Frequently Asked Questions on Section 126 of the Consolidated Appropriations Act (CAA), 2021

Q1. What is section 126 of the Consolidated Appropriations Act (CAA), 2021?

A1. Section 126 of the CAA, 2021, makes available an additional 1,000 Graduate Medical Education (GME) full-time equivalent (FTE) resident cap slots, phased in at a rate of no more than 200 slots per year, beginning in fiscal year 2023.

Section 126 requires that in order to receive additional FTE resident cap slots, a hospital must qualify in at least one of the following four categories: (1) hospitals in rural areas (or treated as being located in a rural area under the law); (2) hospitals training a number of residents in excess of their GME cap; (3) hospitals in states with new medical schools or branch campuses; and (4) hospitals that serve areas designated as health professional shortage areas (HPSAs). This fourth eligibility category refers only to geographic HPSAs and not population HPSAs. Additionally, section 126 requires that at least 10 percent of the cap slots go to hospitals in each of the four categories, and that no single hospital can receive more than 25 additional FTE resident cap slots.

Q2. What is the application deadline for fiscal year 2024/round 2 to apply for FTE resident cap slots under section 126?

A2. For FTE resident cap slots under section 126 for fiscal year 2024, the deadline to submit a completed application to CMS using the online application system is March 31, 2023. The FTE resident cap slots awarded under this round are effective July 1, 2024.

Q3. How can I access the online application system to apply for FTE resident cap slots under section 126?

A3. The electronic application intake system, Medicare Electronic Application Request Information System (MEARIS™), is available for section 126 application submissions, which can be accessed at: https://mearis.cms.gov/public/home.

Additional information on the application submission process and application questions can be found on the Direct Graduate Medicare Education (DGME) web page at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME.

Q4. Is there a paper version of the section 126 application?

A4. There is no paper version of the application. However, applicants can view the questions that are part of the application by accessing the Direct Graduate Medical Education (DGME) web page:

1) Go to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME

2) Under “Section 126: Distribution of Additional Residency Positions”, go to “Section 126 Resources”

3) Select “Section 126 Application Submission Process and Questions (PDF)”

Please note the application does not need to be completed in a single session, the application can be accessed until it is submitted.

Q5. Does a hospital have to meet more than one of the four statutory criteria to be eligible to receive FTE resident cap slots under section 126?

A5. No. A qualifying hospital for purposes of section 126 is a hospital that meets the definitions of one or more of the four statutory categories described in subclauses (I) through (IV) of section 1886(h)(9)(B)(ii) of the Social Security Act, which we refer to as follows: Category One (hospitals located in rural areas or that are treated as being located in a rural area under the law), Category Two (hospitals training a number of residents in excess of their GME cap); Category Three (hospitals in states with new medical schools or branch campuses); and Category Four (hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs), specifically geographic HPSAs).

Q6. Is a hospital required to apply for both indirect medical education (IME) and direct graduate medical education (DGME) FTE resident cap slots?

A6. No, in general a hospital may apply for only IME, only DGME, or both IME and DGME FTE resident cap slots. Hospitals not paid under the Inpatient Prospective Payment System (IPPS) may only apply for DGME FTE resident cap slots. If the applicant hospital is paid under the IPPS, the hospital may not include in its IME request, any time spent training in a psychiatric or rehabilitation distinct part unit at its hospital and any time spent in research that is not associated with the treatment or diagnosis of a particular patient at its hospital. (For additional information refer to 42 CFR §412.105(f)(1)).

Q7. Is there a limit on the number of FTE residents cap slots a hospital can request and be awarded per fiscal year/application round?

A7. Yes, 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 residency 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 Family Medicine program in which the length of the program is 3 years, may request up to 3.0 FTEs per fiscal year/application round.

Please note that a hospital’s request must be prorated for other participating sites, if applicable. For example, if a hospital is applying for an OBGYN program, where the program length is 4 years, and the applicant hospital trains residents for 40 months (for both DGME and IME) out of 48 total program

months, the hospital's request could be: 40/48 equals 83.33 percent, 4 x 0.8333 = 3.33 FTEs for DGME and 3.33 FTEs for IME.

