



**Latest GME Legislation**


*May 7, 2021*  
*GME Finance Information & Workshop*  
*Laura Gillenwater, CPA*

HORNELLP.COM


1

## **Consolidated Appropriations Act 2021**

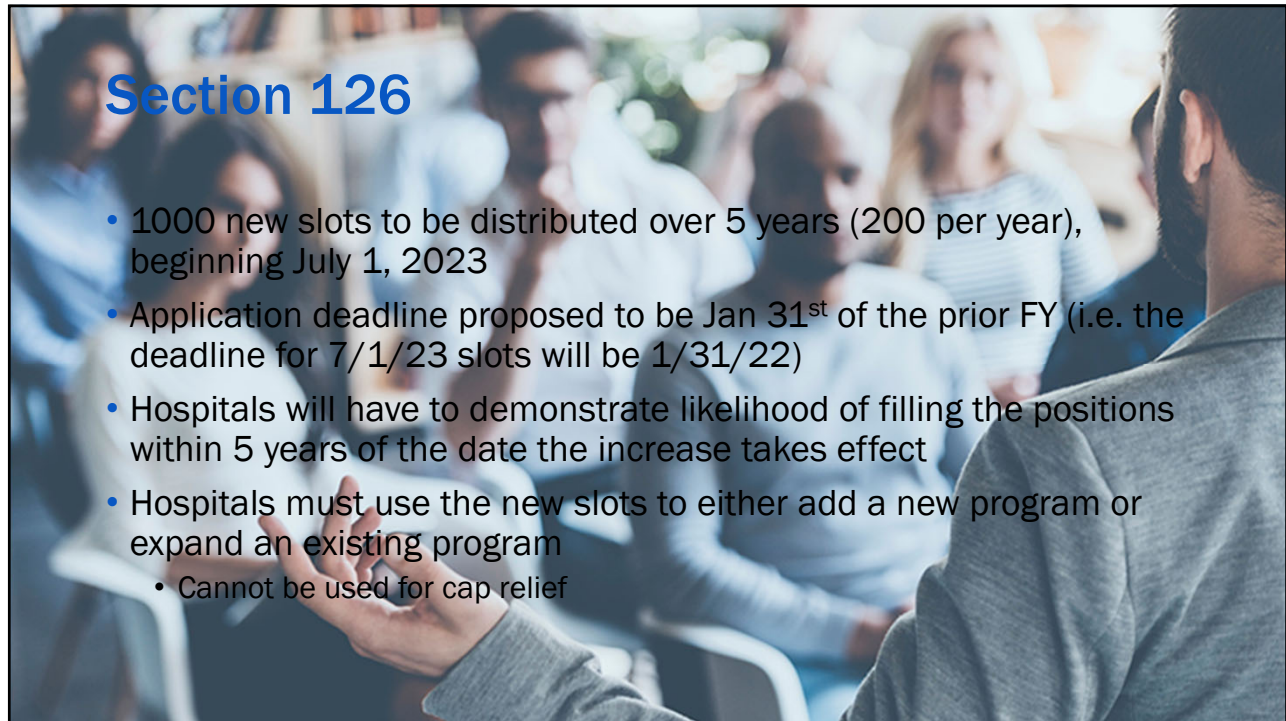
- Section 126 – 1000 new Medicare-funded GME slots
- Section 127 – Rural Training Tracks
- Section 131 – PRA & FTE Cap resets
  
- The recent FY 2022 IPPS Proposed Rule has addressed implementation of these 3 major provisions



HORNELLP.COM



2



## Section 126


- 1000 new slots to be distributed over 5 years (200 per year), beginning July 1, 2023
- Application deadline proposed to be Jan 31<sup>st</sup> of the prior FY (i.e. the deadline for 7/1/23 slots will be 1/31/22)
- Hospitals will have to demonstrate likelihood of filling the positions within 5 years of the date the increase takes effect
- Hospitals must use the new slots to either add a new program or expand an existing program
  - Cannot be used for cap relief


3

## Section 126

---

- Minimum Distributions for Certain Categories by Statute
  - 10% to hospitals in rural areas or treated as being rural
  - 10% to hospitals training residents over their cap
  - 10% to hospitals in states with new medical schools or new branches of existing medical schools
  - 10% to hospitals in HPSAs
- CMS is proposing two methodologies for distributing FTEs
  - First method would be based on HPSA score, with priority given to highest scores (25 on scale of 0-25)
  - Second Method would be based on hospitals meeting criteria above, with those meeting all 4 criteria prioritized above those meeting 3 out of 4, etc.


