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Rural Training Track Programs: A Guide to the Medicare Requirements

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Introduction

Rural Training Track (RTT) programs provide an opportunity for urban and rural hospitals and nonhospital clinical settings to promote rural training by forming residency programs in partnership. This Association of American Medical Colleges (AAMC) publication guides hospitals through the complex regulations related to creating RTTs. Adherence to these regulatory requirements is necessary for urban hospitals to build an additional rural training track cap—separate from their 1996 graduate medical education (GME) cap—specifically for the residents in new RTT programs. Additionally, rural hospitals and clinical settings can add slots to their cap by participating as the rural partner in a new RTT program. The AAMC is providing this resource to help members better understand and make use of the pathways available to engage in rural training.

If you have any questions about the information contained in this document, please contact Health Care Affairs at the AAMC: 202-828-0490.

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Q What is a Medicare Rural Training Track (RTT) program, and why might hospitals interested in training primary care physicians create RTT programs?

A Rural Training Track (RTT) programs provide an opportunity for urban hospitals, rural hospitals, and nonhospital clinical settings to form partnerships to train residents to practice in rural areas. An urban hospital and either a rural hospital or a rural nonhospital clinical training site(s) can together form a separately accredited RTT program. If residents in an RTT program train in a rural hospital or at rural nonhospital sites for more than one-half of their training, and each of the providers participating in the RTT program complies with the Medicare-established conditions for these programs, the urban teaching hospital can receive additional Medicare funding beyond its Medicare-funded graduate medical education (GME) caps to train residents in the RTT program.¹

RTT programs are designed to help alleviate ongoing shortages of primary care physicians in rural areas. Studies have shown that physicians who are trained in RTT programs are more likely to practice in rural settings than those who train in traditional family medicine residencies.

Q What is a GME “cap”?

A To better understand GME caps, it is helpful to know a little more about how Medicare helps defray the cost of training residents.

In enacting the Medicare program in 1965, Congress recognized that providing health care insurance to the 65-and-older population would be effective only if there were enough doctors to care for those individuals. Congress noted that educational activities enhance the quality of care and decided that Medicare should bear some of the educational costs.

Medicare makes payments to support GME using formulas that are tied to the number of resident full-time equivalents (FTEs) training in a hospital in a given year. This is true for both types of GME payments: direct graduate medical education (DGME) payments, which are intended to cover Medicare’s share of the costs directly related to educating residents (for example, residents’ stipends and fringe benefits), and indirect medical education (IME) payments, which are intended to partially compensate for higher patient-care costs at teaching hospitals as a result of the presence of learners, treating more complex patients, and staffing burn units, ICUs, and providing other specialized services around the clock.

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¹ 42 CFR § 413.79(k)(1)-(2)

(Answer Continued)

A At the same time, Medicare GME support is limited. This includes capping the number of Medicare-supported residency positions at each institution based on the number of FTEs the institution was training in 1996. These DGME and IME caps were imposed when Congress passed the Balanced Budget Act of 1997. **Today, even if a teaching hospital is currently training many more residents than it did in 1996, Medicare will make payments only for the number of FTEs that the institution was training in 1996.** However, rural hospitals received a cap based on 130 percent of the number of residents training at that time, which left them some room to grow their training programs. Additionally, each hospital actually has two caps; one for DGME payments and one for IME payments, and the cap numbers may be slightly different based on rules for how residents were counted in 1996.

These GME caps are permanent, and there are few ways to obtain additional Medicare funding to train residents. One of the few exceptions is being able to count additional FTEs in RTT programs, which helps alleviate physician shortages in rural areas.² There is also a separate exception to the 1996 caps that allows rural hospitals to add new medical residency programs (but not to expand current programs) and increase their caps. A rural hospital can increase its 1996 caps only if it is establishing a truly new program (with a new program director, new staff, and new residents).³

Q How can hospitals receive additional payments from Medicare to train residents in an RTT program?