Applicant hospitals may only request FTE training time associated with training occurring at their facilities and any nonprovider settings for which the applicant hospital is paying the residents' salaries and fringe benefits while the residents are training at the nonprovider settings. Applicant hospitals should include nonprovider training time consistent with the IME regulations at 42 CFR §412.105(f)(1)(ii)(E) and the DGME regulations at 42 CFR §413.78(g). An applicant hospital may not request FTE training time at another hospital with a separate CCN even if the applicant hospital is paying the costs of training at the other hospital. Refer to FAQ #9 for how CMS will adjust the applicant hospital's request if the applicant hospital is training below its cap.

The Medicare Electronic Application Request Information System (MEARIS™) requires the applicant hospital to use months or weeks when providing information about the training time occurring at its hospital and any nonprovider settings for which the applicant hospital is paying the residents' salaries and fringe benefits while the residents are training at the nonprovider settings. The following week to month conversions should be used as necessary: 1 week = 0.25 months, 2 weeks = 0.50 months, 3 weeks = 0.75 months, 4 weeks = 1 month, 5 weeks = 1.25 months and 6 weeks = 1.50 months

Q8. If a hospital applied for FTE resident cap slots in round 1, can it also apply in round 2?

A8. Yes, a hospital that continues to be a qualifying hospital can apply for slots in round 2.

A hospital that received an award under round 1, can apply in round 2 for the following:

1) To continue filling positions from the establishment of a new residency program or expansion of an existing residency program associated with its round 1 application. Specifically, the hospital was awarded FTE resident cap slots to establish a new program or expand an existing residency program in round 1, but did not receive the full amount of FTE resident cap slots the hospital was eligible for, after prorating for participating sites. Or, the hospital was awarded FTE resident cap slots to establish a new residency program or expand an existing residency program in round 1, and the hospital continues to have unfilled positions.
2) For a different expansion of the same residency program associated with its round 1 application. Specifically, the hospital applied to the ACGME for a program expansion separate from the expansion associated with its round 1 application.
3) For the establishment of a different new residency program or expansion of a different residency program than the program associated with its round 1 application.

If a hospital was awarded FTE resident cap slots in round 1, but has not yet filled all of the awarded slots, the hospital is not eligible to apply in round 2 for those same unfilled slots.

A hospital that applied in round 1 to establish a new program or expand an existing program, but did not receive an award under round 1 due to its HPSA score, may reapply in round 2 using the same residency program.

Q9. How will CMS adjust a hospital's section 126 request if that hospital is training below its FTE resident cap?

A9. If a hospital is training below its FTE resident cap, CMS will reduce the hospital's request once the hospital's request has been prorated for other participating sites, if applicable.

For example, Hospital A is training below its IME cap by 2.00, but above its DGME cap. Hospital A participates in training residents in a General Surgery program, which is accredited for 25 slots but only 20 are filled. Residents' training time is divided between Hospital A and Hospital B with 50 percent of the residents' training time occurring at each hospital. Hospitals A and B will expand the number of residents training in the program by 5. The length of the General Surgery program is also 5 years. Since residents spend 50 percent of training time at Hospital A, Hospital A's request is first prorated by that fraction (5.00 FTEs x 50.00 percent = 2.50 FTEs). Next, its IME request is reduced by the amount it is training below its IME cap, so its final IME request could be 0.50 FTEs (2.50 FTEs – 2.00 FTEs = 0.50 FTEs). Hospital A's DGME request could be: 50.00 percent of 5.00 = 2.50 FTEs.

Q10. Can a hospital apply for FTE resident cap slots if it intends to use the slots for cap relief?

A10. No. FTE cap slots received under section 126 cannot be used to fund existing positions. Section 1886(h)(9)(C)(ii) of the Social Security Act prohibits an increase in the FTE cap of a hospital unless the hospital agrees to increase its total number of FTE residency positions by the amount of FTE cap slots it is awarded under section 126.

Q11. If a new residency training program received accreditation from the appropriate accrediting body (ACGME or ABMS) and a hospital begins training FTE residents in this new residency training program prior to July 1, 2023, can the hospital use this residency training program to apply for FTE resident cap slots under section 126 using Demonstrated Likelihood Criterion (DLC) 1 (New Residency Program)?

