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Rural Track Programs
A Guide to the Updated Medicare Requirements

May 2023

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Introduction

Medicare reimburses a limited number of residency positions for certain graduate medical education (GME) programs; this number is referred to as a hospital's "cap." Once a hospital's Medicare resident caps for the direct graduate medical education (DGME) payment and indirect medical education (IME) adjustment are set, there are few ways to increase those caps. One way is through establishing a rural training track (RTT) program, now renamed and revised as the rural track program (RTP). This guide explains the regulatory requirements for participating in the new Centers for Medicare & Medicaid Services (CMS) RTP.

The heart of the RTP is a partnership between an urban hospital (primary clinical site) and a rural participating site (or sites) for medical residency training. The original RTT program only provided an increase in DGME and IME caps for the urban hospital. The Consolidated Appropriations Act, 2021 (CAA) made several significant changes to the RTT program that are effective for cost-reporting periods beginning on or after Oct. 1, 2022. For example, both urban and rural hospitals can receive an increase to their DGME and IME caps for the time residents (and fellows) spend in an RTP. In addition, any residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) can take advantage of the RTP as long as greater than 50% of the residents' training takes place in rural areas. The following pages provide details about the program.

How Medicare encourages training in rural areas

The Medicare program encourages training in rural areas in several ways: (1) creating RTPs, (2) providing rural hospitals with a GME cap of 130% of the residents they trained in 1996, and (3) allowing rural hospitals to increase their cap by starting a new residency program in a specialty in which the hospital had not previously provided training.[1]

RTPs give urban hospitals the opportunity to partner with rural hospitals, rural ambulatory clinics, and other non-hospital sites to expand GME training programs and to use their expertise and resources to support rural partners. Urban and rural hospital participating sites that meet all regulatory requirements can take advantage of building an RTP residency cap.

This guide explains the complex regulations related to creating an RTP. The decision to start an RTP or create additional ones is multifaceted and must include many individuals at multiple institutions. This guide is not legal advice. Rather, it is meant to be a resource to use while making the decision about whether to proceed.

How RTPs differ from RTT programs

While existing RTT programs can continue, urban hospitals that wish to engage with rural partners in the future will be doing so under the RTP, which has more flexible rules. Table 1 compares the criteria for the two programs.

Table 1. Comparing the Rural Training Track (RTT) Program and the Rural Track Program (RTP)

Criterion	RTT Programs	RTPs
Urban hospital establishes rural track	✓	✓
Rural hospital and/or rural non-hospital site participate(s) with urban hospital	✓	✓
Must be an ACGME "separately accredited" rural training program	✓	
Can be any ACGME-accredited residency program		✓
Residents spend more than 50% of their time training in rural area(s)	✓	✓
Urban hospital can expand existing program to other rural hospitals		✓
Urban hospital can add additional rural tracks (beyond their first) at rural hospitals or non-hospital sites		✓
Cap adjustment to urban hospital for participating in an RTT program or an RTP	✓	✓
Cap adjustment to rural hospital for participating in an RTT program or an RTP		✓
RTT program or RTP residents excluded in three-year rolling average of FTEs during five-year cap-building period		✓

Q 1. Can you provide a brief history of Medicare's payments to teaching hospitals?

A In enacting the Medicare program in 1965, Congress recognized that providing health care insurance to people age 65 and older would be effective only if there were enough doctors to care for them. Congress noted that educational activities enhance the quality of care and decided that Medicare should bear some of the costs of educating doctors.[2]

At first, graduate medical education Medicare payments to teaching hospitals were made through a cost-based system. In 1983, Congress created the Inpatient Prospective Payment System (IPPS) and established formula-based Medicare payments to teaching hospitals to support residency programs. The formula was tied to the number of resident full-time equivalents (FTEs) a hospital trains each year and the percentage of Medicare inpatients the hospital treats. Medicare also pays teaching hospitals a separate add-on payment, the IME adjustment, to every diagnosis-related group (DRG) when a Medicare patient is discharged to help compensate for the acuteness of the illnesses of the Medicare patients they treat and the special services teaching hospitals provide to their communities.

Initially under IPPS, Medicare did not limit the number of residents it would pay for, but as the number grew rapidly, Congress decided to cap funding at the number of residents the institution was training during the 1996 cost-reporting year.[3] In general, even if a teaching hospital is currently training more residents than it did in 1996, Medicare will make DGME and IME payments only for the number of residents the institution was training in 1996.

Q 2. How does CMS define "rural"?

