percent of graduates practicing in rural areas. Most RTTs still do not receive full GME funding for the rural portion of their programs.[1]

Unfortunately, CMS has interpreted the statute to mean that once a cap is set at an urban hospital, for the establishment of a rural training track, no new training tracks at that hospital will be allowed in the same specialty. CMS views the RTT as an expansion of a current residency program, the funding for which is not allowed in statute, rather than as the establishment of a new training program in a new setting for the 2nd and 3rd years. We ask that CMS, using the same statutory authority cited above, allow the establishment of new training tracks by the same urban hospital, in the same specialty, at any time -- and provide for an increase in that urban hospital's cap strictly for the purposes of establishing a new training site whenever a new site is established and in whatever specialty the programs train. The limits on an urban hospital's cap should not be imposed solely on concurrent RTT startups. The establishment of a RTT in a new community should be considered a "new RTT" rather than an expansion of a preexisting RTT, for the purposes of cap-setting in both the urban "mother" hospital and in the rural hospital, no matter when that RTT is established. All FTE residents training in a RTT should be counted and added toward increasing the urban hospital's cap.

4. Artificially Low Caps and Per-Resident Amounts (PRAs) Restrict Medicare GME Funding

Two major limitations in funding rural GME exist based on current rules establishing caps and per-resident amounts. Transient, episodic training of residents in rural hospitals has resulted in artificially low caps on resident training for these hospitals, and artificially low PRAs associated with that hospital. While the rural hospital may expand its cap by establishing a new program, in a different specialty, once the cap is reset, the program cannot expand in the future. Of more concern, the PRA is set forever, even though the hospital has never sponsored a training program, making it unlikely that such a hospital will ever be able to establish a new training program.
While Congress has constrained the growth of Medicare GME spending by limiting the number of residents and costs that a hospital can claim for Medicare GME payments, at the same time it has provided an avenue for non-teaching hospitals, under appropriate circumstances, to establish new teaching programs supported by Medicare GME funding. Unfortunately, however, CMS has imposed limitations on residents and costs in a manner that unfairly penalizes certain hospitals that have, in the past, agreed to allow very small numbers of residents from programs at other hospitals or medical schools to rotate through their facilities for brief periods to enhance those residents' training. Without fair notice, these hospitals have been deemed to be teaching hospitals --- despite neither having been a sponsoring institution, nor claiming IME on their cost reports and permanently saddled with very low resident and cost limits.

We ask that CMS revise its definition of teaching hospital. If a hospital makes no claims for the training of residents in that hospital and is not the institutional sponsor of an accredited, or approved, graduate medical residency program we ask that it not be considered a teaching hospital, and therefore have no cap or PRA established.

We are concerned that CMS, in its rulemaking, has not sufficiently considered its authority to encourage the production of rural physicians. A recent study by Candice Chen, MD, et al, in *Academic Medicine*[2] reports that only 4.8 percent of all graduates of 759 sponsoring institutions practiced in rural areas and 198 of those 759 institutions produced no rural physicians. This

[1] Rural Training Track Technical Assistance Program. http://www.raconline.org/rtt/about_rtts
[2] Candice Chen, MD, et al. Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions. *Academic Medicine*, Vol.88, No. 9. September 2013.