A11. No. Under Demonstrated Likelihood Criterion (DLC) 1 (New Residency Program), the applicant hospital does not have sufficient room under its FTE resident cap, and the hospital intends to use the additional FTEs as part of a new residency program that it intends to establish on or after July 1, 2023. For round 2 of section 126 with FTE resident cap slots effective July 1, 2024, training residents in the new program cannot begin prior to July 1, 2023. Specifically, if a hospital received accreditation from the ACGME effective July 1, 2022 to train 5 FTE residents in a new residency training program, it must first begin training any of those 5 FTE residents on or after July 1, 2023 to be eligible to receive FTE resident cap slots under section 126, including round 2. If the hospital began training residents in the new program any time prior to July 1, 2023, it is not eligible for additional FTE resident cap slots under section 126, including round 2. As discussed in FAQ #8 above, hospitals that applied for slots in round 1 can reapply in round 2. Please note that a "new" residency program that is currently part of a hospital's five-year cap building period to establish or adjust its cap, cannot be used for a hospital's DLC 1 section 126 application.

Q12. If a residency training program received approval from the appropriate accrediting body (ACGME or ABMS) to expand the number of FTE residents in the program or the program has unfilled slots that have previously been approved, and the hospital begins training additional FTE residents in the program prior to July 1, 2023, can the hospital use this residency training program to apply for FTE resident cap slots under section 126 using Demonstrated Likelihood Criterion (DLC) 2 (Expansion of an Existing Residency Program)?

A12. No. Under Demonstrated Likelihood Criterion (DLC) 2 (Expansion of an Existing Residency Program), the hospital does not have sufficient room under its FTE resident cap, and the hospital intends to use the additional FTEs to expand an existing residency training program within the hospital's first 5 training years beginning on or after July 1, 2023. For round 2 of section 126 with FTE resident cap slots effective July 1, 2024, the hospital cannot begin training residents as a result of the program expansion prior to July 1, 2023. Specifically, if a hospital received approval from the ACGME to expand the number of FTE residents in the program by 5 effective July 1, 2022, it must first begin training additional FTE residents as a result of this expansion on or after July 1, 2023 to be eligible to receive FTE resident cap slots under section 126, including round 2. If the hospital began the program expansion any time prior to July 1, 2023, it is not eligible for additional FTE resident cap slots under section 126, including round 2. As discussed in FAQ #8 above, hospitals that applied for slots in round 1 can reapply in round 2.

Q13. Are FTE resident cap slots awarded through section 126 temporary or permanent?

A13. All FTE resident cap slots awarded through section 126 are permanent.

Q14. How can I determine if a scheduled training site in the program is located in a HPSA and, if so, which HPSA?

A14. A hospital can determine this information using HRSA's HPSA search tool at: https://data.hrsa.gov/tools/shortage-area/by-address . Using this HPSA search tool, an applicant may enter the address of a scheduled training site and the search tool will provide the HPSA, if any, where it is located. When aggregated across the scheduled training sites in the program in a single HPSA, this information can be used to help determine if the program meets the 50 percent requirement for Category Four eligibility (geographic HPSA), and, if not, help determine if the program meets the separate 50 percent criterion for application prioritization.

Q15. Where can I find the HPSA public ID and score information that will be used to prioritize section 126 round 2 applications?

A15. Prior to the beginning of the round 2 application period, HPSA public ID and score information current as of November 2022 will be posted on the Direct Graduate Medicare Education (DGME) web

page at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME to assist hospitals in the application process for the coming year. Only HPSA public IDs and scores in this posting will be used for the purpose of prioritizing section 126 round 2 applications. HPSAs that are proposed for withdrawal as of November 2022 are not excluded from being used for the purpose of prioritizing section 126 round 2 applications and are included in this posting.

Q16. Can multiple geographic HPSAs be combined to meet the 50 percent requirement for Category Four eligibility?

A16. No. To be eligible for Category Four, a hospital cannot choose more than one geographic HPSA to meet the 50 percent requirement.

Q17. Can a hospital qualify under Category Four (hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs)) if it only serves a population HPSA?

A17. No. Under the statutory definition of Category Four, a hospital can only meet that definition by serving a geographic HPSA, that is, a geographic area designated as a HPSA under section 332(a)(1)(A) of the Public Health Service Act (PHSA) on the basis of a shortage of services for the entire population within that area. (Refer to FAQ #20 on the "50 percent HPSA training percentages" for additional information.)

Q18. Can a population HPSA be used for the prioritization of a qualifying hospital's application?

A18. Yes. A qualifying hospital that serves a population HPSA can use that population HPSA score for the for the prioritization of its application. (Refer to FAQ #20 on the "50 percent HPSA training percentages" for additional information.)