A CMS defines "rural" as being outside a metropolitan "core-based statistical area," or CBSA.[4] Every year, CMS publishes an impact file with hospital-specific information on the IPPS final rule webpage.[5] Hospitals can search for their CMS Certification Number (CCN) in the impact file. A two-digit code in the Geographic Labor Market Area indicates the hospital is rural. The IPPS webpage maintained by CMS also contains a table, the County to CBSA Crosswalk File and Urban CBSAs and Constituent Counties for Acute Care Hospitals File, that lists every county in every state. If Column E for a given county in the table is blank, that county is rural.[5]

Rural sites can be "rural hospital sites" (e.g., acute care hospitals) or "rural non-hospital sites" (i.e., settings other than hospitals, such as skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities in which residents furnish services).[6-8] Special rules apply for certain rural sites such as critical access hospitals (CAHs) and sole community hospitals (SCHs), as discussed in Question 12. For RTPs, if the residents spend more than 50% of their training time in a rural area, an urban hospital may partner with either a rural hospital or clinical site or sites that are not hospitals.

Q 3. What is a rural track program (formerly known as a rural training track)?

A Originally enacted as part of the Balanced Budget Refinement Act of 1999 (BBRA), RTT programs provided an opportunity for an urban hospital to establish a medical residency training program in a rural area, generally through a partnership with a rural hospital or at rural non-hospital sites.[9] The intent of the legislation was to encourage physicians to practice where they trained, thereby helping alleviate shortages of physicians in rural areas.

Certain limitations with the BBRA RTT program were apparent from its inception, particularly the requirement that limited program participation to approved separately accredited medical residency programs in rural areas (see Table 1). To date, only ACGME Family Medicine residency programs have been separately accredited. While there were minor updates over the years, the RTT program went largely unchanged until the enactment of Section 127 of the Consolidated Appropriations Act, 2021 (CAA).[10]

In promulgating the regulations to implement Section 127, CMS renamed the RTT program the rural track program, or RTP.[11] CMS defined RTPs as follows: "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 residents(s)/fellow(s) taking place in a rural area."[12] The updated RTP is vastly more flexible than the original RTT program.

Q 4. What is an urban hospital's role in an RTP?

A Urban and rural hospitals can use an RTP to increase the number of residents they train while receiving Medicare payment for those residents because the RTP allows the hospitals to increase their resident caps. Among the requirements for the cap increase is that more than 50% of the resident's RTP training occurs in the rural area.[13] **For cost reports beginning on or after Oct. 1, 2022, hospitals may count the time RTP residents train at their institutions up to what is known as the "RTP FTE limitation."**[11] This limitation refers to the maximum number of RTP residents a hospital may include on their cost report — in other words, the RTP cap for the urban hospital.

If an urban hospital partners with a "rural non-hospital site" (also known as a "rural nonprovider site"), it can claim the time residents spend at that site to increase its RTP resident cap if it meets the following requirements: residents are engaged in patient care activities and the urban hospital incurs the costs of the stipends and fringe benefits of the residents while they are at the site.[14]

Q 5. How does a rural hospital or hospital site benefit from an RTP?

A A major benefit to a rural hospital or hospital site is the advantages that accrue to physicians, staff, and patients from having a training program, including increased access to care for the community. Before enactment of the CAA, rural teaching hospitals that participated in an RTP did not receive a cap adjustment unless the program qualified as "new." **For cost-reporting periods beginning on or after Oct. 1, 2022, rural teaching hospitals can receive a cap adjustment associated with the time RTP residents train at the hospital even if the rural residency program would not be considered a "new" program.**[15]

An urban or a rural hospital that participates in an RTP and that incurs the costs of training residents at non-hospital provider sites may claim the residents' time at those sites as long as the hospital meets certain Medicare requirements, such as paying for the residents' stipends and benefits while they are at the non-hospital site. Urban and rural hospitals that participate in an RTP must supply their Medicare Administrative Contractors (MACs) with information, such as the ACGME accreditation for the residency program, a list of all hospital and non-hospital training sites, resident rotation schedules, and the number of FTE residents training in all five program years at both the urban and rural settings.

Q 6. What are the program accreditation requirements for an RTP?

A Under the original RTT program, a statutory requirement was that the program have "separate accreditation" by the ACGME as a rural training track. The only specialty to meet that requirement was family medicine. The CAA removed the separately accredited requirement, and now any specialty accredited by ACGME can qualify, provided more than 50% of training occurs in the rural area.[16]

Q A 7. Are hospitals limited to one RTP?

