Final Rule GME provisions of Consolidated Appropriations Act, 2020

KEY DEADLINES:

- March 31, 2022 – to apply for new slots under Section 126
- July 1, 2022 – If hospital disagrees with posted HCRIS report regarding eligibility -- to apply to MAC for eligibility redetermination for a cap or PRA reset

I. Section 126 – 1,000 additional slots

The Secretary is required to notify hospitals of the number of positions distributed to them by January 31 of the fiscal year of the increase, and the increase is effective beginning July 1 of that fiscal year. Section 1886(h)(9)(A) of the Act also limits the aggregate number of such positions made available in a single fiscal year across all hospitals to no more than 200.

a) Application deadline:

March 31, of the prior fiscal year is the deadline for applications for additional positions available for a fiscal year. (eg. For FY 2023, all references to the application deadline are references to the March 31, 2022.)

Application process and materials can be found here:
https://mearis.cms.gov/public/resources?app=gme126

b) Number of slots:

No more than 2000 slots per year, statutory maximum of 25 per hospital, but the final rule stipulates maximum of 5 FTEs, a hospital may not submit more than one application in any fiscal year.

- Our comment that the number of FTEs for which a hospital can receive should be based on the length of training, so that the "slot" would continue throughout one resident's training was supported. Specifically, the maximum award amount is contingent on the length of the program for which a hospital is applying, with up to 1.0 FTE being awarded per program year, not to exceed a program length of 5 years or 5.0 FTEs. For example, a hospital applying to train residents in a program in which the length of the program is 3 years may request up to 3.0 FTEs per fiscal year.

c) Demonstrated Likelihood:

- Submit copies of its most recently submitted Worksheets E, Part A and E-4 from Medicare cost report (CMS-Form-2552-10) as part of its application
- Demonstrate and Attest to a planned new program or expansion of existing one by meeting at least one of the two criteria below:
    - Criterion 1: New Residency Program:
        - Not sufficient room under its existing cap
        - It intends to use the additional FTEs as part of a new residency program it will establish on or after the date the new slots would be effective (within 5 years)
        - Must meet at least one of the following:
            - Application to ACGME has been submitted by the application deadline for new slots

- Hospital has written correspondence from ACGME or ABMS acknowledging receipt of application (or similar communication by the application deadline)

- Criterion 2: Expansion of an existing residency program:
  - No sufficient room under their existing cap,
  - Intends to expand an existing program within 5 years and use those slots for that program
  - Must meet at least one of the following:
    - Approval from appropriate governing body (ACGME or ABMS) to expand
    - Hospital has submitted a request by the application deadline

d) Set-aside: 10 percent for each:
(1) hospitals located in rural areas or that are treated as being located in a rural area (pursuant to sections 1886(d)(2)(D) and 1886(d)(8)(E) of the Act);
(2) hospitals in which the reference resident level of the hospital is greater than the otherwise applicable resident limit;
(3) hospitals in states with new medical schools or additional locations and branches of existing medical schools; and
(4) hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs).

A qualifying hospital is a Category One, Category Two, Category Three, or Category Four hospital, or one that meets the definitions of more than one of these categories.

1) Category One: Determination of Hospitals that are Located in a Rural Area or are Treated as Being Located in a Rural Area
- Must fit criteria under sections 1886(d)(2)(D) or 1886(d)(8)(E), as either located in a rural area or treated as such, respectively. (Rural classification under section 1886 (d)(2)(D) is if you are not in an urban Core-Based Statistical Area (CBSA), previously Metropolitan Statistical Area or MSA.
- A table (CMS calls it Table 2) will be posted with the most recent final rule and on the CMS website to identify hospitals that are classified as rural for these purposes.
- If a hospital is not listed as reclassified to rural on Table 2 but has been subsequently approved by the CMS Regional Office to be treated as being located in a rural area for purposes of payment under the IPPS as of the application deadline for additional positions for the fiscal year, the hospital must submit its approval letter with its application.
- CMS will we permit hospitals that previously qualified as an RRC but lost their status due to the Office of Management and Budget (OMB) redesignation of the county in which they are located from rural to urban to be reinstated as an RRC. However, CMS states that “there are a relatively small number of hospitals with RRC status that are neither located in a rural area nor treated as being located in a rural area under section 1886(d)(8)(E) of the Act (approximately 11 percent). CMS clarifies that such hospitals, despite their status as RRCs, would not qualify under Category One.