A Urban teaching hospitals may receive additional DGME and IME funding for the number of residents in an RTT program for the time those residents train at their institutions, up to what is known as the “RTT FTE limitation.” In this document, we will refer to this limitation as the “RTT Cap.” **This means that an urban teaching hospital that forms an RTT program gets a separate cap to provide RTT FTE funding (even beyond its 1996 GME caps) for the time that residents in the RTT program spend training in the urban hospital, if it follows the regulations related to RTT programs.** Note, however, that if an urban hospital with an RTT program is training more resident FTEs than its 1996 caps, that hospital may not include in its RTT Cap the resident FTEs who are training in a rural track residency program who already were included as part of the hospital’s FTE cap.⁴

If a rural teaching hospital is establishing a new RTT program with an urban teaching hospital, then the exception to the GME caps that allows rural hospitals to add new medical residency programs applies, and the rural teaching hospital’s cap will be increased to account for the new program.

² Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2015 Rates; Final Rule, 79 *Fed. Reg.* 49854, 50113 (Aug. 22, 2014)

³ *Id.* at 50105. See also, 42 C.F.R. § 413.79.(e)(3).

⁴ 42 C.F.R. § 413.79(k)(1)

Q Where can the regulations that govern RTT programs be found?

A They can be found in the U.S. Code of Federal Regulations at [42 CFR § 413.79\(k\)](#).

Q How long does a hospital starting a new RTT program have to establish its RTT Cap?

A A rural hospital has a five-year period to establish its RTT Cap for a new RTT program. An urban hospital has five years to establish its RTT Cap.⁵

Q What type of accreditation does the Centers for Medicare and Medicaid Services (CMS) require for RTT programs?

A RTT programs must be separately accredited specifically as RTT programs by the Accreditation Council for Graduate Medical Education (ACGME).

Q How much time does an RTT program resident need to spend training in a rural area?

A More than one-half of a resident's training must occur in a rural area for the urban hospital to be eligible to receive payment for residents in the RTT program up to the RTT Cap. If this condition is met, the urban hospital may then include in its FTE count the residents in the RTT program for the time they train at the urban hospital or in any affiliated nonhospital sites, not to exceed the RTT Cap.⁶

⁵ *Id.* at § 413.79(e)(1)(iii)

⁶ *Id.* at § 413.79(k)(1)-(2)



Q How do urban hospitals establish an RTT Cap, and how are they paid while it is being established?

A For the first five years, a new RTT program at an urban hospital will be paid based on the actual number of FTE residents training in the RTT program at the urban hospital, subject to a three-year rolling average.⁷

In the FY 2017 IPPS final rule, CMS clarified the RTT cap-calculating regulations to conform to the cap-building rules for new teaching hospitals, under which cap calculations are apportioned among all training sites that train residents during the cap-building period.⁸

The RTT Cap will be a product of (1) the highest number of residents in any program year (PGY) who, during the fifth year of the RTT’s existence, are training at all the hospitals to which the residents in that program rotate; (2) the number of years in which the residents are to complete the family medicine residency program based on minimum accredited length; and (3) the ratio of the number of FTE residents that trained at the urban hospital over the course of the five-year cap-building period to the total duration of the program.

New Family Medicine RTT Program FTE Count at Urban Teaching Hospital

	Year 1		Year 2		Year 3		Year 4		Year 5	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
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

The rural track FTE limitation is equal to the product of (1) the highest number of residents in any program year who, during the fifth year of the rural track’s existence, are training in the rural track at the rural nonprovider site(s) and (2) the ratio of the length of time in which the residents are training only at the rural nonprovider site(s) to the total duration of the program.

