May 2024

FAQs on Section 127 of the CAA, 2021 Regarding Residents Training in Rural Track Programs (RTPs)

On December 27, 2021, CMS issued the FY 2022 IPPS final rule with comment period (86 FR 73416) implementing changes to Medicare graduate medical education (GME) payments for teaching hospitals. The rule implements the legislative changes to direct GME and indirect medical education (IME) payments to teaching hospitals included in sections 126, 127, and 131 of the Consolidated Appropriations Act (CAA), 2021.

This is a revised version of a documented initially published on the CMS website in November 2022 that provides answers to certain questions we have received pertaining to residents training in RTPs under section 127. In this document we correct erroneous policy statements present in the original version. Changes made in this revised document are effective prospectively.

For more detailed guidance on section 127:

- Refer to the final rule for full guidance at CMS-1752-FC3.
- Refer to CR 12709, Transmittal 11366, issued April 28, 2022, which provides guidance to hospitals and instructions to the MACs on how to review and implement requests to increase hospitals' IME and direct GME interim rates (and, eventually, rural track FTE limitations) due to participating in new RTPs and/or adding clinical participating sites to existing RTPs.

How does § 412.103 status affect IME and/or DGME reimbursement for an RTP?

Under section 1886(d)(8)(E) of the Act (as implemented in the regulations at § 412.103), hospitals that are geographically urban may opt to reclassify as rural if they meet certain criteria. Pursuant to our current regulations at 413.79(k)(7)(iii), for purposes of rural track programs, hospitals with a § 412.103 reclassification are treated as rural for IME, but remain urban for DGME.

> *Because* § 412.103 *hospitals are considered rural for IME, they can serve as a rural site in an RTP for IME purposes (i.e., additional IME RTP FTE limitations would be granted for training at a* § 412.103 *hospital). However, a* § 412.103 *hospital cannot serve as a rural site in an RTP for DGME purposes (i.e., no additional DGME RTP FTE limitations would be granted for training at a* § 412.103 *hospital). For similar reasons, while a* § 412.103 *hospital cannot serve as the urban site in an RTP for IME purposes, it can be an urban site for DGME purposes.*

What would be the effect on IME and DGME payments if a geographically urban Hospital A (no reclass) partners with another geographically urban Hospital B that has a § 412.103 reclass to use Hospital B as the rural participating site in an RTP?

Hospital A will NOT receive a DGME RTP FTE limitation in this case, as Hospital B is geographically urban for DGME purposes. Hospital A would receive an IME RTP FTE limitation if greater than 50 percent of the program was spent training at Hospital B. (See 86 FR 73455). Hospital B would also receive an IME RTP FTE limitation, but would not receive a DGME RTP FTE limitation.

What would be the effect on IME and DGME payments if two geographically urban hospitals that both reclassify themselves under § 412.103 partner, where Hospital A serves as the "urban" site, and Hospital B serves as the "rural" site?

Neither Hospital A nor Hospital B would receive any RTP FTE limitations under this arrangement. Since Hospitals A and B are both urban for DGME purposes, there can be no RTP in this case, since an RTP by definition involves an urban area for less than 50 percent of the training, and a rural area for more than 50 percent of the training. Similarly, there is no RTP for purposes of IME payment, since both Hospitals A and B are treated as rural for IME purposes and neither can be considered the "urban" site. Thus, two geographically urban hospitals that both reclassify under § 412.103 could not partner with one another and form an RTP. (See further 86 FR 73455.)

(Note: This response has been revised. The original version stated that Hospital B could receive an IME RTP FTE limitation in this scenario.)

Hospital C is a geographically rural hospital in a rural area. It has an established residency program and existing IME and DGME caps. It wants to start a residency program including rotations at nonprovider sites in another rural location. More than 50 percent of resident time would be spent there. Would Hospital C qualify for an RTP cap adjustment?

No. Hospital C is geographically rural. The nonprovider sites are also rural. That is not an RTP. RTPs by definition involve an urban area for less than 50 percent of the training, and a rural area for more than 50 percent of the training. Under 42 CFR 412.105(f)(1)(vii) and 413.79(e)(3), respectively, rural hospitals may receive IME and DGME FTE cap increases at any time for participating in training residents in new programs. Therefore, Hospital C may receive a "regular" IME and DGME FTE cap increase if it starts a new program.

Hospital D is a geographically urban hospital with a § 412.103 reclass and existing IME and DGME caps. Hospital E is a geographically rural hospital with existing IME and DGME caps. They want to partner to create a brand new program in a specialty that neither has trained before. What would the effect be on the IME and DGME caps of both hospitals?