2) Category Two: Determination of Hospitals for which the Reference Resident Level of the Hospital is Greater than the Otherwise Applicable Resident Limit
- These are “over cap” hospitals. Each hospital has a DME and an IME cap. A hospital can only apply for positions related to whichever (or both) caps are “over.” For example, if a hospital has sufficient room under its IME cap to expand an existing program, but not

under its direct GME cap, that hospital may only apply for direct GME residency positions, but not IME residency positions, to facilitate the planned expansion.

3) Category Three: Determination of hospitals located in States with New Medical Schools, or Additional Locations and Branch Campuses

- CMS proposed and now finalizes that hospitals located in the following 35 States and 1 territory" will fit this category:
- Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

4) Category Four: Determination of Hospitals that Serve Areas Designated as Health Professional Shortage Areas under Section 332(a)(1)(A) of the Public Health Service Act

- Geographic primary care HPSAs and mental health HPSAs will qualify (only for psychiatry and subspecialty psychiatric programs for the latter) with the following conditions:
    i. Instead of just hospitals which have their main campuses or provider-based facilities within a geographic primary care or mental health HPSA, CMS's final rule will now allow hospitals where at least 50% of the training occurs in sites located in these HPSA's to be eligible to apply for additional positions under this category. The 50% training time will be substantiated by utilizing resident rotation schedules (submitted as part of IRIS) or similar documentation.
    ii. Our joint family medicine comments recommended that CMS expand beyond hospital (or provider-based) sites of training and include non-hospital and non-provider settings. We prevailed on this point. Specifically, CMS stated, "We are persuaded by commenters' arguments and agree that training in settings other than hospital settings is consistent with our goal of maximizing distribution of GME positions to residency programs serving underserved populations, including serving those in community settings, and should be counted toward meeting Category Four eligibility requirements." This includes training at VA facilities.
    iii. A Category Four hospital must submit an attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report, that it meets the 50 percent requirement.
    iv. CMS continues to welcome further feedback on the dependence of geographic HPSA residents on health services provided outside of their HPSA and are seeking comment on appropriate summary measures of where HPSA residents seek medical care as a feasible alternative for potential use in future rulemaking.

e) Prioritization of Applications from Hospitals for Residency Programs that Serve Underserved Populations"

Note: prioritization is different/separate from qualification or eligibility.

1) Applications from hospitals for a fiscal year are grouped by the HPSA score of the application, with each grouping consisting of those hospitals with the same HPSA score. Applications are prioritized by descending HPSA score. Within each grouping, applications with equal priority (i.e., those with the same HPSA score) are next grouped by whether the application is from a hospital with a bed size of less than 250 beds, or 250 beds or more. Applications from hospitals with less than 250 beds are prioritized within each grouping. The number of beds in the hospital is determined in accordance with § 412.105(b). If there are insufficient slots available to be distributed to all applications with both the same HPSA score and the same bed size grouping,

the remaining available slots are prorated among those applications. See below for discussion of some specific comments and nuances.

