRG relative weight for the hospital. All hospitals must submit a CMI on all patient discharges using the appropriate CMS DRG version, **excluding** healthy newborns. **[Value must be taken to 4 decimal points (i.e., 1.2105).]** The CMI is utilized in the IME formula to determine IME payments. Hospitals that do not submit a CMI are not eligible for IME payments. These hospitals are required to initial the appropriate box on line 1.04 of HRSA 99-2 acknowledging their ineligibility for IME payments.

Intern/Resident-to-Bed (IRB) Ratio

To comply as closely as possible with Medicare rules and regulations, the Department applies a cap on the IRB ratio, similar to the cap applied by the Medicare program pursuant to regulations at 42 CFR 412.105(a)(1), whereby the ratio may not exceed the ratio for the hospital's most recent prior cost reporting period. For those hospitals whose IRB ratio changes, there will be a one-year delay in the implementation of the revised IRB. Starting in FY 2002 the CHGME Payment Program will implement a cap on the IRB ratio. The IRB cap may not exceed the ratio for the hospital's previous cost reporting period.

Calculate the IRB Ratio for the Current MCR Period

The "current" MCR period is defined as the hospital's most recently filed MCR for hospitals that file full MCRs (report residents to Medicare on CMS 2552-10, Worksheet E-4 (formerly named CMS 2552-96, Worksheet E-3, Part IV)) or the most recently completed MCR period for hospitals that file low or no-utilization MCRs.

Hospitals that meet the criteria for an exception or adjustment to the cap should refer to the Centers for Medicare and Medicaid Services August 1, 2001 Federal Register Notice (66 FR 39878) which provides additional information and guidance in calculating the IRB ratio.

1.05	Enter the 3-year adjusted un-weighted FTE rolling average for the current MCR period. The 3-year un-weighted FTE rolling average for the current MCR period is equal to line 2.06 of HRSA 99-1. Enter the data reported on line 2.06 of HRSA 99-1. **[Value must be taken to two decimal points (i.e., 38.00 or 12.43).]**
1.06	Enter the bed count for the current MCR period. The bed count for the current MCR period is the sum of all available beds per day in the cost reporting period, **excluding** beds and bassinets in the healthy newborn nursery, divided by the number of days in that period. If a children's hospital has not completed a Medicare cost report period prior to submission of an application to the CHGME Payment Program , it would base the bed count on the sum of all available beds per day, **excluding** beds and bassinets in the healthy newborn nursery, in the period from the day it became eligible for the CHGME program until the CHGME application deadline, divided by the number of days in that period. A bed is any bed that is permanently maintained for lodging inpatients. The bed count number is utilized in the IME formula to determine IME payments. **[Value must be taken to two decimal points (i.e., 38.00 or 12.43).]**
1.07	Enter the IRB ratio for the current MCR period. The IRB ratio is equal to the 3-year un-weighted rolling average (line 1.05 above) divided by the bed count (line 1.06 above). **[Value must be taken to six decimal points (i.e. 34.567800).]**

Calculate the IRB Ratio for the Previous MCR Period

The "previous" MCR period refers to the annual cost reporting period that ended one year prior to the cost reporting period identified on line 1.01 above. The previous MCR period should equal line 5.01 of HRSA 99-1

Hospitals that were not required to complete section 5 of HRSA 99-1 should contact their regional manager for additional information and guidance for lines 1.08 through 1.11 below.

Hospitals that meet the criteria for an exception or adjustment to the cap should refer to the Centers for Medicare and Medicaid Services August 1, 2001 Federal Register Notice (66 FR 39878) which provides additional information and guidance in calculating the IRB ratio.