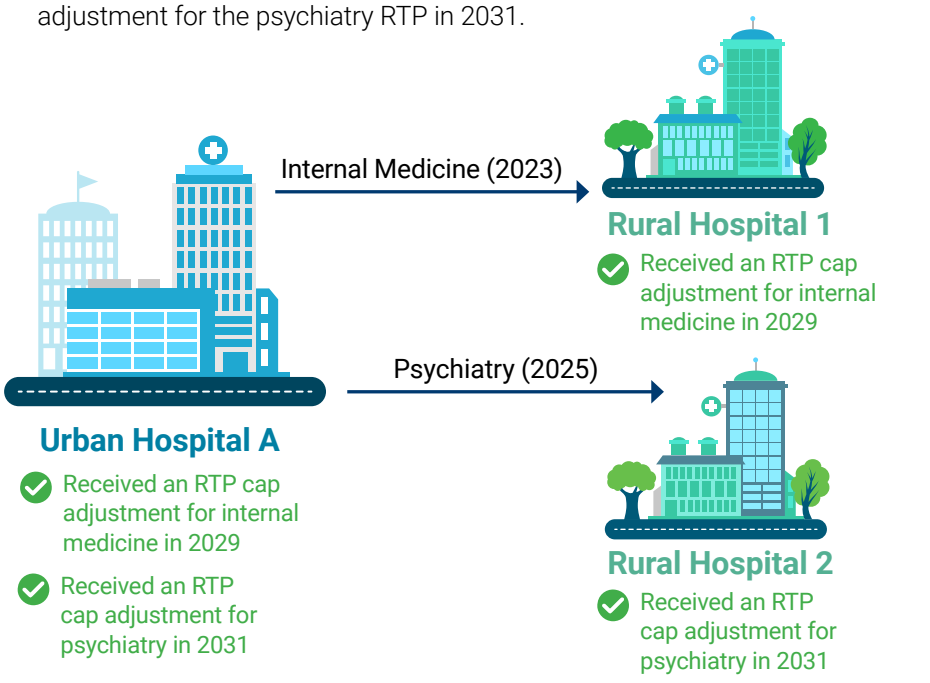
No. In line with program requirements (see Table 2), urban and rural hospitals can participate in multiple RTPs and receive an RTP cap adjustment for each new RTP (but not for an already established RTP). There are slight differences in eligibility for urban and rural hospitals.[17]

Table 2. Eligibility for RTP Cap Adjustments for Urban and Rural Hospitals

1. Starting an RTP in a new specialty with a current rural partner 2. Starting an RTP in ***any*** specialty with a new rural partner	3. Starting an RTP in a new specialty with a current urban partner 4. Starting an RTP in a new specialty with a ***new*** urban partner

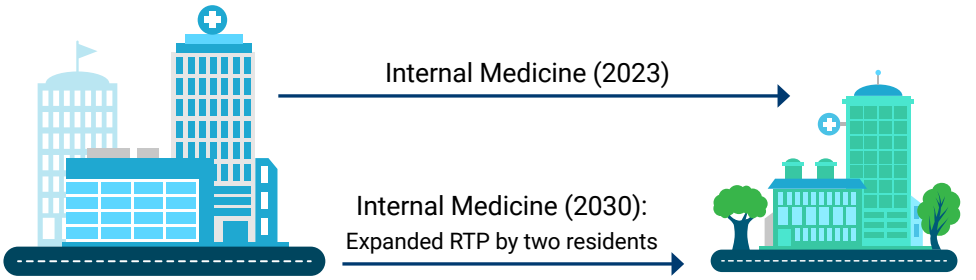
Scenario 1: 1 Urban Hospital, 2 Rural Hospitals, 2 Different Specialties in 2 RTPs

Urban Hospital A has an existing internal medicine program, and in 2023, it partners with Rural Hospital 1 to create an internal medicine RTP from the existing internal medicine program. In 2025, Urban Hospital A, which has an existing psychiatry program, partners with Rural Hospital 2 to create an RTP from the existing psychiatry program. Urban Hospital A and Rural Hospital 1 will receive an RTP cap adjustment for the internal medicine RTP in 2029, at the beginning of the program's sixth year, after completing the five-year cap-building period. Urban Hospital A and Rural Hospital 2 will receive a cap adjustment for the psychiatry RTP in 2031.



Scenario 2: 1 Urban Hospital, 1 Rural Hospital Wants to Add Residents to RTP

Urban Hospital A has an existing internal medicine program, and in 2023, it partners with Rural Hospital 1 to create an internal medicine RTP from the existing internal medicine program. In 2029, after the five-year cap-building period ends, Urban Hospital A and Rural Hospital 1 will receive an RTP cap adjustment to reflect residents in the RTP training at their respective facilities; this cap is set and cannot be changed. In 2030, ACGME allows Urban Hospital A to permanently expand the internal medicine RTP by two residents to train at both Urban Hospital A and Rural Hospital 1. CMS will *not* allow an RTP cap adjustment for the addition of two FTE residents because this is an expansion of an existing RTP.