- CMS notes that there is a difference between the Category Four qualification "requirement" and the prioritization "criterion" that 50 percent of a program's training time occur at training sites physically located in a HPSA. This section further refines the prioritization within eligible/qualifying hospitals.
- CMS adds population HPSA's to the prioritization. Specifically, training in designated underserved population of a population HPSA must be greater than 50%, and adds Tribal sites to the entities beyond HPSAs.
- CMS will use HPSA scores to determine prioritization (higher HPSA score equates with higher prioritization.) Also, the training time spent in Indian and Tribal facilities outside of a HPSA can count towards the minimum training time criterion for that HPSA, up to a maximum of 45 percentage points of the 50 percentage points required.
- We commented that CMS should include CMS should include as qualifying criteria (for a set-aside) applications from small hospitals with less than 250 beds and generally smaller hospitals with only one residency program. CMS declined to do that, but within the prioritization of allocation of positions, CMS stated that "there is merit in considering smaller hospital size as a tiebreaker when prioritizing applications with equal HPSA scores in order to further reduce the impact of proration. Of the two suggestions by commenters, bed count is one of the most transparent and currently used measures of hospital size (42 CFR § 412.105(b)). Therefore, if there are insufficient FTE slots remaining to distribute to applications with equal HPSA scores, we will first distribute FTE slots to applications from hospitals with less than 250 beds. If there are insufficient FTE slots to distribute to applications from hospitals with less than 250 beds, only then would we prorate among those applications. If there are sufficient slots to distribute to applications from hospitals with less than 250 beds, we would prorate the remaining slots among the applications from hospitals with 250 beds or more."
- CMS was intrigued by our recommendation of the incorporation of an "impact factor" that measures the proportion of residents that ultimately go on to practice in HPSAs, to help ensure that section 126 of the CAA distributions support physician pipelines that produce lasting benefits for underserved areas. CMS agrees that a measure of the extent to which residents later practice in underserved areas may be beneficial. To inform potential future rulemaking, they asked for further comment on how to best estimate the impact factor using appropriately comprehensive and transparent data sources across physician specialties, and how to weigh an impact factor in the prioritization.

II. Section 127 – Promoting Rural Hospital GME Funding Opportunity (RTT provisions)

a) New Provisions:

This section of the statute does several things: 1) it removes the requirement that a rural track must be separately accredited.; 2) it allows for an increase in the cap for rural hospitals, not just the urban hospital, when an existing program establishes a training program in a rural hospital even if the rural program does not meet Medicare payment newness criteria; 3) it removes the rolling average provision for rural training programs, during its cap-setting period, and 4) it allows an urban hospital to establish additional sites for rural training programs rather than just the one first established. These changes apply to both direct and Indirect GME.

Regarding the rolling average, new programs beginning prior to Oct 1, 2022 will still be subject to the rolling average until the first cost period beginning on or after October, 1, 2022. This is a win for us in that the proposed rule stated that any programs started before October 1, 2022 would not be eligible for

the exemption from the rolling average. We requested that CMS allow the exemption for the cost periods after October 1, 2022. In the final rule CMS stated that "even for RTTs started prior to October 1, 2022, so long as the urban hospital and rural hospital are within the 5-year growth window for FTE residents participating in the RTT, the earliest a hospital can first benefit from the rolling average exemption is a hospital's first cost reporting period beginning on or after October 1, 2022.

Also, the term rural track will no longer be used. Rural tracks will now be considered rural track programs (RTPs[1]). To be considered a rural training program, at least 50% of training time of at least a subset of residents, must be in rural locations. In other words, the entire approved program is now a rural track program with a portion or all of its residents training in rural areas for at least 50% of their training time. Specifically, "Rural Track Program means, effective for cost reporting periods beginning on or after October 1, 2022, an ACGME-accredited program in which all, or some, residents/fellows gain both urban and rural experience with more than half of the education and training for the applicable resident(s)/fellow(s) taking place in a rural area as defined at 42 CFR 412.62(f)(iii). Other programs that don't meet these criteria will just be called programs.

b) Clarification of regulations not altered in this section:

- The new regulations do not allow for expansion of existing rural sites.
- GME affiliation agreements are not allowed

c) Documentation Requirements:

CMS will amend or clarify as necessary the Medicare cost report, CMS-2552-10, Worksheets E, Part A for IME and E-4 for direct GME, to accommodate additional rural track limitations.