1.08	Inclusive dates of the previous MCR period. Enter the inclusive dates of the MCR period reported on line 5.01 of HRSA 99-1.
1.09	Unweighted FTE count for the previous MCR period. Enter the un-weighted FTE count for the previous MCR period which is equal to line 5.19 of HRSA 99-1. **[Value must be taken to two decimal points (i.e., 38.00 or 12.43).]**
1.10	Bed count for the previous MCR period. Calculate the available bed count for the previous MCR period. The bed count for the previous MCR period is the sum of all available beds per day in the cost reporting period, **excluding** beds and bassinets in the healthy newborn nursery, divided by the number of days in that period. **[Value must be taken to two decimal points (i.e., 38.00 or 12.43).]**
1.11	IRB ratio for the previous MCR period. Calculate the IRB ratio for the previous MCR period. The IRB ratio is equal to the un-weighted FTE count for the previous MCR period (line 1.09 above) divided by the bed count (line 1.10 above). **[Value must be taken to six decimal points (i.e. 34.567890 or 12.540000).]**
IRB Cap	
1.12	IRB Cap. Enter the lesser of 1.07 or 1.11. **[Value must be taken to six decimal points (i.e. 34.567890.]** Hospitals that have not completed three (3) MCR periods should enter the amount from line 1.07 above.
§422 of the MMA IRB Ratio for the Current MCR Period	
1.13	§422 of the MMA un-weighted resident FTE count for the current MCR period. The un-weighted resident FTE count for the current MCR period is equal to line 4.19 of the §422 of the MMA column of the HRSA 99-1. Enter the data reported on line 4.19 from the §422 of the MMA column of HRSA 99-1. **[Value must be taken to two decimal points (i.e., 38.00 or 12.43).]**
1.14	Bed count for the current MCR period. Enter the available bed count for the current MCR period. This should be consistent with the data reported in line 1.06 above. **[Value must be taken to two decimal points (i.e., 38.00 or 12.43).]**
1.15	§422 of the MMA IRB ratio for the current MCR period. Calculate the §422 of the MMA IRB ratio for the current MCR period. The §422 of the MMA IRB ratio is equal to the increase in the un-weighted FTE count (line 1.13 above) divided by the bed count (line 1.14 above). **[Value must be taken to six decimal points (i.e., 34.567890 or 12.540000).]**
Outpatient Data	
1.16	Number of Ambulatory Surgery Visits. Total number of scheduled outpatient ambulatory surgical visit provided to patients who do not remain in the hospital overnight. The surgery may be performed in operating suites also used for inpatient surgery specifically designed surgical suites for outpatient surgery, or procedure rooms within an outpatient care facility.
1.17	Number of Radiology Visits. Total number of diagnostic radiology visits provided to patients in the outpatient setting such as computed tomographic scanner (CT scan), magnetic resonance imaging (MRI), position emission tomography (PET), Single photon emission computerized tomography (SPECT), and ultrasound. (Do not include inpatient testing)
1.18	Number of Urgent Care Visits. Total number of urgent care visits that provide care and treatment for problems that are not life threatening but require attention over the short term.
1.19	Number of Emergency Department Visits. Total number of emergency room visits for patients whose condition requires immediate care.
1.20	Number of Clinic Visits. Total number of clinic visits to each specialized medical unit responsible for the diagnosis and treatment of patients on an outpatient, non-emergency basis. Visits to the satellite clinics and primary group practices should be included if revenue is received by the hospital.

Instructions for Completing HRSA 99-4

Government Performance and Results Act Tables

Hospitals must report data from the cost reporting period reflected on line 4.01 of HRSA 99-1

Table 1. Number of FTE Residents Supported by the Children's Hospitals in Approved Residency Training Programs

Note: Applicants requesting funding must submit the required data in the following format. This data is for residents rotating through both the inpatient and outpatient settings of the hospital. Resident FTE counts reported below should be un-weighted and line 1.04 (below) should be consistent with the un-weighted resident FTE counts reflected in Form HRSA 99-1 Section 4.