Urban Hospital A

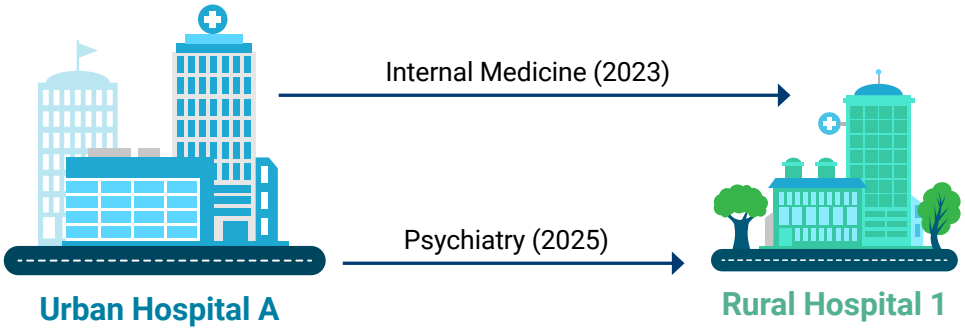
- Received an internal medicine RTP cap in 2029 associated with Rural Hospital 1
- No new RTP cap adjustment for expanding the internal medicine RTP with Rural Hospital 1

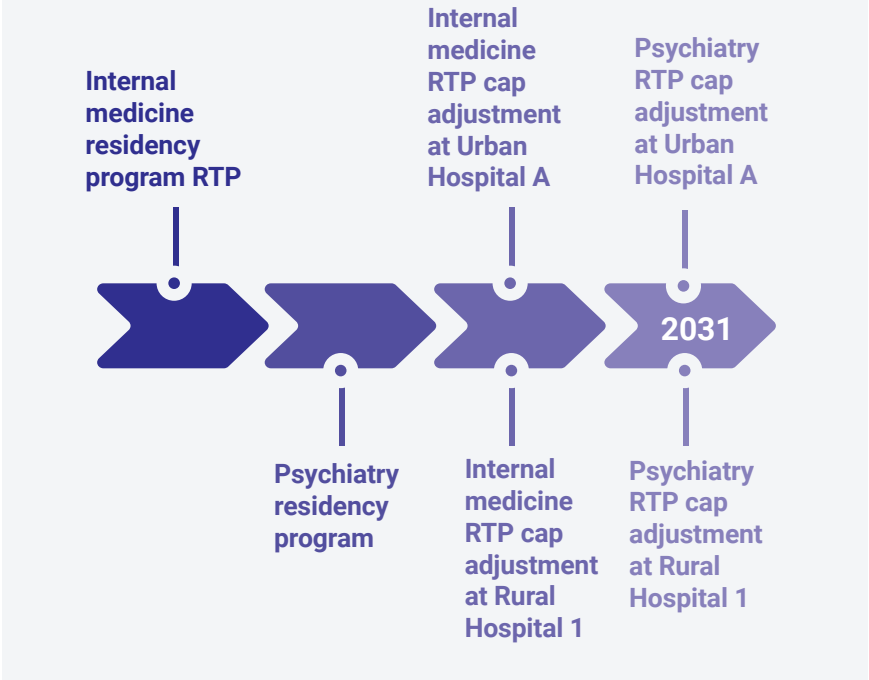
Rural Hospital 1

- Received an RTP cap starting in 2029
- No new RTP cap adjustment for expanded program

Scenario 3: 1 Urban Hospital, 1 Rural Hospital, 2 RTPs

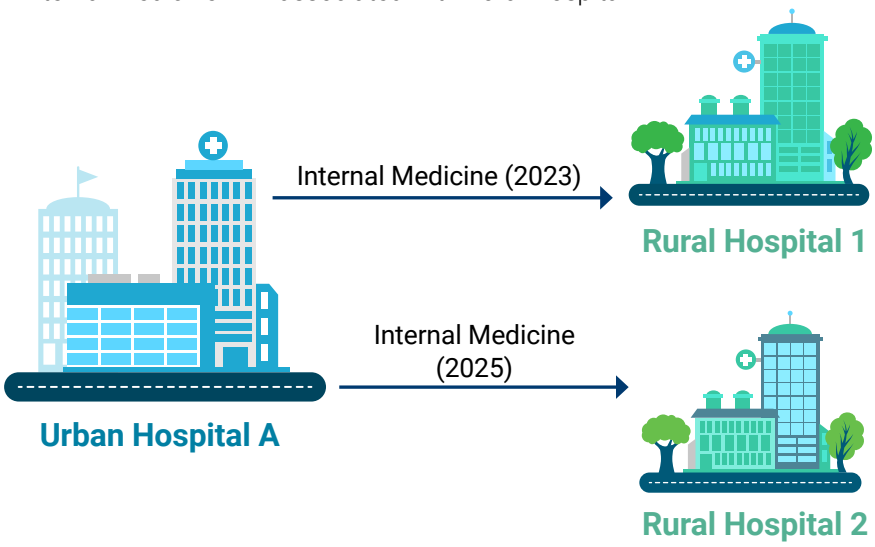
Urban Hospital A has an existing internal medicine program, and in 2023, it partners with Rural Hospital 1 to create an internal medicine RTP from the existing internal medicine program. At the beginning of the program's sixth year, in 2029, Urban Hospital A and Rural Hospital 1 will receive an RTP cap adjustment to reflect residents in the RTP at their respective facilities. In 2025, Urban Hospital A partners again with Rural Hospital 1 to create an RTP in psychiatry. Both Urban Hospital A and Rural Hospital 1 will receive RTP cap adjustments after completing the five-year cap-building period, to reflect the time residents spend in the psychiatry RTP and the time residents spend in the internal medicine RTP at their respective facilities.