Multiply the highest number of residents in any program year by the number of years to complete the family medicine program:

Highest number of FTE residents training in any program year = 2

Minimum accredited length of family medicine program = 3

2 x 3 = 6 → **Urban Hospital Cap Before Apportionment = 6**

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

The ratio of the number of FTE residents in the new program that trained at the urban hospital over the entire five-year period to the total number of FTE residents that trained at all hospitals over the entire five-year period = 11.1/24 = **0.46**

The urban hospital’s RTT Cap will be the product of all three factors:

6 x 0.46 = 2.76 → **Urban Hospital RTT Cap = 2.76**

⁷ *Id.* at § 413.79(k)(1)(i)

⁸ 81 *Fed. Reg.* 56762, 57027-57031 (Aug. 22, 2016)

Q How are hospitals paid while establishing the RTT Cap if RTT residents are rotating to rural, clinical nonhospital sites (e.g., physician offices)?

A **When an urban hospital rotates residents to rural clinical nonhospital sites (and pays stipends and benefits for those residents), the urban hospital may include those residents in its FTE count up to the RTT limitation.** The RTT Cap is established a little differently in this context than if the urban hospital is rotating residents to a rural hospital when building the RTT.

As noted previously, when an urban hospital rotates residents to rural hospitals, the RTT Cap is determined at the beginning the sixth year of the RTT program's existence by determining the product of the highest number of residents in any PGY who, during the fifth year of the RTT, are training in the rural track at the urban hospital or the rural hospital(s) and are designated from the beginning as RTT residents, multiplied by the number of years those residents are training at the urban hospital.⁹

When residents are rotated to rural nonhospital sites, the RTT Cap is established the same way, with one important **exception**. Instead of multiplying the highest number of RTT-designated residents in any PGY by the number of years the residents are training at the urban hospital, **multiply by the number of years in which the residents are expected to complete each program based on the minimum accredited length for the type of program (the IRP).**¹⁰

Using the previous example, if residents trained in rural nonhospital settings for their second and third years instead of at a rural hospital, the urban hospital's RTT Cap would be 6 instead of 2.76.

Highest number of residents in any PGY who, during the fifth year of the RTT, are training in the rural track at the urban hospital and the rural nonhospital site(s) and are designated from the beginning as RTT residents = 2

The number of years in which the residents are expected to complete each program based on the minimum accredited length for a family medicine program (the IRP) = 3

$2 \times 3 = 6 \rightarrow$ Urban Hospital RTT Cap = 6

This is because hospitals may not count time residents spend rotating to another teaching hospital, but they may count the time residents spend rotating to clinical nonprovider sites.

⁹ *Id.* at § 413.79 (k)(1)(ii)

¹⁰ *Id.* at § 413.79(k)(2)(ii)

Q Can a rural hospital expand its FTE cap by partnering with an urban hospital with an *existing* RTT program?

A No. A rural hospital can get a cap adjustment (more slots) only for starting truly new programs. **If an urban hospital with an established RTT program begins rotating residents to a rural hospital (that did not start the program with the urban hospital and participate in the first three years training the RTT residents), the rural hospital cannot get any extra slots for being part of the RTT program.** This means that if an urban hospital wants to rotate residents to a few different rural hospitals, any rural hospital that did not start the RTT program with that urban hospital will not get any extra slots to train those residents because it will not be considered a new RTT program.

Q What happens if the urban hospital rotates RTT residents to the rural hospital for less than the amount of time required?

A Meeting the time requirement is essential to being able to receive Medicare funding for residents training in RTT programs. If the time requirement is not met for a particular resident, a rural hospital that is training above its FTE cap and is not in the process of starting a new program may not count that RTT resident. Similarly, the urban hospital may not count those residents toward its RTT Cap.¹¹

Q How does CMS ensure that hospitals with RTT programs meet the RTT requirements?

