CMS Finalizes Rules for Distribution of 1000 New Medicare-Funded Residency Positions and Changes to Rural Training Track Programs

Kristin Schleiter Hitchell, JD, LLM
Lauren Johnson, EdD, MNA

In 2020, Congress passed legislation to expand eligibility for rural training track (RTT) funding and add 1000 new Medicare-funded positions for the first time since 1997. In August 2021, we discussed proposed rules the Centers for Medicare and Medicaid Services (CMS) put forward to guide the parameters of both programs.[1] This follow-up article summarizes core concepts of both expanded programs and explains the December 2021 final rule in which CMS finalized details about how it will implement them.

Consolidated Appropriations Act of 2021 and COVID-19 Relief Bill

In December 2020, the fiscal year (FY) 2021 omnibus spending bill, the Consolidated Appropriations Act of 2021 (CAA), was signed into law.[2] The CAA extended certain graduate medical education (GME) training programs through FY 2023, including the Teaching Health Center GME program, the National Health Service Corps, community health centers, and the Children's Hospitals GME program. Many programs critical to GME, including the Children's Hospitals GME program, received increased funding from last year's levels.

In addition, the CAA contained 3 provisions affecting Medicare direct GME (DGME) and indirect medical education (IME) payments to teaching hospitals. Section 126 of the CAA makes available 1000 new Medicare-funded GME positions (but no more than 200 new positions each FY), to be distributed beginning in FY 2023, with priority given to hospitals in 4 statutorily specified categories.

Section 127 of the CAA makes statutory changes relating to the determination of both urban and rural hospitals' full-time equivalent (FTE) limit for DGME and IME payment purposes with regard to residents training in an accredited RTT, and the 3-year rolling average used to calculate payments for these hospitals.

Section 131 of the CAA makes statutory changes to the determination of direct GME per resident amounts and DGME and IME FTE resident limits of hospitals that hosted residents for a short duration.

Each of these provisions will be discussed in turn, along with information from the final rules CMS published in December 2021 that included details on how CMS will implement the new provisions.[3]

1000 New CMS-Funded Residency Positions

The spending measure added 1000 new Medicare-funded residency positions for the first time since 1997. The framework resembles the recurrent Resident Physician Shortage Reduction Act, which has been reintroduced in the 117th Congress and calls for an additional 14 000 positions to be funded.

Until now, increases for urban teaching hospitals with resident caps set at the time of the Balanced Budget Act of 1997 have only occurred from policy changes directing the redistribution of existing residency slots. The new provision lifts the cap on Medicare-funded positions by creating 1000 new DGME and IME slots beginning October 1, 2022. Starting in FY 2023, CMS will award no more than 200 slots per year until the 1000 spots are filled. Final rules released in December 2021 provided guidance on how the slots will be awarded.

High-Priority Hospital Categories

The new law establishes some parameters for the new slots, including what kind of hospitals qualify. For example, at least 10% of the slots must be awarded to hospitals in each of the following categories:

- Category 1–Hospitals in a rural area or treated as being in a rural area for payment;
- Category 2–Hospitals training residents above the DGME and IME caps;

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- Category 3–Hospitals in a state with new medical schools, additional locations, or branch campuses; or
- Category 4–Hospitals serving Health Professional Shortage Areas (HPSAs; primary care, mental health, dental health, and geographic), counting toward the 50% requirement any program training that occurs in a primary care or mental health only geographic HPSA at scheduled program training sites, including non-provider settings and Veterans Affairs facilities, and training time spent in American Indian and tribal facilities outside of a HPSA to a limited extent. This means that the applicant hospital itself will not be required to be physically located in a geographic HPSA in order to be eligible for Category 4.

There are also rules for receipt of the slots—for example, hospitals must agree to increase the number of residency positions by the same number as the additional slots. There are also payment rules for receipt of the slots.

How Many Positions May Be Requested

CMS initially proposed limiting the increase in residency positions made available to no more than 1.0 FTE for each hospital (not each program) each year. However, comments submitted through the open comment period suggested that this limit was insufficient to establish a new residency program or meaningfully expand an existing residency program, particularly for hospitals in rural and underserved areas. Commenters also suggested that this limit would result in an impractical, unpredictable, and burdensome application process. As such, CMS reconsidered its proposal, and according to the final rule, will allow hospitals to receive a maximum of 5.0 FTE residency positions per year.

CMS will adjust the size of the award to the length of the program for which a hospital is applying, with 1.0 FTE awarded each year 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 3-year program may request up to 3.0 FTEs per fiscal year. A hospital applying to train residents in a 5-year program may request up to 5.0 FTEs per fiscal year.