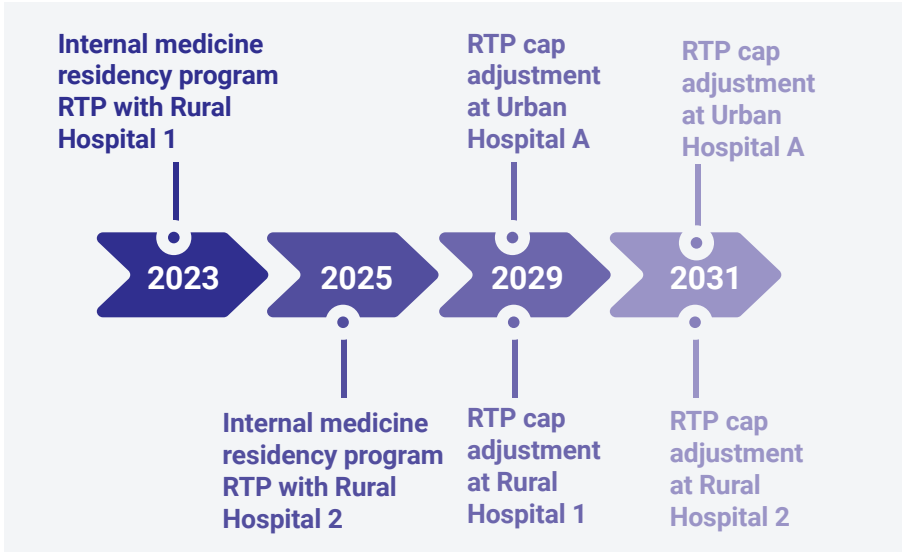




Scenario 4: 1 Urban Hospital, 2 Rural Hospitals, 2 RTPs in the Same Specialty

Urban Hospital A has an existing internal medicine program, and in 2023, it partners with Rural Hospital 1 to create an internal medicine RTP from the existing internal medicine program. In 2029, Urban Hospital A and Rural Hospital 1 will receive an RTP cap adjustment to reflect the time residents training in the RTP spend, respectively, at Urban Hospital A or Rural Hospital 1. In 2025, Urban Hospital A partners with Rural Hospital 2, to create an additional internal medicine RTP (adding another rural partner to the existing urban program). Both Urban Hospital A and Rural Hospital 2 will receive RTP cap adjustments in 2031 to reflect the portion of the time residents in the second internal medicine RTP spend at their respective facilities. Urban Hospital A will have two adjustments to its RTP cap: one for the internal medicine RTP associated with Rural Hospital 1 and one for the internal medicine RTP associated with Rural Hospital 2.





Q 8. What is the RTP cap-building period?

A The RTP cap-building period is the five-year period that starts from the time the first resident begins training in the new RTP. The RTP cap is set at the end of the cap-building period. In other words, the cap is set at the beginning of the sixth year of training. Question 10 goes into detail about how to calculate the RTP cap.

Q 9. During the RTP cap-building period, are residents included in the three-year rolling FTE averages for DGME and IME?

A No. For cost-reporting periods beginning on or after Oct. 1, 2022, RTP residents are not included in the three-year rolling-average calculations while the urban and rural hospitals are in the five-year RTP cap-building period.[18] This is true for RTT programs started prior to Oct. 1, 2022, as long as the urban and rural hospitals are within the five-year cap-building period.[19]

Q 10. How are RTP caps determined?

A 10a. For urban and rural hospitals

Only residents who participate in the RTP are considered for the cap adjustment. For some programs, this may mean all residents; for other programs, it may mean a subset of the residents. If a hospital creates an RTP with a subset of residents, the hospital must keep accurate records to identify the residents participating in the RTP (answer 10a continued on next page).

(Answer 10a continued)

Example 1. Determining RTP caps for urban and rural hospitals: Urban Hospital A and Rural Hospital 1 create an RTP in internal medicine where residents train more than 50% of their time at the rural hospital. The RTP adds two residents per year during the five-year RTP cap-building window (see Table 3).