Line	Instructions
1.01	**Sponsored* by the Children's Hospital and Rotating at the Children's Hospital.** Provide the number of FTE residents (family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, general surgery, subspecialty pediatric & fellows, and all other non-pediatric) training in your hospital and sponsored by your hospital during the cost reporting period.
1.02	**Sponsored by the Children's Hospital and Rotating at Non-provider Sites.** Provide the number of FTE residents family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, general surgery, subspecialty pediatric & fellows, and all other non-pediatric sponsored by your hospital but are rotating to non-provider sites during the cost reporting period.
1.03	**Sponsored by Other Hospitals and Rotating at the Children's Hospital.** Provide the number of FTE residents (family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, general surgery, subspecialty pediatric & fellows, and all other non-pediatric sponsored by another hospital but are rotating to your hospital during the cost reporting period.
1.04	**Total Number of FTE Residents.** Provide the total number of FTE Residents from the sum of Lines 1.01 through 1.03 (above)
1.05	**Sponsored by the Children's Hospital and Rotating at Other Hospitals.** Provide the number of FTE residents family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, general surgery, subspecialty pediatric & fellows, and all other non-pediatric sponsored by your hospital but are rotating to other hospitals during the cost reporting period.

Definitions	
Sponsoring Institution	*CHGME Payment Program defines a sponsoring institution as an institution, which assumes the ultimate responsibility for a graduate medical education program. According to the Accreditation Council for Graduate Medical Education (ACGME), the following are the institutional requirements for a Sponsoring Institution: 1) A residency program must operate under the authority and control of a sponsoring institution. 2) There must be a written statement of institutional commitment to GME that is supported by the governing authority, the administration, and the teaching staff. 3) Sponsoring institutions must be in substantial compliance with the Institutional Requirements and must ensure that their ACGME-accredited programs are in substantial compliance with the Program Requirements and the applicable Institutional Requirements. 4) An institution's failure to comply substantially with the Institutional Requirements may jeopardize the accreditation of all of its sponsored residency programs.
Family Medicine Resident	Residents training in their initial residency period of a family medicine residency program
General Internal Medicine Resident	Residents training in their initial residency period of a general internal medicine residency program

General Pediatric Resident	Residents training in their initial residency period of a general pediatric residency program
Preventive Medicine Resident	Residents training in their initial residency period of a preventive medicine residency program
Geriatric Medicine Resident	Residents training in their initial residency period of a geriatric medicine residency program
Osteopathic General Practice Resident	Residents training in their initial residency period of a osteopathic general practice residency program
General Surgery Resident	Residents training in their initial residency period of a general surgery residency program
Subspecialty Pediatric Resident	Residents training beyond their initial residency period (i.e., fellows)
All Other Non-Pediatric Resident	Residents training in their initial residency period not specifically in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, general surgery (i.e., radiology, pathology, endocrinology, dental)

Table 2. Hospital's Total and Operating Margins

Margin Types	Hospitals Filing Low or No-Utilization Medicare Cost Reports	Hospitals Filing Full Medicare Cost Reports
Total Margins	Total margin is defined as the net income from all sources [(net patient revenue + all other income)-[(total operating expenses + other expenses)] divided by total hospital revenues (net patient revenues + total other income) multiplied by 100	To calculate the total margin take Worksheet G-3 Line 31 and divide it by Line 3 + Line 25.
Operating Margins	The operating margin is defined as the net income from service to patients (net patient revenues – total operating expenses) divided by net patient revenues (total patient revenues – contractual allowances) multiplied by 100	To calculate the operating margin, take the number from Worksheet G-3 line 3, subtract the number from worksheet A Column 3 line 118, divide by the number from worksheet G-3, line 3 and multiply it by 100.