Demonstrated Likelihood of Filling Positions

In determining which hospitals will receive new residency positions, CMS must consider the likelihood of the hospital filling the positions made available within the first 5 training years after the increase would go into account. Under the policy finalized in the final rule, a hospital must demonstrate that it does not have sufficient room under its current FTE resident cap(s) to accommodate a planned new program or expansion of an existing program, and that it intends to use the additional FTEs to establish a new residency program or expand an existing residency program. Hospitals can demonstrate this likelihood in several ways (see the BOX).

BOX Demonstrated Likelihood of Filling Positions

Under "Demonstrated Likelihood Criterion 1 (New Residency Program)" a hospital must meet at least one of the following conditions:

- An application for a new residency program has been submitted to the ACGME (or application for approval of the new residency program has been submitted to the ABMS); or
- The hospital has received written correspondence from the ACGME (or ABMS) acknowledging receipt of the application, or other information concerning the accreditation process, such as notification of a site visit.

Under "Demonstrated Likelihood Criterion 2 (Expansion of Existing Residency Program)" a hospital must meet at least one of the following conditions:

- The ACGME (or ABMS) has approved the hospital's request to expand a residency program;
- The hospital submitted a request for a permanent complement increase for its residency program; or
- The hospital has unfilled positions in its residency program that have previously been approved by the ACGME, and the hospital is now seeking to fill these positions.

Under "Demonstrated Likelihood Criterion 2," the hospital must, as part of its application, attest to increase the number of residency positions by the amount the hospital's FTE residency caps are increased based on the potential newly awarded positions.

The new law requires CMS to report back at least twice on distribution of the new positions and where the physicians who filled those slots went on to practice.

Application Process and Deadlines

CMS will engage in a separate round of applications for the new slots, with applications to be submitted March 31 of a FY for positions, effective July 1 of the following FY. For FY 2023, the application deadline was March 31, 2022. The completed application must be submitted using an online application available on the CMS DGME website.[4]

Changes to Rural Training Track Rules

The spending bill eased RTT requirements to provide greater opportunity for Medicare funding for permanent DGME and IME cap increases for hospitals that

develop rural-urban partnerships to address the physician workforce needs of rural areas.

Medicare rules include an RTT provision incentivizing urban hospitals to partner with hospitals and other settings in rural areas to cross-train residents. However, several challenges were identified:

- Only the urban hospital and not the rural hospital in an urban-rural partnership was allowed to receive additional cap slots based on the time the residents in the RTT trained at the hospital;
- No cap adjustment was allowed when an urban hospital added rural locations to an existing RTT;
- The residency program was required to be "separately accredited" with approved residency training tracks in a rural area, which in practice, limited RTTs to family medicine programs; and
- Residents added to an RTT were not exempt from the 3-year rolling average for IME and direct GME.

The CAA addressed these concerns in several ways.

Elimination of Separate Accreditation Requirement

First, the new law removes the requirement that RTTs be separately accredited programs. Instead, CMS has proposed that any ACGME-accredited program may qualify as an RTT if all other requirements are met, such as the requirement that greater than 50% of the program occur in a rural area. This provision will go into effect for cost reporting periods beginning on or after October 1, 2022.

The CAA also authorizes both urban and rural hospitals to be eligible for DGME and IME cap increases. According to the final rule, both rural and urban hospitals with an RTT will be authorized to include in their FTE counts the time RTT residents train in the urban and rural hospital, respectively.

Expanded Eligibility for RTT Funding Cap

The CAA also removed previous language stating that hospitals would be eligible for cap adjustments only if the applicable residency program was deemed to be a newly established program. Now, both urban and rural hospitals may receive a rural track FTE limitation each time an RTT is established for the first time, even if the RTT program doesn't meet newness criteria for Medicare payment purposes.

However, CMS wants to be judicious in its approach. As such, CMS will *not* allow increases where the urban and rural hospitals add FTE residents to an existing participating site. For example, Urban Hospital A with a rural track in family medicine at Rural Hospital A could not add more family medicine residents to that program and expect those spots to be funded by the RTT program.

CMS will adjust the urban and rural hospital FTE limitations in the instance when additional residents are recruited to add a new rural RTT participating site in the same specialty. To take the previous example, Urban Hospital A with a rural track in family medicine at Rural Hospital A could add a second rural track in family medicine at Rural Hospital B. CMS has stated that allowing experienced urban primary clinical sites to branch out and partner with additional rural communities rather than starting from scratch is an efficient means of addressing rural health care workforce shortages.