A **If an urban hospital ends an RTT program, CMS will terminate the hospital's RTT Cap (thereby eliminating the hospital's ability to count residents in an RTT program for any FTEs that exceed its GME cap).** Additionally, if a resident begins training in the RTT program and leaves before the rural training portion, the urban hospital may receive payment only for the portion of the time the resident trains at the urban hospital if another resident fills the vacated FTE slot and completes the rural portion of the training.¹²

If CMS discovers during the hospital's three-year reopening period for its cost report that residents included in the urban hospital FTE count did not complete training in the rural area, CMS will reopen the urban hospital's cost report and adjust the hospital's GME payments (and where applicable, the hospital's rural track FTE limitation).¹³

¹¹ *Id.* at § 413.79(k)(3)

¹² *Id.* at § 413.79(k)(5)(iii)

¹³ *Id.* at § 413.79(k)(6)

Q What hospitals are in “rural” areas, such that Rural Training Track (RTT) residents can rotate there under this program?

A The hospital impact file posted on CMS’s [website](#) lists all hospitals by Medicare provider number. If a two digit code is indicated for the geographic labor market area of a particular hospital, then CMS considers the hospital to be rural.

Q What happens if a rural hospital in an RTT is reclassified as urban?

A The FY 2015 Hospital Inpatient Prospective Payment Systems (IPPS) final rule included FY 2015 Core Based Statistical Areas (CBSAs) based on updated (2010) Census data. In the rule, CMS states that **if an urban hospital’s RTT trains residents in a rural hospital that is reclassified as urban, there will be a transition period during which the formerly rural hospital must classify back to rural or the urban hospital must find a new rural partner.** The transition period will begin on the date of the implementation of the new Office of Management and Budget (OMB) delineations (October 1, 2014) and will extend through the end of the second residency training year following the implementation date of the new OMB delineations (September 30, 2016).¹⁴

It is important to note that if the formerly rural hospital reclassifies back as rural, **the rural hospital would only receive IME funding** (not DGME funding because of statutory language).¹⁵ It could prove difficult for the urban hospital to find a new rural partner because any rural hospital that would partner with the urban hospital in an existing RTT program will not be permitted to expand its GME cap. As noted above, a rural hospital can get a cap adjustment only for starting truly new programs. Because the urban hospital in this scenario would be looking for a rural partner for its **existing** RTT program, any rural hospital it partners with would not get additional funded slots for training residents in the RTT program.

The FY 2015 IPPS final rule also states that if the rural hospital has received a letter of accreditation for the RTT program or already has started to train residents in a program when the rural hospital is redesignated as urban, the rural hospital still may receive a permanent cap adjustment for the new program after the five-year cap-building period.¹⁶ If an urban hospital’s rural partner is reclassified as urban during the original urban hospital’s three-year cap-building period for its RTT Cap, the original urban hospital has a two-year transition period (lasting through September 30, 2016, which is the end of

¹⁴ 79 *Fed. Reg.* at 50114-50115

¹⁵ *Id.* at 50117

¹⁶ *Id.* at 50112

(Answer Continued)

A the second residency training year following the implementation date of the new OMB designations) during which the formerly rural hospital would have to classify back to rural or the urban hospital would have to find a new rural partner.¹⁷ If these conditions are not satisfied during the two-year transition period, but one of the conditions is satisfied at a later point, the original urban hospital would be able to receive an RTT FTE limitation based on the training that occurred from July 1, 2014 through June 30, 2017.¹⁸

If at a later point, the original urban hospital decides to develop an RTT program in a different specialty with a different rural partner, it would be able to receive a separate RTT Cap for the RTT program in that different specialty.¹⁹ Given that this would be a new program, the new rural partner also would be able to get slots for the time that the residents in this new RTT program spend training at the rural hospital.

Q **What documentation is required if an urban hospital wishes to count FTE residents in rural tracks up to the hospital's RTT FTE limitation?**

A The urban hospital must have written contemporaneous documentation that it intended for each resident enrolled in the RTT to be rotated to a rural area for more than half of the residency program. The hospital must follow through and rotate the residents to the rural area accordingly and base its count of residents in the rural track on this documentation.²⁰

¹⁷ *Id.* at 50114

¹⁸ *Id.* at 50116

¹⁹ *Id.* at 50116-50117

²⁰ 42 CFR § 413.79(k)(5)(ii)-(iii)