The RTP cap is calculated for each hospital at the end of the fifth year of the RTP by this formula:

$(G \times Y) \times (N/T)$

where

G = the greatest number of residents in any program year (PGY) who are training at all hospitals to which residents in that RTP rotate during the fifth year

Y = minimum number of years it will take for residents to complete the RTP (that is, the minimum accredited length of the RTP in years)

N = number of residents who trained at the urban (or rural) hospital over the course of the five-year cap-building period

T = total number of residents over the five-year cap-building period at all sites

Table 3. Example 1 for Question 10a: New Internal Medicine RTP Resident Count at Urban and Rural Teaching Hospitals for Six Residents Over the First Five Years

Post-Graduate Year (PGY)	Year 1 Resident counts		Year 2 Resident counts		Year 3 Resident counts		Year 4 Resident counts		Year 5 Resident counts	
	Urban Hospital	Rural Hospital	Urban Hospital	Rural Hospital	Urban Hospital	Rural Hospital	Urban Hospital	Rural Hospital	Urban Hospital	Rural Hospital
PGY 1	2.0	0.0	2.0	0.0	2.0	0.0	2.0	0.0	2.0	0.0
PGY 2	0.0	0.0	0.2	1.8	0.2	1.8	0.2	1.8	0.2	1.8
PGY 3	0.0	0.0	0.0	0.0	0.1	1.9	0.1	1.9	0.1	1.9
Total	**2.0**	**0.0**	**2.2**	**1.8**	**2.3**	**3.7**	**2.3**	**3.7**	**2.3**	**3.7**

Using the numbers in Table 3 to calculate the RTP cap for the urban hospital, multiply the greatest number of residents in any program year by the number of years to complete the internal medicine program:

In the fifth year, the greatest number of residents training in any program year across **all hospitals** to which residents rotate = **2.0**	x	Minimum accredited length of the internal medicine program = **3 years**	**2x3 = 6** **Urban hospital RTP cap before apportionment = 6 FTEs**

Then, calculate the ratio of the number of residents who trained at the urban hospital to the total number of residents who trained at all hospitals over the five-year period:

The number of residents in the RTP who trained at the **urban hospital** over the entire five-year period = **11.1**	/	The total number of residents who trained at **all** hospitals over the entire five-year period = **24**	**11.1/24 = 0.46**

The urban hospital's RTP cap will be the product of all three factors:

STEP 3

6 FTEs x 0.46 = 2.76 FTEs → Urban hospital RTP cap = 2.76 FTEs

The rural hospital uses the same method to calculate its RTP cap except that it uses the time residents spend training at the rural hospital.

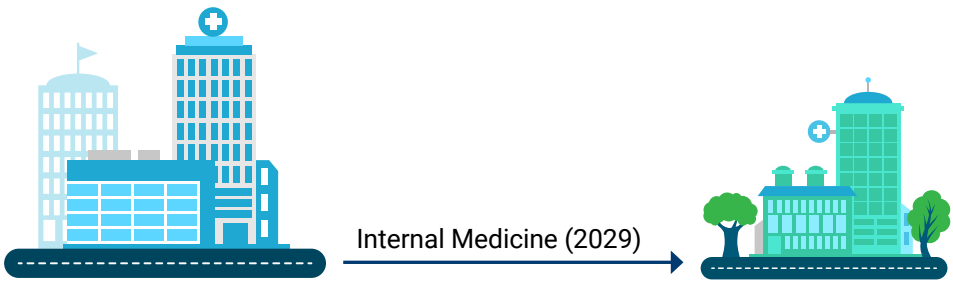
In the fifth year, the greatest number of residents training in any program year = **2.0**	x	Minimum accredited length of the internal medicine program = **3 years**	**2x3 = 6 Rural hospital RTP cap before apportionment = 6 FTEs**

Then, calculate the ratio of the number of residents who trained at the rural hospital to the total number of residents who trained at both hospitals over the five-year period:

The number of residents in the new program who trained at the **rural hospital** over the entire five-year period = **12.9**	/	The total number of residents who trained at **both hospitals** over the entire five-year period = **24**	**12.9/24 = 0.54**

The rural hospital's RTP cap will be the product of all three factors:

6 FTEs x 0.54 = 3.24 FTEs → Rural hospital RTP cap = 3.24 FTEs



2.76 FTEs
RTP adjustment at
urban hospital

3.24 FTEs
RTP adjustment at
rural hospital

10b. For multiple RTPs between the same urban and rural hospitals

Example 2. Determining caps for multiple RTPs between the same urban and rural hospitals:

Building on Example 1, a hospital will perform the RTP cap calculation for each new RTP at the end of the new RTP's fifth training year. Table 4 provides an example of an urban and a rural hospital that established both an internal medicine RTP and a psychiatry RTP. The urban and rural hospitals will each adjust their respective RTP resident caps to reflect both programs.

