

## Section 131 of the CAA: Guidance on Teaching Hospitals' Eligibility for Direct GME Resets

On December 27, 2021, CMS issued a [FY 2022 IPPS final rule with comment period \(86 FR 73416\)](#) that implements changes to Medicare graduate medical education (GME) payments for teaching hospitals. The rule implements the legislative changes to direct GME and indirect medical education (IME) payments to teaching hospitals included in sections 126, 127, and 131 of the Consolidated Appropriations Act (CAA), 2021.

This note serves as a summary of guidance to hospitals that may be affected by section 131 of the CAA. Refer to the final rule for full guidance at [CMS-1752-FC3](#).

Section 131 of the CAA provides an opportunity for certain hospitals with very low direct GME Per Resident Amounts (PRAs) or resident caps to reset those PRAs and resident caps during the time frame of December 27, 2020 to December 26, 2025. Generally, we refer to eligible hospitals as either Category A or Category B. A Category A Hospital is one that, as of the date of enactment (December 27, 2020), has a PRA or resident cap(s) that was established based on less than 1.0 FTE in any cost reporting period beginning before October 1, 1997. A Category B Hospital is one that, as of the date of enactment (December 27, 2020), has a PRA or resident cap(s) that was established based on training of no more than 3.0 FTEs in any cost reporting period beginning on or after October 1, 1997, and before the date of enactment (December 27, 2020).

We posted on our website an extract of the Medicare cost reports from the Hospital Cost Report Information System (HCRIS) going back to 1995 to assist hospitals in determining their eligibility for a PRA or resident cap reset. Hospitals are responsible for reviewing the HCRIS posting to determine by themselves if they are eligible for a PRA and/or a resident cap resets. Medicare Administrative Contractors (MACs) will not reach out to hospitals to inform them of eligibility, nor will MACs review requests to confirm eligibility.

### What should a hospital do to determine whether it is eligible for a PRA and/or resident cap resets?

It must consult the HCRIS posting here –

- [FYS 1995 AND 1996 AND COST REPORT FORM-2552-96 GME DATA \(ZIP\)](#)
- [COST REPORT FORM-2552-10 GME DATA \(ZIP\)](#)
  - The hospital should carefully review this information, and look for what is or is not reported in the PRA fields and in the FTE counts and FTE cap fields for IME and direct GME.
  - If no PRA fields are filled in, and no resident cap fields are filled in, the hospital as reflected in HCRIS is not a teaching hospital and does not need section 131, as there is no PRA and/or resident cap to “reset.”

Examples of hospitals that are eligible for a PRA and/or resident cap resets are:

- The hospital's cost report in HCRIS that ended on or before December 31, 1996 shows an FTE count of less than 1.0 for either IME or direct GME.
- The hospital's cost report in HCRIS that began on or after October 1, 1997, and before December 27, 2020 shows an FTE count of not more than 3.0 for either IME or direct GME.
- A hospital where FTEs are reported on a settled cost report, but the FTE cap lines are not filled (this hospital would be eligible for new FTE caps).
- A hospital with FTEs reported on a settled cost report, but the PRA lines are not filled in on that earliest cost report where FTEs are reported (this hospital would be eligible for a new PRA).
- A hospital with a PRA reported on a settled cost report, but no FTEs are reported on the earliest cost report in which the PRA is reported, so the amount of FTEs used to determine that PRA cannot be determined (this hospital would be eligible for a new PRA).
- A hospital's employee(s) recall that residents were trained at the hospital, but no FTEs were reported on any settled Medicare cost report, as shown in HCRIS (this hospital as reflected in HCRIS is not a teaching hospital and does not need section 131, as there is no PRA and/or resident cap to "reset").

### **How and when would an eligible hospital receive a new PRA and/or resident caps?**

A Category A hospital may choose to receive a recalculated PRA either when it trains at least 1.0 FTE in the earliest cost reporting period beginning on or after December 27, 2020, and before December 26, 2025, or when it trains at least 1.0 FTE in the first cost reporting period beginning after December 27, 2021. A Category B hospital may choose to receive a recalculated PRA either when it trains more than 3.0 FTEs in the earliest cost reporting period beginning on or after December 27, 2020 and before December 26, 2025, or when it trains more than 3.0 FTE in the first cost reporting period beginning after December 27, 2021. In either case, residents need not be on duty during the first month of the cost reporting period. The PRA reset can result from residents in either an existing program or a new program. The Category A or B hospital should contact its MAC at the first time that it trains the requisite amount of FTEs, and request a PRA reset. The recalculated PRA is effective prospectively to the first cost report it trains the requisite number of FTEs, and after. The MAC would follow regulations at 42 CFR 413.77(e)(1) for establishing a new PRA.

To receive new resident caps, first, the hospital must start a new residency program(s) during the 5-year period of December 27, 2020 through December 26, 2025. The hospital should notify its MAC that it is starting to train residents in a new program. The MAC would review documentation and must confirm that the hospital is training at least 1.0 FTE in the new program(s). Then the MAC would confirm the hospital's eligibility by reviewing the HCRIS posting, and calculate resident caps based on the new program(s) using the existing regulations in place at 42 CFR 413.79(e)(1).

**What if the HCRIS posting shows a hospital is NOT eligible for a reset, but the hospital believes the HCRIS posting is incorrect?**

If, for open or reopenable cost reports, there is a PRA and/or FTE caps reported on the HCRIS web posting, and the potential Category B hospital believes its PRA in fact was established based on not more than 3.0 FTEs, or its IME and/or direct GME FTE caps were based on not more than 3.0 FTEs, the hospital has a **one-time opportunity** to demonstrate to the MAC that it is eligible for a reset. For example, the HCRIS posting shows the hospital has resident caps of 4.0, and the hospital believes that is NOT correct, and wants to show the MAC documentation that in fact, its FTE caps are less than 3.0. The hospital must electronically submit complete and unambiguous documentation demonstrating reset eligibility, which must be **received** by the MAC no later than **July 1, 2022**. In its submission, the hospital must state the fiscal year begin and end dates and the NPR date of the cost report(s) it believes are incorrect.

**What if a hospital's cost report is not included in HCRIS posting?**

There may be situations where a cost report is not in HCRIS web posting, or even if the cost report is in the HCRIS web posting, there is no PRA or no FTE caps reported because the cost report has not yet been settled and/or the MAC has not yet determined the PRA or the FTE caps. Such a hospital must submit a request to the MAC by July 1, 2022 requesting that the MAC issue a determination regarding possible reset eligibility for the PRA and/or FTE caps using cost reports that began prior to enactment. The review request must be received by July 1, 2022, and must include complete and unambiguous documentation for FTE counts and for FTE cost and payment information (see response regarding documentation requirements). The MAC would use existing regulations at 42 CFR 413.77(e) and 42 CFR 413.79(e)(1) to determine the hospital's PRA and FTE caps from the cost report(s).

**Who should a hospital contact with additional questions?**

A hospital can contact its MAC with additional questions.