Scenario 1 – NOT an RTP - Residents spend 75 percent of the training in urban Hospital D, and 25 percent of the training at rural Hospital E:

Since this is a brand new program, Hospital D (as a rural hospital for IME purposes) can get an adjustment to only its IME cap for time spent training at Hospital D. Hospital E can get a new program adjustment to both its IME and DGME caps.

Scenario 2 – An RTP – Residents spend less than 50 percent of the training at urban Hospital D, and more than 50 percent of the training at rural Hospital E:

Since Hospital D is urban for DGME purposes and rural for IME purposes, while Hospital E is rural for purposes of both DGME and IME, this program qualifies as an RTP for purposes of DGME payment only. Thus, both Hospitals D and E may receive a DGME RTP FTE limitation for this program. Additionally, since this is a brand new program, both Hospitals D and E may receive a new program adjustment to their IME caps under § 412.105(f)(1)(vii).

Note – On the Medicare cost report Form CMS-2552-10, Worksheets E, Part A for IME and E-4 for DGME, Hospitals D and E must be careful to report FTEs in this new program on the appropriate lines for either new programs or for an RTP. Note that in Scenario 2, both Hospitals D and E would report the FTEs on Worksheet E, Part A on the new program lines, while they would report the FTEs on Worksheet E-4 on the RTP lines. In Scenario 1, Hospital E (as a geographically rural hospital) would report the FTEs on the new program lines on both Worksheets E, Part A and E-4, while Hospital D (as a rural hospital for IME) would report the FTEs on the new program line of Worksheet E, Part A only. (Form 2552-10 has been revised to reflect recent GME policy changes.)

(Note: This response has been revised. The original version stated that Hospital E could receive an IME RTP FTE limitation under Scenario 2.)

Following is a comment and response from the FY 2022 IPPS final rule with comment period (86 FR 73454-5) about RTPs and § 412.103 reclass that is worth reprinting here:

Comment: A commenter requested that CMS confirm that a hospital that is physically located in an urban area but treated as rural for purposes of payment under the IPPS as implemented in § 412.103 would be considered urban for purposes of meeting the requirements for the RTT provision and would be eligible for both DGME and IME cap adjustments as an urban hospital should it successfully partner with a hospital physically located in a rural area.

Response: Hospitals physically located in urban areas, but that are reclassified to rural areas under 42 CFR 412.103 are treated as rural for IPPS payment purposes, which includes IME. This is because 42 CFR 412.103 affects payments under section 1886(d) of the Act, which are the IPPS payments, and IME is an add-on to the teaching hospital's IPPS payment. However, 42 CFR 412.103 does not affect direct GME because direct GME is addressed under section 1886(h) of the Act. This means that such a hospital is rural for IME purposes, but it is urban for direct GME purposes (because it is still physically located in an urban area). Therefore, we are not confirming the commenter's statement that the urban hospital reclassified as rural under 42 CFR 412.103 would be considered urban for the purpose of meeting the RTP requirements. Rather, the hospital would be rural for IME and urban only for direct GME. We did not propose any changes to this policy. Thus, as long as an urban hospital retains its 412.103 reclassification, CMS would treat that hospital as rural for section 1886(d) purposes, which includes all ramifications to the IME adjustment. With regard to urban hospitals that are reclassified as rural under § 412.103 and participate in RTPs, there are challenges associated with correctly determining the payment implications for an RTP that has, as its primary clinical site, or even as a participating site, a hospital that is rural for IME purposes, but is urban for direct GME purposes. For instance, in determining whether greater than 50 percent of residents' training time occurs in an urban area or a rural area, would the training that occurs in this hospital that is rural for IME but urban for direct GME be counted towards the urban portion or the rural portion? The answer is that for the purpose of qualifying for an adjustment to only the IME FTE limitation, the residents' training time spent in the urban hospital reclassified as rural under 42 CFR 412.103 could count toward the rural portion of training time. However, the hospital would be in the awkward position of needing to send those same residents to train in a geographically rural participating site in order to separately meet the greater than 50 percent rural training requirement to qualify for the adjustment to the direct GME FTE limitation. Urban hospitals reclassified as rural under 42 CFR 412.103 that wish to participate in RTPs may decide that it is preferable both from an educational and economic standpoint to synchronize the time spent in

geographically rural participating sites, so that the IME and direct GME rotations would be synchronized as well. It would also be much easier to document the training time to the MAC for the purpose of receiving the IME and direct GME FTE limitation adjustment.