Hospitals will need to provide the following:

- The ACGME accreditation for the program as a whole (that is, both urban and rural training components), and documents showing whether the urban and rural participating sites are starting the RTP for the first time in this particular specialty, or whether the urban and rural hospital already have an RTP in this specialty, but are adding additional participating sites to the RTP.
- Resident rotation schedules (or similar documentation) showing that residents in the specified RTP spend greater than 50 percent of their training in a geographically rural area in the 5-year growth window in order to receive IME and direct GME rural track FTE limitations. In the instance where only a subset of the residents in the particular program are participating in the RTP, and the training time of the RTP residents is included in the main rotation schedule for the entire program, the hospital must specifically highlight the names of the residents and their urban and rural training locations on the main rotation schedule, so that the MAC can easily identify which residents are training in the RTP, where they are training, and be able to verify that over 50 percent of their training time is spent in a rural area.
- The number of FTE residents and the amount of time training in all 5 program years at both the urban and rural settings since establishment of a Rural Track Program (based on the rotation schedules), so that this information is available to the MAC when needed in auditing the accuracy of the RTP FTE cap limitation established by the hospital in the cost reporting period that coincides with or follows the start of the sixth program year of the RTP.

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[1] the ACGME defines Rural Track Program (RTP) as follows: **ACGME Rural Track Program (RTP) –** An ACGME-accredited program with a unique 10-digit identifier in which residents/fellows gain both urban and rural experience with more than half of the education and training for each resident/fellow taking place in a rural area (any area outside of a Core-Based Statistical Area (CBSA)). CMS doesn't require a unique 10 digit identifier or that "each" resident spends more than 50% time in rural training.

CMS recommends that a hospital that believes it qualifies for an RTP FTE limitation should approach its MAC showing it meets the greater than 50 percent rural training requirement, and the MAC may adjust the hospital's interim rates so that effective for a cost report starting on or after October 1, 2022, the hospital could receive increased IME and direct GME payment as appropriate.

d) Clarification of Definitions:

- CMS, in response to comments will be using ACGME terminology going forward. The will, instead of referring to the "core" and "hub" for the urban hospital, and "spoke" for the rural training sites, they will refer to the urban hospital(s) as the "primary clinical site," and will refer to the various other training locations as either the "rural hospital participating site," if the site is a rural hospital, or the "rural non-provider participating site" if the site is an ambulatory clinic, or some other non-hospital site.

- If a hospital is physically located in an urban area but is reclassified to rural areas under 42 CFR 412.103, it is treated as rural for IPPS payment purposes, which includes IME. However, 42 CFR 412.103 does not affect direct GME because direct GME is addressed under section 1886(h) of the Act. This means that such a hospital is rural for IME purposes, but it is urban for direct GME purposes (because it is still physically located in an urban area).

III. Section 131: Addressing Adjustment of Low Per Resident Amounts (Direct GME) and Low FTE Resident Caps (Direct GME and IME) for Certain Hospitals (Rotator Issues)

This section of the CAA was legislation we supported and worked for its enactment for years. A legislative fix to a problem many hospitals faced after being deemed teaching hospitals by CMS by hosting a minimal number of rotators (residents training for brief periods of time), even just one. Many hospitals were frozen with low caps (below 1 or 3 FTEs) or with low or even zero PRAs. This section of the final rule implements changes to allow for a one-time resetting (within 5 years of enactment) of either the cap or PRA, or both, for eligible hospitals and for hospitals to allow up to 1 FTE a year of rotators in the future without a cap or PRA being set. Date of enactment for these provisions is December 27, 2020. The recalculation period begins on December 27, 2020 and ends 5 years later – December 26, 2025.

Key Information:
If a hospital is eligible for a reset according to the HCRIS data (see below), it should request a reset from its MAC *when it starts a new program* and trains more than 1 FTE in that new program *on or after enactment and 5 years after that*.

If a hospital disagrees with the information regarding eligibility contained in the HCRIS report they have a one-time only opportunity to request a redetermination. Applications, including all documentation must be received by the MAC by July 1, 2022

To identify if your hospital is eligible for a reset, without further review from your MAC, find your hospital in a posting on the CMS website (see below) containing an extract of the HCRIS cost report worksheets on which the FTE counts, caps, and PRAs, if any, would have been reported, starting with cost reports beginning in 1995.