Table 4. Example 2 for Question 10b: RTP Caps for Two RTPs for Urban and Rural Hospitals

Specialty	Urban Hospital	Rural Hospital
RTP for Internal Medicine	2.76 FTEs	3.24 FTEs
RTP for Psychiatry	3.29 FTEs	4.71 FTEs
Total RTP Cap Adjustment	**2.76+3.29 = 6.05 FTEs**	**3.24+4.71 = 7.95 FTEs**

10c. For non-hospital sites

Example 3. What is the impact of training at a non-hospital site during the cap-building period?

Using Example 1, if residents trained in rural non-hospital sites for their second and third years instead of at a rural hospital and the Medicare requirements for counting resident time at a non-hospital site are met, then the urban hospital could count the time the residents spent at the non-hospital sites. The urban hospital's RTP cap would be 6 FTEs instead of 2.76 FTEs.

Step 1. Greatest number of residents in any PGY who, during the fifth year of the RTP, are in the RTP at the urban hospital and the rural non-hospital site(s) and are designated from the beginning as RTP residents = 2.

Step 2. The number of years residents are expected to complete each residency program based on the minimum accredited length for an internal medicine program (also known as the initial residency period [IRP]) = 3 years.

2x3 = 6 FTEs → urban hospital RTP cap = **6 FTEs**

Hospitals may count the time residents spend rotating to clinical non-hospital sites if the Medicare requirements (such as paying for the residents' stipends and benefits while at the non-hospital site) for counting a non-hospital site are met. Since this urban hospital may count all the resident's time, there is no need to proportionally adjust the RTP cap increase.

Q 11. Once an RTP cap-building period ends, are slots in the RTP cap fungible among specialty programs?

A Yes. After the five-year cap-building period, the actual number of residents in each RTP at a hospital may be reduced in one RTP and increased in another RTP. A hospital that increases the RTP resident count in one RTP must proportionally reduce the RTP resident count for another RTP at the hospital.[20] Hospitals may not "share" RTP residents through affiliation agreements.

For example, Hospital A has an established internal medicine RTP with three residents and an established psychiatry RTP with three residents. Hospital A has an RTP cap of six residents, total. If Hospital A wants to increase the number of residents in their psychiatry RTP by one resident, they could reduce the number of residents in their internal medicine RTP by one resident and stay within their RTP resident cap of 6 FTEs.

Q 12. Can federally qualified health centers (FQHCs), critical access hospitals (CAHs), and sole community hospitals (SCHs) participate in RTPs?

A Yes, *rural* FQHCs, CAHs, and SCHs may participate as rural partner sites for an RTP. In some cases, an urban hospital may count the time residents spend at a rural non-hospital site toward their own RTP count.[21]

Q 13. Can an urban hospital that has reclassified as rural (as a rural referral center) participate with an urban hospital in an RTP?

A Yes, hospitals that have reclassified as rural under 42 CFR § 412.103 may participate as the rural partner hospital for an RTP. However, the reclassification only applies for the IME adjustment, which creates challenges to the participation of the reclassified hospital. For example, a reclassified hospital that partners with an urban hospital would meet the requirement that the resident spend more than 50% of their training time at a rural site for the IME adjustment but would not meet the requirement for the direct GME payment.

Q 14. Can a geographically rural hospital that has an established Medicare cap partner with a rural non-hospital site to create an RTP and receive a cap adjustment?

A No. An RTP requires an urban and a rural partner. In this example, there is no urban hospital partner, and, therefore, the rural hospital will not receive the cap adjustment associated with participating in an RTP. Under 42 CFR § 413.79(e)(3), a rural hospital can receive a cap adjustment when they start a new program.

Q 15. Can a hospital receive a cap adjustment for an already established RTP (or RTT program) that expands?

A No. A hospital cannot receive a cap adjustment for expansion of an established RTP (or RTT program) cap.

Q 16. What happens if the RTP does not meet the requirement that residents spend more than 50% of their time in a rural area?

A Meeting the requirement to spend more than 50% of their time in a rural area is essential to Medicare reimbursement for residents training in RTPs. Urban and rural hospitals cannot receive an RTP FTE limitation if the training program does not meet the more-than-50% time requirement.[22]

Q 17. What happens if a resident starts training in an urban hospital and does not complete training in a rural area?

A For hospitals over their cap, if a resident included in an urban hospital's RTP count did not complete the required rural training, CMS will reopen the hospital's cost report (if it is within the three-year reopening period) and adjust the GME payments and, where applicable, the RTP resident cap.[23] (Hospitals under their cap can count the resident as part of the already established cap.)

Q 18. What documentation is required for MACs to pay for RTP cap increases?