CMS also will allow an urban hospital with an existing RTT in a specialty to receive an adjustment to its rural track FTE limitation if it starts another RTT in a different specialty. CMS will not consider the RTT in a different specialty an expansion of an existing RTT. So, Urban Hospital A with an RTT in family medicine at Rural Hospital A could add a new rural track in psychiatry at Rural Hospital A.

CMS has observed that slots are fungible, and as such, urban and rural hospitals with multiple RTT participating sites may reallocate the number of FTE residents training at each track in order to accommodate increases or decreases in training and funding at such participating sites.

Finally, the revised rules provide that, while the RTT specialty cap is being built, both the rural and urban hospitals are eligible for a temporary exemption from the 3-year rolling average rule and the intern and resident-to-bed ratio cap rule. This change mirrors the exemption from these rules for hospitals creating new residency programs and is intended to fix a temporary lag in DGME and IME payments when the RTT specialty cap is being built—a particular challenge to rural hospitals' ability to participate in RTTs. The method for calculating cap assignments and adjustments is outlined in detail in the final rule.

New Definitions

Consistent with ACGME terminology, and in the interest of clarity and transparency, CMS is adopting new terminology for its RTT program, starting with the name of the program itself. The program will now be called the "Rural Track Program." New definitions are as follows:

- Rural Track Program: For the cost reporting period 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)..."[3]
- Primary Clinical Site: The urban hospital participating in the Rural Track Program. CMS adopted the term "Primary Clinical Site" in lieu of the term "Hub," which it used throughout the proposed rule. In its final rule, CMS notes that the ACGME defines a Primary Clinical Site as the primary facility designated for clinical instruction in the program.
- Participating Site: The various other training locations participating in the Rural Track Program. CMS referred to these locations as "spokes" in its proposed rule. In its final rule, CMS clarifies that rural hospitals will be referred to as "Rural Hospital Participating Sites," and other sites such as ambulatory clinics or non-hospital sites will be referred to as the "Rural Non-Provider Participating Site." Also in the final rule, CMS notes that the ACGME defines a participating site (not necessarily rural) as an organization providing educational experiences or educational assignments/rotations for residents and fellows.

Fix for Artificially Low Cap

The spending bill eliminated the CMS penalty imposed on certain community hospitals that have hosted "rotator" residents for brief periods. CMS will now allow those hospitals to establish new residency programs without limitations on the number of residency slots. It will also allow hospitals to host a certain number of medical residents for short-term rotations without triggering the permanent FTE resident cap or per-resident amounts (PRAs).

The provision is structured to delay the establishment of the PRA, DGME cap, and, if applicable, IME cap, or to provide a "restart" opportunity for hospitals that had their PRAs and Medicare GME caps inadvertently set because of a small number of residency rotations.

The section sets a new threshold amount level below which CMS is not permitted to calculate hospital-specific amounts in the future. It also provides an opportunity for more reasonable PRAs and Medicare GME caps for certain hospitals for future payment periods, if the hospitals have already had those amounts set at low levels.

CMS will categorize hospitals based on the current cap to determine when a hospital's cap-building period will start or be reset.

The FTE resident cap adjustment will 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 of each type of program; and
- The ratio of the number of FTE residents in the new program who trained at the hospital over the 5-year period to the total number of FTE residents who trained at all hospitals over the 5-year period.

The final rule specifies that CMS will reset the FTE resident caps only when a hospital "begins training" residents in a new residency program. That is, the rule applies when the hospital begins to train the requisite number of residents for the first time on or after enactment of the CAA (December 27, 2020) and up to 5 years after (December 26, 2025). In its final rule, CMS highlighted a one-time opportunity for Category B hospitals for which there are open or reopenable cost reports and that believe the PRA or its IME and/or DGME FTE caps were established based on no more than 3.0 FTEs, to request reconsideration by the Medicare Administrative Contractor on or before July 1, 2022.

The opportunity to reset the FTE resident cap will not be afforded to hospitals that trigger low caps or PRAs after enactment of the Consolidated Appropriations Act of 2021. CMS plans to issue instructions to Medicare Administrative Contractors and hospitals to provide for an orderly process of request and review for the purpose of receiving replacement PRAs.

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Kristin Schleiter Hitchell, JD, LLM, is Vice President, Public Policy and External Affairs, Accreditation Council for Graduate Medical Education (ACGME); and **Lauren Johnson, EdD, MNA,** is Associate Director, Public Policy, ACGME.

Corresponding author: Kristin Schleiter Hitchell, JD, LLM, Accreditation Council for Graduate Medical Education, khitchell@acgme.org