Table 3. Hospital’s Allowable Operating Expenses

Margin Types	Hospitals Filing Low or No-Utilization Medicare Cost Reports	Hospitals Filing Full Medicare Cost Reports
Total Allowable Operating Expenses	Contact the hospital’s fiscal intermediary to clarify what Medicare accepts as allowable operating expenses, if mechanism is not already identified in the hospital’s financial statements	The total allowable operating expenses can identified on the hospital’s Medicare cost report - Worksheet G-2 Part II Line 29

Table 4. Hospital’s Revenue and Expenses Attributed to Patient Care

Revenue/Expense Type	Inpatient	Outpatient
Hospital’s gross revenue attributed to Medicaid and SCHIP (Medicaid refers to any funding provided by Title XIX including that from Medicaid HMOs and DSH payments. SCHIP-State Children’s Health Insurance Program refers to funding provided under Title XXI).	Revenue received by the hospital from the Medicaid and SCHIP programs for inpatient care. Report as dollar amounts rather than percentages	Revenue received by the hospital from the Medicaid and SCHIP programs for outpatient care. Report as dollar amounts rather than percentages

Hospital’s gross revenue attributed to Medicare	Revenue received by the hospital from the Medicare for inpatient care. Report as dollar amounts rather than percentages	Revenue received by the hospital from the Medicare for outpatient care. Report as dollar amounts rather than percentages
Hospital’s gross revenue attributed to self-pay	Revenue received by the hospital directly from patients for inpatient care. Report as dollar amounts rather than percentages	Revenue received by the hospital directly from patients for outpatient care. Report as dollar amounts rather than percentages
Hospital ‘s gross revenue attributed to other sources	Revenue received by the hospital from other sources for inpatient care not listed above. Report as dollar amounts rather than percentages	Revenue received by the hospital from other sources for outpatient care not listed above. Report as dollar amounts rather than percentages
Hospital’s total gross revenue attributed to patient care	Total gross revenue received by the hospital for inpatient care (sum of inpatient columns 1-4). Report as dollar amounts rather than percentages.	Total gross revenue received by the hospital for outpatient care (sum of outpatient columns 1-4). Report as dollar amounts rather than percentages.
Hospital’s total expenses attributed to uncompensated care	Total expenses that the hospital attributes to uncompensated inpatient care. Report as dollar amounts rather than percentages.	Total expenses that the hospital attributes to uncompensated outpatient care. Report as dollar amounts rather than percentages.
Hospital’s total expenses attributed to charity care	Total expenses that the hospital attributes to charity care in the inpatient setting. Report as dollar amounts rather than percentages.	Total expenses that the hospital attributes to charity care in the outpatient setting. Report as dollar amounts rather than percentages.

Instructions for Completing HRSA 99-5

Application Checklist

The application checklist must be completed following the instructions provided on the checklist itself. All required forms and supporting documentation should be included in the application package submitted in the HRSA Electronic Handbooks to the CHGME Payment Program in the order that the forms and supporting documentation are listed on the checklist.

Section XIV

References

Commonly Used Acronyms

ACGME	ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION
AF	AS FILED
CH	CHILDREN'S HOSPITAL
CHGME Payment Program	CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM
CMI	CASE MIX INDEX
CMS	CENTERS FOR MEDICARE AND MEDICAID SERVICES
D(G)ME	DIRECT (GRADUATE) MEDICAL EDUCATION
EHB	ELECTRONIC HANDBOOK
FEL	FELLOW
FI	FISCAL INTERMEDIARY
FY	FEDERAL FISCAL YEAR
FRN	FEDERAL REGISTER NOTICE
FTE	FULL-TIME EQUIVALENT
GME	GRADUATE MEDICAL EDUCATION
GPRA	GOVERNMENT PERFORMANCE AND RESULTS ACT OF 1993
HRSA	HEALTH RESOURCES AND SERVICES ADMINISTRATION
IME	INDIRECT MEDICAL EDUCATION
IRB	INTERN RESIDENT BED COUNT
IRP	INITIAL RESIDENCY PERIOD
MAC	MEDICARE ADMINISTRATIVE CONTRACTOR
MCR	MEDICARE COST REPORT
NBME	NATIONAL BOARD OF MEDICAL EXAMINERS
PGY1	POST-GRADUATE YEAR (1,2,….)
PPS	PROSPECTIVE PAYMENT SYSTEM
RES (R)	RESIDENT (1,2,…)
USMLE	UNITED STATES MEDICAL LICENSING EXAMINATION
WI	WAGE INDEX