CMS is instructing MACs to only first accept reviews of PRAs or FTE caps from open or reopenable cost reports, with the exception of a Category A hospital or a Category B hospital that agrees with what is/is not reported in the HCRIS posting). This file can be found on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME

Examples of hospitals that would qualify for a reset based on the HCRIS extract without need for further MAC review are as follows:

- 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 (Category A).
- The hospital's cost report in HCRIS that began on or after October 1, 1997, and before enactment of section 131 of CAA shows an FTE count of not more than 3.0 for either IME or direct GME (Category B).
- 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.
- 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).

1) Adjusting the PRA:

a) Eligibility for adjusting a hospital's PRA:

The rule establishes two categories of hospitals (Category A and B). A Category A Hospital is one that (as of date of enactment) has a PRA that was established based on less than 1.0 FTE in any cost-reporting period before Oct 1, 1997 (enactment of the Balanced Budget Act – when caps were first set.) A Category B hospital as of date of enactment has a PRA that was established based on training 3 or less FTEs in a cost reporting period on or after Oct 1, 1997 and before the date of enactment. (See CMS website mentioned above to check your hospital's eligibility.)

A reset would not be triggered until a hospital trains at least one FTE (for a Category A hospital) or more than three FTEs (for a Category B hospital) in a cost reporting period beginning after enactment and within the five year window.

b) Setting a new PRA:

The current regulations on how a PRA is set will be used to determine a new PRA for eligible hospitals. Once set (re-set) the PRA will become permanent, only updated for inflation in subsequent years. CMS will not round up the FTE numbers when addressing thresholds. For example, an FTE count of .99 would not trigger a reset for a category A hospital.

The new teaching hospital's PRA generally will be based on the lower of –

- The hospital's actual cost per resident incurred in connection with the GME program(s) based on the cost and resident data from the hospital's replacement base year cost reporting period; and
- The updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area is calculated using all per resident amounts (including primary

care and obstetrics and gynecology and nonprimary care) and FTE resident counts from the most recently settled cost reports of those teaching hospitals.
- If there are fewer than three existing teaching hospitals with per resident amounts that can be used to calculate the weighted mean value per resident amount, for base periods beginning on or after October 1, 1997, the per resident amount equals the updated weighted mean value of per resident amounts of all hospitals located in the same census region.

c) GME affiliation agreement exception:

CMS will establish a PRA in the instance where a hospital trains less than 1.0 FTE and that hospital has entered into a Medicare GME affiliation agreement for that training. However, in the instance where a hospital did not enter into a Medicare GME affiliation agreement for that training, CMS will only establish a PRA when a hospital trains at least 1.0 FTE.

d) Documentation Requirements:

All hospitals, even if they do not classify as Category A or Category B Hospitals, must enter the FTE counts on Worksheets E, Part A and E-4 of the CMS-Form-2552-10, for cost reporting periods during which the hospital trains at least 1.0 FTE. In addition, the hospital must provide the information required by the Interns and Residents Information System (IRIS) software for a cost report that contains at least 1.0 FTE on Worksheets E, Part A (IME) and E-4 (direct GME). Note: If the hospital participates in a GME affiliation agreement it must report on all FTEs whether they reach the 1.0 FTE threshold or not.

2) Adjusting a hospital's FTE Resident Caps:

Similar to the PRA reset, CMS establishes two categories of hospitals; Category A has a cap of less than 1.0 FTE determined in 1997 (based on 1996 base year); Category B would have a cap of 3 or less FTEs based on any year since 1997 until enactment. (Check the CMS website for eligibility)

The adjustment to each qualifying hospital's cap for new residency training program(s) would be equal to the sum of the products of--

- The highest total number of FTE residents trained in any program year during the fifth year of the first new program's existence at all of the hospitals to which the residents in the program rotate;
- The number of years in which residents are expected to complete the program, based on the minimum accredited length for each type of program.
- The ratio of the number of FTE residents in the new program that trained at the hospital over the entire 5-year period to the total number of FTE residents that trained at all hospitals over the entire 5-year period.