Q19. Can multiple geographic and/or population HPSAs be combined to meet the 50 percent prioritization criterion?

A19. No. A hospital cannot choose more than one HPSA to prioritize its application. However, when a hospital finds that it participates in a program that meets the 50 percent criterion to be prioritized by program training occurring in more than one HPSA, then it may choose which HPSA to use for its application.

Q20. How do the 50 percent HPSA training percentages differ for purposes of a qualifying hospital and prioritization of applications?

A20. There are 2 separate 50 percent HPSA training percentages under the policy for additional FTE resident cap slots under section 126: a 50 percent requirement for a hospital to qualify under Category Four; and a 50 percent criterion for a prioritization of applications.

For purposes of qualifying under Category Four, a hospital must meet the "50 percent requirement" such that for the residency program for which the hospital is applying, at least 50 percent of the residents' training time over the duration of the program must occur at locations in the geographic HPSA.

Separately, hospitals that qualify under Categories One through Four are then subject to the prioritization criteria. Specifically, for purposes of prioritization of applications (regardless of which of the four categories the hospital qualifies under), a hospital must meet the "50 percent criterion" such that at least 50 percent of a program's training time occur at facilities physically located in a geographic or population HPSA.

Q21. Are there other ways to satisfy the 50 percent Category Four requirement or 50 percent prioritization criterion?

A21. For purposes of the prioritization criterion only, training time spent at Indian and Tribal facilities outside of a HPSA counts towards the minimum training time criterion for that HPSA (geographic or population), up to a maximum of 45 percentage points of the 50 percentage points required.

Q22. Does the 50 percent Category Four requirement or 50 percent prioritization criterion apply to the program in its entirety or to individual residents?

A22. The 50 percent Category Four requirement and 50 percent prioritization criterion apply to the program in its entirety, not to individual residents. As such, hospitals would not need to track the training time of individual residents to ensure each individual resident spends 50 percent or more of their training time in a HPSA, so long as the program in its entirety meets the requirement. Any and all program training based on resident rotation schedules (or similar documentation) that occurs in the HPSA at program training sites that are physically located in the HPSA and treat the HPSA's population, including nonprovider settings and Veterans Affairs facilities, will count towards meeting the 50 percent Category Four requirement and 50 percent prioritization criterion.

Q23. Does the 50 percent Category Four requirement or 50 percent prioritization criterion apply based on the program at the time of application or based on the program if it were to receive the FTE resident cap slots requested?

A23. The 50 percent Category Four requirement and 50 percent prioritization criterion apply based on the status of the program at the time of application.

Q24. Is the applicant hospital required to be physically located inside of the HPSA for the purposes of meeting the 50 percent Category Four requirement or 50 percent prioritization criterion?

A24. No. Both the 50 percent Category Four requirement and 50 percent prioritization criterion are based on any and all program training that occurs in the HPSA at program training sites that are physically located in the HPSA and treat the HPSA's population, including nonprovider settings and Veterans Affairs facilities.

Q25. What program training sites can be used to satisfy the 50 percent Category Four requirement or 50 percent prioritization criterion?

A25. Any and all program training based on resident rotation schedules (or similar documentation) that occurs in the HPSA at program training sites that are physically located in the HPSA and treat the HPSA's population, including nonprovider settings and Veterans Affairs facilities.

Q26. To meet the 50 percent Category Four requirement or 50 percent prioritization criterion does the hospital have to maintain documentation for each rotation that the training site(s) is in the HPSA or that the patient lives in the HPSA?

A26. The hospital does not have to document whether each and every patient does or does not live in the HPSA. In its application, the hospital must attest that the training site(s) is located in the HPSA and treats the HSPA's population, and have a factual basis for that attestation at the time it is made.

If a question or concern arises, the hospital must be able to show the training site used for purposes of its section 126 application is located in the HPSA. The location verification can be done by using HRSA's Find Shortage Areas by Address Tool at this link https://data.hrsa.gov/tools/shortage-area/by-address.

Q27. If a hospital is applying with a mental health HPSA for purposes of the 50 percent Category Four requirement or the 50 percent prioritization criterion, are there any restrictions that apply?

A27. Yes, if a hospital is applying with a mental health HSPA, the hospital must apply for FTE resident cap slots for a psychiatry program or a subspecialty of psychiatry.