[HORNE LLP.COM](https://www.hornellp.com)


  
**HORNE**

4

## Section 126

---

- Statute states that an individual hospital may receive no more than 25 FTEs
- However, CMS is proposing to limit the increase of positions to each individual hospital to no more than **1.0 FTE per year**
- Similar to the 5503 program, these FTEs will be subject to the 3-year rolling average

5

## Section 127

- Previously, only urban hospitals were guaranteed increase in FTEs for RTTs. If the program did not meet the “newness” criteria for CMS purposes, the rural hospital would not get an increase for the RTT
- Section 127 changes that, and CMS is proposing that each time an urban and rural hospital establish an RTT program for the first time, even if does not meet newness criteria, both urban and rural hospitals may receive RTT FTEs

6

## Section 127

---

- Urban hospitals with existing RTTs can now create additional RTTs with different rural hospitals and both can add to their cap
  - Example of a new “spoke” from the “hub”
- ACGME no longer has to “separately accredit” an RTT program for it to qualify. This opens RTTs up to specialties beyond family medicine.
- New RTTs treated like other new programs in initial years and not subject to 3-year rolling average during first 5 years of program

7

## Section 131

---

- Reset of Per Resident Amount for hospitals with extremely low or \$0 PRAs
  - Must meet certain criteria:
    - Hospital has a PRA that was established based on less than 1.0 FTE in any cost reporting period beginning before Oct 1, 1997 (Category A Hospital)
    - Hospital has a PRA that was established based on training of no more than 3.0 FTEs in any cost reporting period beginning on or after Oct 1, 1997 and before Dec 27, 2020 (Category B Hospital)
- If a Category A Hospital trains at least 1.0 FTE in a cost reporting period beginning on/after Dec 27, 2020 and before Dec 26, 2025, then it can reset its PRA

8

## Section 131

---

- If a Category B Hospital trains more than 3.0 FTEs in a cost reporting period beginning on/after Dec 27, 2020 and before Dec 26, 2025, then it can reset its PRA
- Resetting of PRA will follow same methodology as a new teaching hospital (42 CFR 413.77(e))
- Hospital does not have to be training these residents in a new program in order to qualify
- Once reset, the PRAs are permanent



9

## Section 131

---

- For cost reporting periods beginning on/after Dec 27, 2020, CMS is proposing to only establish a PRA when a hospital trains at least 1.0 FTEs
  - Exception – hospital enters into Medicare GME affiliation agreement
- Similarly, for all hospitals that have not yet triggered a cap, permanent FTE caps will no longer be triggered until a hospital trains at least 1.0 FTE.
- Also proposing that all hospitals must enter the FTE counts on E, Part A and E-4 of the cost report for cost reporting periods during which the hospital trains at least 1.0.



10

## Section 131

---

- Resetting FTE resident caps
  - Category A Hospital – Hospital with an IME or DGME FTE cap of less than 1.0 that was established from their 1996 cost report
  - Category B Hospital – Hospital with an IME or DGME FTE cap established after 1997 (and before Dec 27, 2020) based on training of no more than 3.0 FTEs
- Thresholds for resetting FTE caps are similar to PRA, with the exception that FTE caps will only be reset if a Category A or B Hospital begins training FTE residents in a new residency program.
- FTE replacement caps will be calculated based on existing regulations (42 CFR 413.79(e)(1))



11

## Future Legislation

---

### Modern Healthcare

NEWS    INSIGHTS    TRANSFORMATION    DATA/LISTS    OP-ED    AWARDS    EVENTS    LISTEN    MORE

Home > Politics & Policy

April 23, 2021 04:18 PM

### Congress eyes adding more Medicare GME slots in infrastructure package

JESSIE HELLMANN [T](#) [in](#) [✉](#)

[TWEET](#) [f SHARE](#) [in SHARE](#) [✉ EMAIL](#)

[PRINT](#)



12




  
HORNE

# Questions?


HORNELLP.COM

13





# THANK YOU!

HORNELLP.COM



**Laura Gillenwater, CPA**

Senior Manager | HORNE  
laura.gillenwater@hornellp.com



14