CMS will issue instructions to the MACs and to hospitals to provide for an orderly process of request and review for the purpose of receiving replacement FTE resident caps. The MACs of the Category A and Category B Hospitals will review the FTEs reported in the Medicare cost reports, as well as rotation schedules, information regarding any non-provider-site training, and accreditation information, etc., to determine at what point the requisite threshold of FTE residents are trained.

Note: It is incumbent on a hospital to approach its MAC to request a PRA or cap reset; CMS will not instruct MACs to reach out to individual hospitals.

a) Documentation Requirements if hospital is eligible based on HCRIS:

- Hospitals must provide at a minimum, rotation schedules, training agreements, and ACGME accreditation information
- CMS doesn't plan to reopen cost reports beyond their 3-year reopening period, but would refer to and use whatever contemporaneous documentation they might need to establish the FTE resident caps.

a) One-Time Deadline to Request Reconsideration and Review by the MAC for Possible Category B Hospitals:

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 the information is incorrect and that it is eligible, the hospital has a 1-time opportunity to request reconsideration by its MAC which must be submitted electronically and received by the MAC on or before July 1, 2022.

The MAC will then review the information within a specified timeframe to be determined by CMS and make a determination as to the hospital's eligibility for a PRA and/or FTE cap reset based on the adequacy of the documentation submitted by July 1, 2022. The decision issued by the MAC to the hospital would be final. Hospitals that disagree with the MAC's determination could appeal to the Provider Reimbursement Review Board for review, assuming that all conditions for appeal are met.

Additional documentation needed for these hospitals:

PRA: The hospital must include documentation showing that the PRA base period started prior to December 27, 2020, and that the 5-year cap building window ended in a cost reporting period that started prior to December 27, 2020. Such documentation includes the following:

- The date that residents in a new program first rotated into this hospital (see August 27, 2009 IPPS final rule (74 FR 43908) for definition of new program).
- Whether that date was the first time residents began training at ANY rotational site for that program, or whether residents in that program had previously rotated to other sites before rotating into this hospital.

FTE Cap: The main documentation needed for FTE cap support and for the FTEs claimed on the earliest cost report which will be used to determine if the hospital meets the less than 1.0 FTE or not more than 3 FTEs requirement for the PRA is:

- the program approvals;
- the rotation schedules showing the location of the residents, either within hospitals or nonprovider sites.
- The Intern and Resident Information System (IRIS) (to be used only as an audit tool until direct GME and IME counts on the IRIS and the cost report match);
- a resident's Foreign Medical Graduate Examination in the Medical Sciences certificate (FMGEMS) status for direct GME;
- information whether the resident is full-time/parttime at the hospital;
- agreements between the hospitals and program approval if the resident is floating from another hospital's program.

Documentation to establish a PRA includes payroll and employment data indicating payment of residents' salaries and fringe benefits if the hospital employs the residents, contracts with medical schools or other hospitals which employ the residents specifying the charges to the

host hospital for these expenses and related invoices, evidence that the host hospital actually paid the charges from the medical school or other hospital, documentation of the expenses the host hospital paid for the portion of the teaching physicians' compensation and fringe benefits related to teaching and supervision of the residents, and documentation supporting payment of other Medicare allowable costs that are directly related to operating the program (such as salaries of the program director and other office staff associated with operating the program, and operating and overhead costs directly attributable to training the residents).

CMS states that unofficial copies or deviations from the official program rotation schedule and other substitutions will not be accepted.

3) Miscellaneous:

- Choice of base period for new PRA: This is only an option used if the hospital already started training at least 1.0 FTE or more than 3.0 FTEs in a cost reporting period beginning immediately following enactment. The hospital could choose to use either that cost report as the PRA base period, or the hospital could wait to see if the first cost reporting period beginning after issuance of this final rule with comment period may result in a more favorable PRA.

- CMS is not requiring that residents be on duty during the first month of the PRA base period for teaching hospitals receiving a PRA reset, and for new teaching hospitals in general.

- CMS is seeking comment on how to handle reviews of PRAs or FTE caps from cost reports beyond the 3-year reopening period (except for Category A and Category B hospitals that agree with the HCRIS posting.)