A The following information must be provided by the urban and rural hospitals upon request:

- ACGME accreditation for the program and documents showing whether the urban and rural participating sites are starting the RTP for the first time in this specialty or whether the urban and rural hospitals already have an RTP in the specialty but are adding rural participating site(s) to the RTP.
- Resident rotation schedules showing that residents spend more than 50% of their training in a geographically rural area during the five-year cap-building period. *Note:* If only a portion of residents in the program are in the RTP, the hospital must highlight the names of the residents and their urban and rural training locations in the main rotation schedule.
- The number of resident FTEs and the amount of time training in all five program years at both the urban and rural settings.[24]

Q 19. What else do I need to know about participation in an RTP?

A We suggest reviewing the regulations at 42 CFR § 413.79(k) before starting an RTP. You also may want to meet with your MAC to ensure that you're both in agreement that the requirements will be met. Highlighted here are four requirements for urban hospitals:

> "(i) A hospital may not include in its rural track FTE limitation or (assuming the hospital's FTE count exceeds its FTE cap) FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap.
>
> "(ii) Each hospital must base its count of residents in a rural track on written contemporaneous documentation that each resident enrolled in a rural track program at the hospital intends to rotate for a portion of the residency program to a rural area.
>
> "(iii) All residents that are included by the hospital as part of its rural track FTE count (not to exceed its rural track FTE limitation) must train in the rural area. However, where a resident begins to train in the rural track program at the urban hospital but leaves the program before completing the total required portion of training in the rural, the urban hospital may count the time the resident trained in the urban hospital if another resident fills the vacated FTE slot and completes the training in the rural portion of the rural track program. An urban hospital may not receive GME payment for the time the resident trained at the urban hospital if another resident fills the vacated FTE slot and first begins to train at the urban hospital.
>
> "(iv) Effective for cost reporting periods beginning on or after October 1, 2022, in order for an urban or rural hospital to receive a rural track FTE limitation, greater than 50 percent of the program must occur in a rural area."[25]

Q 20. Are any federal funds available to assist hospitals that want to start RTPs?

A The Health Resources and Services Administration (HRSA) provides grant opportunities that could benefit organizations considering participating in an RTP. For instance, the HRSA-administered Rural Residency Planning and Development Program provides grants that can be used to assist urban and rural hospitals with some startup costs associated with new RTPs. Please review the grant opportunities posted periodically on the HRSA website for more information (hrsa.gov). Some states may have funding available, too. (Information about state funding is beyond the scope of this guide.)

Notes

1. Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106–113) (1999).

2. For more information about the formulas CMS uses to calculate GME payments, see the CMS Direct Graduate Medical Education website, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME.

3. Balanced Budget Act of 1997 (Pub. L. No. 105-33) (1997).

4. 42 CFR § 412.64(b)(1)(ii).

5. For information about the Acute Inpatient Prospective Payment System (IPPS), see the CMS website, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS.

6. Nursing facility is defined at 42 CFR § 57.302.

7. Resident is defined at 42 CFR § 415.152.

8. Physician is defined at 42 CFR § 405.400.

9. Balance Budget Refinement Act of 1999, Pub. L. No. 106-113 (1999).

10. Consolidated Appropriations Act of 2021 (Pub. L. No. 116-260) (2020).

11. 42 CFR § 413.79(k).

12. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals; Changes to Medicare Graduate Medical Education Payments for Teaching Hospitals; Changes to Organ Acquisition Payment Policies, 86 Fed. Reg. 73453 (Dec. 27, 2021).

13. 42 CFR § 413.78.

14. 42 CFR § 413.78(g).

15. As of August 2021, 31 rural hospitals were over their DGME cap by at least 1.0 FTE, and 33 rural hospitals were over their IME cap by at least 1.0 FTE. These data are based on the AAMC's analysis of FY 2019 Medicare cost-report data from the Healthcare Cost Report Information System (HCRIS), July 2021 release. If FY 2019 data were not available, FY 2018 data were used. The hospitals included were AAMC members as of July 2021.

16. The ACGME offers a Rural Track Program designation for training programs, but the ACGME designation is not required for Medicare payment purposes.

17. Hospitals with established separately accredited family medicine RTT programs may take advantage of the updated RTP.

18. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals, 86 Fed. Reg. 73449 (Dec. 27, 2021).

19. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals, 86 Fed. Reg. 73456 (Dec. 27, 2021).

20. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals, 86 Fed. Reg. 73455 (Dec. 27, 2021).

21. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals, 86 Fed. Reg. 73457 (Dec. 27, 2021).

22. 42 CFR § 413.79(k)(3).

23. 42 CFR § 413.79(k)(6).

24. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals, 86 Fed. Reg. 73450 (Dec. 27, 2021).

25. 42 CFR § 413.79(k)(5).

If you have any questions about the information contained in this guide, please contact the AAMC at GMEQuestions@aamc.org.

Association of
American Medical Colleges
655 K Street, NW, Suite 100, Washington, DC 20001-2399
T 202 828 0400
aamc.org

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